POLICY AND PROCEDURE CONCERNING ADVANCE DIRECTIVES

APPENDIX B
POWER OF ATTORNEY FOR HEALTH CARE INFORMATION

1. Whenever possible, the IPP Team should discuss, in advance, the wishes of the person in services concerning medical treatment and life support. The person must play an active role in such a discussion. It is the responsibility of staff to encourage this participation and to keep the discussion conducive to the topic at hand. Staff may be able to offer any insight they may have about the individual's feelings/opinions based on shared personal experience. They may also assist the individual in expressing her/his thoughts.

2. A Power of Attorney for Health Care may be established at any point. It should be encouraged for any person who does not require a guardian. This person will have an active role in choosing the person who will speak/act on her/his behalf in a medical emergency. The person should be one who knows the individual well and shares similar beliefs with the individual. The person who is given this Power of Attorney for Health Care must be willing and able to operate with the individual's interest in mind, regardless of their own personal beliefs.

   A Power of Attorney for Health Care is limited to specific situations when informed consent is not able to be received from the individual personally. It is in effect only in those situations, and does not limit the rights of the individual at any other time.

3. If time and situation warrant, an emergency petition may be filed with the Court to prevent a delay in crucial treatment.

4. If time allows, a temporary, limited guardianship may be established. Physicians and people who know the person well may offer statements, or testimony, indicating the need for the measure. It is crucial that any guardianship be limited in scope and duration to meet the needs of the person without unnecessarily limiting rights.

11/97
7/98
9/05

POWER OF ATTORNEY FOR HEALTH CARE

I appoint____, whose address is ____, and whose telephone number is___________________, as my attorney in fact for health care. I appoint___________________________________, whose address is ____, and whose telephone number is___________________, as my successor attorney in fact for health care. I authorize my attorney in fact appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions. I have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care. I direct that my attorney in fact comply with the following instructions or limitations:____
____
____
____
____

I direct that my attorney in fact comply with the following instructions on life-sustaining treatment: (optional)____
____
____
____
____

I direct that my attorney in fact comply with the following instructions on artificially administered nutrition and hydration: (optional)_______________________________
____
____
____
____

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY IN FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

____
(Signature of person making designation/date)
DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witnessed By:

____

(Signature of Witness/Date) (Printed Name of Witness)

____

(Signature of Witness/Date) (Printed Name of Witness)

OR

State of Nebraska)
) ss.
County of___________)

On this________ day of_________________________ 20____, before me, ____, a notary public in and for ________________________ County, personally came______________________, personally to me known to be the identical person whose name is affixed to the above power of attorney for health care as principal, and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated by this power of attorney for health care. Witness my hand and notarial seal at

____

in such county the day and year last above written.

____

Seal Signature of Notary Public