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Advance Directives Document **(Page 1 of 4)**

INFORMATION ABOUT MY SURROGATE DECISION-MAKER(S)

I, _____, appoint _____, whose address is _____, and whose telephone number(s) are: (home) _____ (cell) _____ as my surrogate decision-maker, known in this document as my "Attorney-in-Fact for Healthcare".

I appoint _____ whose address is _____ and whose telephone number(s) are: (home) _____ (cell) _____ as my successor surrogate decision-maker (known in this document as my "Attorney-in-Fact for Healthcare") if the person named above is unavailable or unwilling to make decisions on my behalf.

I authorize these individuals to receive information and to make healthcare and treatment decisions on my behalf if and when it is determined that I am unable to make my own decisions. I give them responsibility for advocating on my behalf for healthcare and treatment that represents my values, beliefs and preferences, and ensures my physical, emotional, and spiritual well-being.

SURROGATE DECISION-MAKING SCOPE

I understand that this Advance Directives document refers specifically to my **general healthcare and treatment needs**. Regarding my mental healthcare and treatment needs (check one below):

☐ I have not completed separate Advance Directives documents for my mental healthcare and treatment needs at this time, and direct the individuals named here to make decisions for my mental healthcare and treatment needs.

☐ I have completed separate Advance Directives documents for my mental healthcare and treatment needs. A copy is located: _____.

(Note: Talk with a member of your healthcare team if you would like information about completing Advance Directives documents for your mental health care and treatment needs.)

SHARING MY INFORMATION

In addition to the individuals listed above, I give my permission for the following people to be given information related to my healthcare and treatment:

(Note: Due to privacy laws, healthcare facilities may need additional HIPAA Authorization forms completed in order to release your Protected Health Information.)

ADDITIONAL INSTRUCTIONS

I direct my surrogate decision-maker(s); my doctors and other healthcare providers to comply with the following instructions regarding my healthcare and treatment needs (check one of the options below):

☐ I have no specific instructions, and direct only that healthcare and treatment decisions made on my behalf reflect my values, beliefs and preferences.

☐ I have specific instructions included in the supplemental information I have provided in this Advance Directives document, and direct that these instructions be taken into consideration when making healthcare and treatment decisions on my behalf.

Person completing this form initial _____ Date: _____

Advance Directives Document (Page 2 of 4)

LIVING WILL DECLARATION

I understand that this section of this Advance Directives document is a Living Will Declaration which tells my doctor or other healthcare providers and my surrogate decision-maker(s) about my preferences regarding life-sustaining treatments or procedures.

Please select from the following options:

☐ I choose **NOT TO** complete a Living Will Declaration at this time, and instruct my doctor, other healthcare providers and surrogate decision-maker(s) to make decisions regarding life-sustaining treatments or procedures that they believe are appropriate and in keeping with my values, beliefs and preferences.

☐ I choose **TO** complete the following Living Will Declaration at this time.

Please select one of the following options:

☐ **For Iowa residents:** I direct that my doctor and any person charged with the responsibility for my care be guided by this expression of my preferences. If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my healthcare decisions, I direct my attending doctor to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

☐ **For Nebraska residents:** I direct that my doctor and any person charged with the responsibility for my care be guided by this expression of my preferences. If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending doctor, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending doctor, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

☐ **For anyone:** I would like to share the following information about my preferences for life-sustaining treatments or procedures as my personal Living Will Declaration.

Advance Directives Document (Page 3 of 4)

MY STATEMENT OF UNDERSTANDING, AGREEMENT & SIGNATURE

STATEMENT OF UNDERSTANDING

I have read this Advance Directives document and understand that it does one or both of the following:

- Allows the individuals I named as my surrogate decision-maker(s) (my "Attorney-in-Fact") to make decisions on my behalf if I do not have the capacity to do so for myself.
- Provides information about my healthcare and treatment preferences.

I also understand that I can change or revoke these Advance Directives documents under the following circumstances:

- **For Nebraska Residents:** I can change or revoke my Durable Power of Attorney for Healthcare document any time I have **decision-making capacity**, and in any manner by which I am able to communicate my intent to revoke. I can change or revoke my Living Will Declaration at any time regardless of my decision-making capacity or physical condition* by notifying my surrogate decision-maker(s) and my doctor or other healthcare provider.

  ***Optional for Nebraska Residents:**
  ____ My initials here indicate that I want to be able to revoke my Living Will Declaration document **only when I have decision-making capacity**.

- **For Iowa Residents:** I can revoke both my Durable Power of Attorney for Healthcare document and Living Will Declaration by notifying my surrogate decision-maker(s) (my "Attorney-in-Fact") and my doctor or other healthcare provider any time **regardless of my decision-making capacity***.

  ***Optional for Iowa Residents:**
  ____ My initials here indicate that I want to be able to revoke my Durable Power of Attorney and Living Will Declaration documents **only when I have decision-making capacity**.

SIGNATURE OF PERSON COMPLETING THIS DOCUMENT (Required)

Printed Name: _____

Signature: _____ Date: _____

REVIEWING MY ADVANCE DIRECTIVES DOCUMENTS

SIGNATURES OF MY DOCTOR AND OTHER HEALTHCARE PROVIDER(S) *(Recommended)*

I have reviewed the information in this Advance Directives document.

Printed Name: _____

Signature: _____ Date: _____

Printed Name: _____

Signature: _____ Date: _____

Printed Name: _____

Signature: _____ Date: _____

SIGNATURES OF MY SURROGATE DECISION-MAKER(S) (MY "ATTORNEY-IN-FACT") *(Recommended)*

I have reviewed the information in this Advance Directives document.

Printed Name: _____

Signature: _____ Date: _____

Printed Name: _____

Signature: _____ Date: _____

Advance Directives Document (Page 4 of 4)

NOTARY OR WITNESS STATEMENT OF UNDERSTANDING, AGREEMENT AND SIGNATURE

NOTARY OR WITNESS OPTIONS (REQUIRED)

In order for this document to be legally valid, **you must complete ONE of the two options** below.

Option 1 – Notarization:

This option requires the person completing this document to have his/her signature notarized. In this case, signatures by witnesses are not necessary.

State of _____. County of _____. On this____day of_____, 20____, before me personally came _____, personally to me known to be the identical person whose name is affixed to this Advance Directives document as principle, and I declare that (he/she) acknowledges the execution of the same to be (his/her) voluntary act and deed, and that I am not the Attorney-in-fact for Healthcare or the successor Attorney-in-fact for Healthcare designated by this Advance Directives document. Witness my hand and notarial seal at _____(place notarized) in such county the day and year last above written.

_____

Signature of Notary Public

Option 2 – Declaration of Witnesses:

This option requires the person completing this document to have his/her signature witnessed by two adult witnesses who meet the state guidelines listed below. In this case, notarization is not necessary.

- **For Iowa residents:** Each witness must be at least 18 years old, and cannot be the attending healthcare provider or an employee of the attending healthcare provider for the person completing this document. Only one witness can be related to the person completing this document.
- **For Nebraska residents:** Each witness must be at least 19 years old, and cannot be the spouse, parent, child, grandchild, sibling, presumptive heir, or known devisees (any person designated in the patient's will to receive real or personal property) ; or the attending doctor of the person completing this document; or the person named as the Surrogate Decision-Maker(s) (Attorney-in-Fact) within this document; or an employee of a life or health insurance provider for the person completing this Advance Directives document. No more than one witness can be an administrator or employee of a healthcare provider who is treating the person completing this document.

We declare:

- That the person completing this document is known to us.
- That the person completing this document signed or acknowledged (his/her) signature on this Advance Directives document in our presence.
- That neither of us, nor the person's attending doctor is the person appointed as the surrogate decision-maker ("Attorney-in-fact") within this document.
- That we meet the guidelines for witnesses as set forth by state law.

This section to be completed by witnesses of both Nebraska and Iowa Residents:

Witness 1 Printed Name: _____

Signature: _____ Date: _____

Witness 2 Printed Name: _____

Signature: _____ Date: _____

This section to be completed by at least one of the witnesses of Iowa Residents only:

I further declare under penalty of perjury under the laws of the State of Iowa that I am not related to the person completing this document by blood, marriage, or adoption within the third degree of consanguinity (relationship).

Witness 1 and/or 2 Signature: _____ Date: _____

This section to be completed for Nebraska Residents only:

We also affirm that (he/she) acknowledges the execution of this document to be (his/her) voluntary act and deed.

Witness 1 Signature: _____ Date: _____

Witness 2 Signature: _____ Date: _____

SUPPLEMENTAL INFORMATION ABOUT MY HEALTHCARE AND TREATMENT PREFERENCES (Page 1 of 2)

I, _____ , on this date _____ would like to provide the following supplemental information to my surrogate decision-maker(s) (my "Attorney-in-Fact"), my doctor and other my healthcare providers, and ask that this information be considered when making healthcare and treatment decisions on my behalf. I understand they will do their best to comply with this information to the extent they are technically, ethically and legally able; and as long as such decisions do not risk causing harm to myself or others.

General information I would like you to know about me:

Information about symptom management and pain control: *(i.e. my definition of adequate pain management; balance between alertness and pain/symptom control; things I find helpful for treating my pain and other symptoms)*

Information about food and nutrition: *(i.e. foods and drinks I like, my preferences about medically assisted nutrition and hydration, or "tube feeding")*

Information about other healthcare and treatment preferences: *(i.e. complimentary therapies such as massage, aroma therapy, or meditation)*

Information about where I would like to receive care for my healthcare and treatment needs, including care at the end of my life: *(i.e. at home, in a hospital, in a specific care facility, by a hospice team)*

SUPPLEMENTAL INFORMATION ABOUT MY HEALTHCARE AND TREATMENT PREFERENCES (Page 2 of 2)

Information about life-sustaining treatments that may prolong the dying process: *(i.e. long-term ventilator support to help me breathe, antibiotics to treat infections such as pneumonia)*

Things that bring me comfort *(i.e. prayers or religious readings that I like, pictures of loved ones, a special blanket or piece of clothing, favorite music or stories, people and things I would like surrounding me)*

Specific instructions about:
Organ, Tissue, Eye and Body Donation:

Autopsy Preferences:

Burial or Cremation Preferences:

Funeral Arrangements/Memorial Service:

I recognize that it is important to discuss the information in this document with the people who will be involved in making decisions related to my healthcare and treatment needs if I cannot make decisions for myself. Because of that, *(check any of the following that apply):*

__ I have discussed this information with my surrogate decision-maker(s):

__ I have discussed this information with the following doctors and other healthcare providers:

__ I have discussed this information with the following people *(i.e. other family members, friends, or emergency contacts who may be present as healthcare and treatment decisions are made on my behalf):*

Be sure to attach copies of this supplemental information form to your Advance Directives documents and provide copies of this supplemental information to your doctor, surrogate decision-maker(s) and other healthcare providers.

Person completing this form initial _____ Date: _____

Wallet Cards

Cut out and complete the cards below. Fold the cards in half and put one card in the wallet or purse you carry most often, along with your driver's license or health insurance card. You may keep the other cards on your refrigerator, in your motor vehicle glove compartment, in a spare wallet or purse, or in another easy-to-find place.

Attn: Healthcare Providers

My name is _____

I have created the following Advance Directives:
(Check one or more, as appropriate)

- ____ Advance Directives document for my General Healthcare and Treatment
- ____ Advance Directives document for my Mental Healthcare and Treatment
- ____ Other: _____

(FOLD HERE)

Please Contact: _____
(Name)

at _____ for more information.
(Telephone)

_____
(Signature) *(Date)*

Attn: Healthcare Providers

My name is _____

I have created the following Advance Directives:
(Check one or more, as appropriate)

- ____ Advance Directives document for my General Healthcare and Treatment
- ____ Advance Directives document for my Mental Healthcare and Treatment
- ____ Other: _____

(FOLD HERE)

Please Contact: _____
(Name)

at _____ for more information.
(Telephone)

_____
(Signature) *(Date)*

Attn: Healthcare Providers

My name is _____

I have created the following Advance Directives:
(Check one or more, as appropriate)

- ____ Advance Directives document for my General Healthcare and Treatment
- ____ Advance Directives document for my Mental Healthcare and Treatment
- ____ Other: _____

(FOLD HERE)

Please Contact: _____
(Name)

at _____ for more information.
(Telephone)

_____
(Signature) *(Date)*

Attn: Healthcare Providers

My name is _____

I have created the following Advance Directives:
(Check one or more, as appropriate)

- ____ Advance Directives document for my General Healthcare and Treatment
- ____ Advance Directives document for my Mental Healthcare and Treatment
- ____ Other: _____

(FOLD HERE)

Please Contact: _____
(Name)

at _____ for more information.
(Telephone)

_____
(Signature) *(Date)*