Triage Health Estate Planning Toolkit: Nebraska

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Nebraska probate courts accept written and holographic wills. To make a valid written will in Nebraska:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
    - Free from coercion or outside pressure
2. You need to sign the will or authorize someone to do so for you, in front of two witnesses who are not included in your will.
3. Your will does not need to be notarized to be legal in Nebraska. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign an affidavit affirming the will in front of a notary.

Nebraska does not allow you to execute your will remotely (e.g. sign an affidavit by teleconferencing with a notary).

A holographic will is one that is handwritten by you. To make a valid holographic will in Nebraska:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
    - Free from coercion or outside pressure
2. Your will must be written entirely in your handwriting and you must sign and date it

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove that they are valid in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

In Nebraska, a power of attorney allows you to appoint someone to manage your finances, including your property, taxes, and government benefits. You can also appoint a successor agent, and a second successor agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. You can also use this document to nominate a guardian in

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advance, in case a court decides one is necessary. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it. This document will remain in effect until you die, unless you revoke your power of attorney.

Part III includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In Nebraska, this document contains three parts.

1. **Nebraska Power of Attorney for Health Care:** This document lets you chose someone (your "attorney-in-fact") to make health care decisions for you, including decisions about life-sustaining care, any time your doctor determines that you cannot make them yourself. You can also appoint an alternate person to make these decisions if the first person you chose isn't available. If there are directions you want your agent to honor, you can share those in the "other directions" section.

2. **Nebraska Living Will Declaration:** Also known as a "living will," this document lets you express your preferences for life-sustaining procedures (including medically assisted nutrition and pain management) if you develop a terminal condition and can no longer make your own health care decisions. This document goes into effect if your doctor determines you have become terminally ill or entered a vegetative state.

3. **Signature and Witnessing Provisions:** You must sign your advance health care directive in front of a notary public or two witnesses. Only one witness can be an administrator or employee of your health care provider, and neither can be an employee of your health or life insurer. If you filled out part one, your witness cannot be your spouse, parent, child, grandchild, sibling, a beneficiary in your will, your physician, or your attorney-in-fact.

At the end of your AHCD, you can indicate if you would like to make an organ donation upon death.

If you are pregnant and the decisions you make in this document would interfere with facilitating life-sustaining treatment to the fetus, then it will not be honored.

You can indicate that you would like to change any other instruction included in your AHCD at any time. You can simply tell your physician you would like to revoke or change your AHCD, do so in writing, or just tear up this directive. But, you have to tell your attorney-in-fact, physician, or treating health care provider that you revoked this person's powers for it to be effective.

If you appoint your spouse as your attorney-in-fact, this will be automatically revoked if your marriage dissolves.

Part III of this toolkit includes a sample advance health care directive.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Nebraska, this form is called a Nebraska Emergency Treatment Declaration (NETO). The NETO does not replace an advance directive. You can complete a NETO form with your doctor.

This form lets you indicate your preferences for:

- Scope of treatment for medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Continuing or stopping life-sustaining treatments, if treatment has begun and you have not improved
- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medically assisted nutrition, or food and hydration offered through surgically-placed tubes

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

You can find this form in Part III of this toolkit.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Nebraska does not have a dedicated funeral designation form, but you can include instructions for how you would like your remains handled in your power of attorney for health care. Part III of this toolkit includes a sample form.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Nebraska does not have a death with dignity law.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Health Estate Planning Toolkit: Nebraska

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Nebraska Emergency Treatment Declaration (NETO)
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

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Nebraska Power of Attorney

DESIGNATION OF AGENT

I, _____ (your name) name the following person as my agent (individual with power of attorney):

Agent: _____

Address: _____

Phone Number: _____

DESIGNATION OF SUCCESSOR AGENT(S) *(OPTIONAL)*

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent: _____

Address: _____

Phone Number: _____

If my agent is unable or unwilling to act for me, I name as my second successor agent ***(OPTIONAL)***:

Name of Second Successor Agent: _____

Address: _____

Phone Number: _____

RELEASE OF INFORMATION

I agree to, authorize, and allow full release of information, by any governmental agency, business, creditor, or third party who may have information pertaining to my assets or income, to my agent named on this form.

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects (as defined in the Nebraska Uniform Power of Attorney Act):

(CHECK ☐Yes or ☐No AND initial for each of the subjects that follow. These subjects represent those you may want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may check ☐Yes for "All Preceding Subjects" AND initial that line instead of checking each subject.)

Check one: **Initials:**

☐Yes ☐No _____ Real Property

☐Yes ☐No _____ Tangible Personal Property

☐Yes ☐No _____ Stocks and Bonds

☐Yes ☐No _____ Commodities and Options

☐Yes ☐No _____ Banks and Other Financial Institutions

☐Yes ☐No _____ Operation of Entity or Business

☐Yes ☐No _____ Insurance and Annuities

☐Yes ☐No _____ Estates, Trusts, and Other Beneficial Interests Claims and Litigation

☐Yes ☐No _____ Personal and Family Maintenance

☐Yes ☐No _____ Benefits from Governmental Programs or Civil or Military Service

☐Yes ☐No _____ Retirement Plans

☐Yes ☐No _____ Taxes

☐Yes ☐No _____ All Preceding Subjects (includes all items listed above)

GRANT OF SPECIFIC AUTHORITY *(OPTIONAL)*

My agent **MAY** do any of the following specific acts for me **IF** I have **CHECKED** the specific authority listed below:

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. CHECK YES AND INITIAL ONLY the specific authority you WANT to give your agent. NOTE: If you do not mark yes and initial the authority, the authority is not granted.)

Check one: **Initials:**

☐Yes ☐No _____ Create, amend, revoke, or terminate an inter vivos trust

☐Yes ☐No _____ Make a gift, subject to the limitations of the Nebraska Uniform Power of Attorney Act and any special instructions in this power of attorney

☐Yes ☐No _____ Create or change rights of survivorship

☐Yes ☐No _____ Create or change a beneficiary designation

☐Yes ☐No _____ Delegate to another person to exercise the authority granted under this power of attorney

☐Yes ☐No _____ Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan

☐Yes ☐No _____ Exercise fiduciary powers that the principal has authority to delegate

☐Yes ☐No _____ Renounce or disclaim an interest in property, including a power of appointment

LIMITATION ON AGENT'S AUTHORITY

If I did not check the "Power of Personal and Family Maintenance" or the "All Preceding Subjects" in the Grant of General Authority above, my agent MAY NOT use my property to benefit themselves or anyone they support except for those items listed below in the Special Instructions.

SPECIAL INSTRUCTIONS *(OPTIONAL)*

You may give special instructions on the following lines:

_____

_____

_____

_____

_____

_____

_____

NOMINATION OF [CONSERVATOR OR GUARDIAN] *(OPTIONAL)*

If it becomes necessary for a court to appoint a conservator of my estate, I nominate the following person(s) for appointment:

Name of Nominee for conservator of my estate:

_____

Address: _____

Phone Number: _____

If it becomes necessary for a court to appoint a guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for guardian of my person:

_____

Address: _____

Phone Number: _____

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

EFFECTIVE DATE: This power of attorney is effective immediately unless I have stated otherwise in the special Instructions.

SIGNATURE AND ACKNOWLEDGMENT

(CAUTION: This document MUST be signed IN THE PRESENCE of a notary to comply with the Nebraska Uniform Power of Attorney Act)

_____ _____
Your Signature *Date*

_____
Your Name Printed

_____
Your Address

_____
Your Phone Number

NOTARY

State of Nebraska)
) ss.
[County] of _____)

This document was acknowledged before me on _____
Date

by _____
Name of Principal

_____ *(Seal, if any)*
Signature of Notary

My commission expires: _____

Power of Attorney, DC 6:12 PSC, Rev. 08/12 §30-4041

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

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☑ Printing the form and handwriting the answers.
☐ Completing the form electronically.

Nebraska Power of Attorney

Health Care

POWER OF ATTORNEY FOR HEALTH CARE

I, _____(your name) name the following person as my attorney in fact for health care:

Name: _____

Address: _____

Phone Number: _____

SUCCESSOR TO POWER OF ATTORNEY FOR HEALTH CARE

If my agent (above) is unwilling or unable to act, I appoint the following person as my successor power of attorney for health care:

Name: _____

Address: _____

Phone number: _____

By initialing the below, I acknowledge that I have read and understand each statement and the consequences of executing a power of attorney for health care.

____ I authorize my attorney in fact for health care 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 direct that my attorney in fact for health care comply with the following instructions or limitations:

_____
_____
_____
_____

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

_____
_____
_____
_____

____ I direct that my attorney in fact for health care 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 for health care, 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.**

____ **I have read the above warning which accompanies this document and understand the consequences of executing a power of attorney for health care.**

_____ _____

Signature of person making designation *Date*

Do not sign this form until you are in the presence of either the two witnesses or a notary.

DECLARATION OF WITNESSES

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

Witnessed By:

_____ _____

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

_____ _____

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

OR

NOTARY

State of Nebraska)

) ss.

[County] of _____)

This document was acknowledged before me on _____
(Date)

by _____.
(Name of Principal)

_____ (Seal, if any)

Signature of Notary

My commission expires: _____

Nebraska Living Will Declaration

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 physician, 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 physician, 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.

Other directions: _____

_____

_____

_____

Signed this _____ day of _____

Signature _____

Address: _____

_____

The declarant voluntarily signed this writing in my presence.

Witness _____

Address: _____

_____

Witness _____

Address: _____

_____

OR

The declarant voluntarily signed this writing in my presence.

Notary Public _____

Source: § 20-404 Neb Rev Stat

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

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Nebraska Emergency Treatment Declaration (V2.0 7/2019)

Declaration: This is my authorization to accept, limit, or refuse treatment if I have a life-threatening condition AND I am unable to make or communicate my own decisions. I have initialed the medical directives I have chosen for treatment in each section below. I understand that my directives will be followed whether I have a life threatening injury/accident or a medical emergency. If other decisions are required, those decisions should be as consistent with these choices as my condition allows.

Last Name
First, Middle Name
Date of Birth

Section A Initial **ONE** choice	**Scope of Treatment** If I have a life-threatening emergency and my heart is still beating, I want:	
		ALL medically indicated interventions. Use any intensive life sustaining treatments required to attempt to reverse or stabilize the emergency condition.
		LIMITED medically indicated interventions. Use general medical interventions including but not limited to fluids, blood products, medications, and non-invasive ventilation. I DO NOT WANT TO BE INTUBATED (DNI). I hope to avoid surgery and avoid ICU transfer if possible.
		NO TREATMENT to reverse or stabilize the emergency condition. I want to be allowed to die naturally, using medication and oxygen for comfort purposes only. DO NOT use antibiotics or fluids to prolong my life. I agree to Hospice if indicated for my care.
Section B Initial **ALL that apply**	**Stopping Life Sustaining Treatment** If Life Sustaining Treatment has begun and I am still unable to make my own decisions. I want to:	
		CONTINUE life sustaining treatments as long as possible. I understand this may require a transfer to a long-term care facility on a breathing machine or other life sustaining measures.
		STOP life sustaining treatment if I worsen or do not improve either: (Check ONE of the following) ☐ after a trial of a few days. (Usually for those with serious illness who still want to try treatment.) ☐ before long-term measures are required, usually about 10-14 days.
		STOP life sustaining treatment if I appear to have lasting, serious brain damage.
		STOP life sustaining treatment if my surrogate decision maker(s) believe the burdens of treatment are too high for the expected benefit, or my life after treatment would be unacceptable to me based on what I've told them or what they know about me.
Section C Initial **ONE** choice	**Cardio-Pulmonary Resuscitation (CPR)** If my heart stops beating (cardiac arrest)	
		ATTEMPT CPR to try to restart my heart (**CPR**).
		DO NOT ATTEMPT CPR/ Allow Natural Death **EXCEPT** for cardiac arrest occurring during a medical intervention or procedure for which I have given consent. (**DNR except procedures**)
		DO NOT ATTEMPT CPR/ Allow Natural Death. (**DNR**)
Section D Initial **ONE** choice	**Long-Term Nutrition/Tube Feeding** provided through a tube into stomach or veins. If, after following the instructions above, I am still unable to make my own decisions AND I am not able to safely take food by mouth:	
		I accept long-term nutrition/tube feeding if medically recommended.
		I refuse long-term nutrition/tube feeding.

Declarant Signature	Date

Signature witnessed by TWO Adults (only one of whom can work for health care provider) OR NOTARY PUBLIC

Witness One Sig:	Acknowledgement State of _____ County of _____
Printed Name and Address:	The foregoing was acknowledged before me this (date) _____ by (name) _____
Witness Two Sig:	Notary Public Signature _____
Printed Name and Address:	(seal)

Nebraska Emergency Treatment Orders (NETO™) (V2.0 7/2019)

These orders assure your directives are followed by Emergency Medical Services (EMS). They are only necessary if you are refusing CPR, Intubation, or Transport by EMS. Limitations of treatment must be completed and signed by a license medical provider.

Patient Name:	Date of Birth

Medical Orders for EMS			Medical Provider Attestation
Medical Orders for EMS DO NOT APPPLY in situations of apparent intentional injury.			
Resuscitation: Cardiac Arrest			**"I attest that the patient and I have discussed the choices they have indicated on the reverse side of this form, and I have written the adjacent orders accordingly. In my opinion, the patient has capacity to make these decisions. I believe the patient understands that their decisions will apply to both life-limiting injuries/accidents and medical emergencies."**
Provider Initial One		**Attempt CPR per protocol**	
		DO NOT Attempt CPR	
Intubation: Non-Cardiac Arrest			
Provider Initial One		**Intubate** per protocol	
		DO NOT Intubate	
Transportation to higher level of care			
Provider Initial One		**Transport** per protocol	
		DO NOT transport unless symptoms cannot be managed in current setting *(Usually reserved for those enrolled in hospice or other reliable home care)*	
Provider Signature, Name and Date			Provider License and Office Phone

Description and Authority

The Nebraska Emergency Treatment Declaration and Orders document (NETO™) was created by Nebraska physicians and attorneys to improve patient and family participation in critical clinical decision making. The Treatment Declaration Page allows patients to express their right to accept or refuse medical care and treatment if they are unable to speak for themselves, in accordance with US Common Law and The Nebraska Rights of the Terminally Ill Act. The Declaration is an Advance Directive and should be treated as such in all medical records. It replaces any prior declarations/living wills. It does not appoint a surrogate decision maker, though it does provide guidance for surrogates to follow regarding medical decision making. The Treatment Orders page contains out-of-hospital orders for EMS and other first responders consistent with Nebraska Emergency Medical Services protocol.

Instructions

- This legal document belongs to the patient. The original should follow the patient from location to location.
- The Declaration is an Advance Directive and should be treated as such with respect to medical records.
- A patient may revise or revoke the instructions at any time by informing a medical professional who should update any medical records accordingly. A new form can be used to record new decisions. Copies are valid instruments. If there are multiple versions, the version most recently signed by the patient should be followed.
- The Declaration is voluntary, no one may be required to complete a declaration.
- More information can be found on the internet at https://NebraskaNETO.org

Review: Forms should be rewritten when the declarant's decisions change. Write a NEW document, do NOT alter a completed form. The form has no expiration date, but review is suggested every 2 years to assure choices match current health status. Initial and date each time these decisions are reviewed and approved.

Patient Initials & Date	Patient Initials & Date	Patient Initials & Date	Patient Initials & Date

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Part III: Your State's Estate Planning Forms

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HIPAA Authorization Form

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Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524