PLANNING FOR HEALTH CARE DECISION-MAKING

The following "Do-It-Yourself" packet of materials are produced and distributed by the Elder Law Center of the Coalition of Wisconsin Aging Groups as a service to consumers. The contents of this packet are described on the following page.

CWAG "Advocating for All Generations"

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DO-IT-YOURSELF CONSUMER PACKET

PLANNING FOR FUTURE HEALTH CARE DECISION-MAKING

It is important to plan ahead for future health care decision-making so that you can ensure that your wishes will be followed in the event that you are unable to speak for yourself. Wisconsin law has created two forms to assist adults in making future health care decisions – the Power of Attorney for Health Care and the Living Will (officially called a "Declaration to Physicians"). This packet provides both forms, as well as instructions and additional information to assist you in planning for future health care decisions.

This packet contains nine pieces, plus this cover sheet:

1. **A five-page brochure entitled "Powers of Attorney: An Overview."** This brochure answers frequently asked questions about Powers of Attorney for Health Care.
2. **25 Suggested Topics to Discuss With Your Health Care Agent.** Because the agent you select in your Power of Attorney for Health Care is required to follow your wishes, it is important that you talk to your agent about your wishes.
3. **Suggested Additional Language for Your Power of Attorney for Health Care Document** to be included in the "Special Provisions" section of the Power of Attorney for Health Care form and to discuss with your agent.
4. **Step-By-Step Instructions for Completing the Wisconsin Statutory Power of Attorney for Health Care.**
5. **The Wisconsin Power of Attorney for Health Care form**, including "To Whom It May Concern." This form was created by the Wisconsin legislature. It is also called the "statutory form" or the "state form."
6. **Comparison of Wisconsin's Living Will and Power of Attorney for Health Care.** This chart explains the difference between a Living Will and a Power of Attorney for Health Care.
7. **Step-By-Step Instructions for Completing the Wisconsin Statutory Living Will (Declaration to Physicians).**
8. **The Wisconsin Living Will (Declaration to Physicians) form**, including "To Whom It May Concern." This form was created by the Wisconsin legislature.
9. **A "Wallet Card"** to complete and carry, indicating that you have completed one or both of these forms. If possible, have it laminated.

If you have questions about completing a Power of Attorney of Health Care or Living Will, please contact CWAG's Guardianship Support Center at 608-224-0606 or 800-488-2596 or guardian@cwag.org. 08/11

cover page

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POWER of ATTORNEY for HEALTH CARE: An OVERVIEW

05/01/2011

I. What is a Power of Attorney for Health Care?

A power of attorney for health care (POA-HC) is a document that you (the "principal") complete and sign, naming another individual (the "agent") to make your health care decisions for you if you ever become unable to make those decisions for yourself.

II. Why should I have a Power of Attorney for Health Care?

A POA-HC is a way for you to plan ahead to authorize someone else (the "agent") to make your health care decisions if you ever become temporarily or permanently unable to do so yourself. Completing a POA-HC allows you to choose the individual you want to make these decisions and to discuss with her or him what you want those decisions to be.

If you do not complete a POA-HC but later are unable to make your own health care decisions, there may be health care decisions that need to be made which no one else is authorized to make for you. ***In Wisconsin, a family member is not automatically authorized to make health care decisions for you unless you complete a POA-HC document naming the family member as your agent.***

Without a POA-HC, it may be necessary for your family or others to ask the court to appoint a guardian of the person for you. This process can be costly, time-consuming, cumbersome and emotionally draining. It may not result in the appointment of the person *you* would have chosen to be your guardian. Additionally, the person chosen to be guardian may not know your wishes about your health care or what care you might or might not want.

III. What is the Difference Between a Living Will and a Power of Attorney for Health Care?

A Living Will is a set of instructions signed by a patient telling a doctor what to do in very limited situations. A Living Will only covers health care decisions when a person is in a persistent vegetative state or when a person is terminally ill and death is imminent. A Living Will does not name an agent to make decisions for you.

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A POA-HC covers all health care decisions, not just those that are covered by a Living Will. A POA-HC names an agent to make your health care decisions in accordance with your wishes if you ever become incapacitated.

IV. Should I Have Both a Living Will and a Power of Attorney for Health Care?

It is not necessary to have both a Living Will and a POA-HC. The Living Will is not a grant of authority to another person to make your health care decisions. It is only instructions to your doctor about what to do in two limited situations. A POA-HC can include the same kind of written instructions contained in a Living Will, or you can give your agent oral instructions. If you do have a Living Will and a POA-HC, make sure that your wishes are expressed consistently in both documents so that your agent or loved ones do not struggle to discern your true wishes should you become unable to make your own health care decisions.

V. When Does the Agent's Authority Become Effective? May I Continue to Make Decisions After Completing a Document?

The agent's power is activated upon a determination by two physicians or one physician and one psychologist who have personally examined you that you have become incapacitated. The certification of incapacity must be attached to the POA-HC document. Incapacity means that a person is unable to "receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions." If you remain able to make your health care decisions, the agent's authority to make health care decisions is not effective. You can change the manner of activation by specifying the number or type of professionals you want to activate the document. Despite creating the document, you continue to handle all of your own health care decisions as long as you retain the capacity to make your own health care decisions.

VI. What Kinds of Decisions Will My Agent be Able to Make?

Decisions that an agent might make include choosing a doctor, treating a medical condition, managing pain, maintaining or refusing artificial hydration and nutrition, and consenting to or refusing surgery. Health care decisions include decisions about services, procedures, treatment, and care. Your agent will not have the power to make decisions about non-health care issues. Consider completing a Durable Power of Attorney for Finances to handle non-health care issues.

VII. Whose Wishes Control After a Power of Attorney for Health Care is Completed?

You remain in charge of your health care decisions. If you are no longer able to make your own health care decisions, your agent must act in good faith consistent with your wishes.

Because your agent is required to follow your wishes, it is imperative that you talk to your agent about your wishes in advance of your possible incapacity. If you have become incapacitated and are not able to express your wishes, your agent must act according to your previously expressed wishes. You may have included these wishes in your POA-HC document or you may have expressed them verbally to your agent or other family or friends. If you have become incapacitated and are still able to express your wishes, your agent is required to follow your current expression of wishes. If your wishes are not known, your agent must act in your best interests.

VIII. What are the Requirements for a Valid Power of Attorney for Health Care?

POA-HC documents that are created in Wisconsin must meet certain requirements to be valid. The document must:

a) be in writing,

b) be voluntarily executed by an individual who is 18 or older and who is of sound mind,

c) be dated and signed by the principal in the presence of two disinterested witnesses,

d) be signed and dated by two disinterested witnesses and by the principal, and

e) include the exact notice provisions contained in the state form or a certificate signed by the principal's attorney stating: "I am a lawyer authorized to practice law in Wisconsin. I have advised my client concerning his or her rights in connection with this POA-HC and the applicable law."

These requirements apply to all POAs-HC, even documents that also contain financial powers.

In Wisconsin, certain actions may not be undertaken by the agent without specific authorization by the principal in the POA-HC document. If you would like your agent to be able to admit you to a nursing home or community-based residential facility (CBRF) for long term care, your POA-HC must explicitly grant that authority to your agent. Specific authorization is also required if you would like your agent to have the power to withhold or withdraw feeding tubes. Specific authorization is also required for an agent to make health care decisions for a principal who is pregnant.

IX. How can I Complete a Power of Attorney for Health Care?

There are several ways to complete a POA-HC. One way is to use the fill-in-the-blank form created by the state. Another way is to hire a lawyer to draft a document tailored to your specific needs. One may also purchase blank forms. Some facilities like hospitals and clinics may distribute their own POA-HC forms. Any form is acceptable as long as it meets the statutory requirements for a valid POA-HC in Wisconsin noted above.

X. What are the Advantages of Using the State Form?

The state form is free and easy to complete. It contains specific provisions instructing your agent as to your wishes about admission to nursing homes and CBRFs, feeding tubes and decisions for pregnant women. It also has a section so that you can include any other special desires, provisions, or limitations.

Using the state form that has been correctly completed can ensure that you have a valid POA-HC that will satisfy all of Wisconsin's requirements. The provisions covering nursing homes, CBRFs, feeding tubes and pregnant women ensure that these issues are not overlooked. The section where you can include special desires, provisions or limitations allows you to communicate clearly to your agent what your wishes are in particular situations.

Copies of the state POA-HC form are available free if you send a stamped, self-addressed business-size envelope to:

Power of Attorney, Division of Public Health
P.O. Box 309, Madison
Wisconsin 53701-0309

You may request two copies of the form and may photocopy the forms if you need more. You can also request our "Planning for Future Health Care Decision-Making Do-it-Yourself Packet" that includes the state POA-HC form by contacting us at:

Guardianship Support Center
Coalition of Wisconsin Aging Groups
2850 Dairy Drive, Suite 100
Madison WI 53718-6851

(800) 488-2596 ext. 314 for a voluntary donation of $2.

Copies of the packet are also available on the Internet at:
http://cwagwisconsin.org/publications/guardianship-support/

XI. What Factors Should I Consider in Selecting an Agent?

The most important consideration is whether the individual you are considering to be your agent is willing to follow your wishes about your health care decisions. Will she or he be able to resist pressure from friends and family members who want to influence your health care choices in a manner that may be inconsistent with your wishes? Will she or he be willing to make decisions consistent with your wishes and not according to the agent's own ideas of what the right decision would be?

Also consider the individual's experience in dealing with hospitals, doctors, and stressful health care situations. Will the individual be able understand the choices surrounding your particular

injury or conditions? Will the individual be good at communicating with doctors and hospitals about your needs and wishes?

Is the individual assertive? Will she or he be able to ensure that you are being treated properly? Will she or he ask enough questions about the impact of certain decisions? Will your agent be able to insist that providers contact her or him with details about your treatment, about any change in your condition or medications or about injuries?

Is the individual geographically close? If the individual does not live near you, is she or he willing and able to travel in order to be with you when you need health care decisions made for you? How long would it take your agent to arrive? If your agent is not near you, it may be essential to have an alternate to ensure that you have someone there to make your health care decisions for you if you or your agent are unable.

Your agent cannot be your health care provider or a spouse or employee of your health care provider or an employee of a facility where you are a patient or reside, unless she or he is a relative.

XII. What Should My Agent do to Advocate for Me in Making My Health Care Decisions?

Your agent should visit you as often as possible with a minimum visit of once a month. If you are experiencing rapid medical changes, your agent should be visiting you much more often. This is a responsibility that you should discuss with your agent before completing your POA-HC. Your agent will also serve to ensure that you are not suffering abuse or neglect in your incapacitated state.

Your agent should attend meetings discussing your health care to ensure that your wishes are represented and respected when developing care plans.

Your agent must also provide informed consent or refusal for all your health care needs once your POA-HC document becomes activated. To adequately do this, your agent must be willing to understand your condition and the proposed treatments and be able to apply your wishes to unforeseen health care decisions.

XIII. Should I Name an Alternate Agent?

Your agent could be on vacation, ill, unable to assist you or deceased when you need help. Because of this, it is important to consider naming at least one alternate agent on the POA-HC form. If for any reason, the primary agent cannot fulfill the responsibilities of the agency, the alternate can be called upon to make your health care decisions for you should you ever become unable to do so.

XIV. What Should I do if I Cannot Physically Sign the Document?

The statute governing the requirements of the POA-HC allows you to execute the document even if you are physically unable to sign the document. If you are unable to sign, you may direct a person 18 or older to sign in your presence and in the presence of two disinterested witnesses. The person you chose to sign for you should not be your agent, alternate agent or witness.

XV. Can I Add an Addendum to My Power of Attorney for Health Care Document?

If you use the state POA-HC form, you will notice that the space for adding specific instructions to your agent is small. You may wish to add an addendum with longer instructions. If you wish to do so, make sure to reference the addendum in the document. Also be sure that the dates in the addendum are the same as in the POA-HC document. Finally, sign, date and witness the addendum in the same manner as the POA-HC document.

XVI. What is the Definition of a "Feeding Tube"?

A feeding tube is a "medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth, or any other body opening." It is important to understand that a "feeding tube" can be used to administer both nutrition and hydration. If you want your agent to have the authority to withhold or withdraw a feeding tube, you must provide specific authorization in your POA-HC. An agent may never withhold or withdraw orally ingested nutrition or hydration unless provision is medically contraindicated.

XVII. Will a Power of Attorney for Health Care Allow Me to be Admitted to a Nursing Home or Community-based Residential Facility for Long-term Care Against My Wishes?

No. In order for your agent to have the authority to admit you to a nursing home or CBRF for long-term care, you must specifically grant that power in the POA-HC. Without that specific grant of authority, your agent cannot admit you for long-term care. However, your agent can still admit you for short-term stays. If the nursing home or CBRF admission is for recuperative care for less than three months and admission is directly from the hospital, your agent can admit you even if you withheld the specific grant of authority, unless the hospitalization was for psychiatric treatment. If the admission is for respite care for less than 30 days and you and your agent live together, your agent may admit you even if you withheld the specific grant of authority. Even if you grant your agent authority to admit you for long-term care purposes, you can withdraw the authority by objecting. However, a guardianship and protective placement order may then be obtained in order to keep you in a nursing home or CBRF against your wishes.

XVIII. What Happens if I Check "No" or Leave Blank the Questions about Admission to a Nursing Home or a Community Based Residential Facility or don't Specifically Authorize Admission?

If you check "no" to these questions or leave them blank on the state form, your health care agent may only admit you to a nursing home or CBRF for short-term stays for recuperative or respite care. Your health care agent may not admit you for any other purpose including long-term care. If you use an attorney-drafted form that does not include specific authorization for nursing home or CBRF admission, your agent may not admit you for long-term care. However, refusing to give your agent this authority does not mean you will never be admitted to a nursing home or CBRF for long-term care. If your condition requires admission to either a nursing home or CBRF, a guardian will have to be appointed and a protective placement order issued by the court to give consent.

XIX. Will Completing a Power of Attorney for Health Care Always Avoid the Need for a Guardian?

Completing a POA-HC will usually prevent needing to have a guardian of the person appointed in the event that you are unable to make your own health care decisions. However, there are some circumstances where a guardian of the person may still need to be appointed. If your agent is unable to fulfill his or her responsibility and no alternate was named, a guardian will be needed. A guardian will also be needed if you did not authorize nursing home or CBRF admission but now need those services. Another reason is if you object to any of the decisions your agent is making, such as admission to a nursing home for long-term care which you previously authorized. Also there might be decisions that need to be made that are not covered by a POA-HC.

XX. Is a Power of Attorney for Health Care that was Executed in Another State Valid in Wisconsin?

If your POA-HC is valid in the state in which it was executed, it is valid in Wisconsin. However, the agent only has the authority that is permitted by Wisconsin law. For instance, specific authorization for nursing home and CBRF admission, withholding or withdrawing of feeding tubes, and making decisions for a pregnant principal must be specifically authorized in the POA-HC document. This is so regardless of the law of the state where your document was executed. If your document lacks the specific authorization required in Wisconsin for long term admission to a nursing home or CBRF, your agent will not be able to admit you to a Wisconsin nursing home or CBRF for long term care without a guardianship and protective placement order.

XXI. What Should I do Once I Complete the Power of Attorney for Health Care Form?

Once the form is completed, you should make several photocopies. You should keep the original in an accessible place (not in a safe deposit box) and distribute copies to your physician, your agent, your alternate agents, your hospital, and family members. CWAG's "Do-it-Yourself Packet" includes a card for your wallet. For a small fee, you may file a copy at the probate court in the county in which you live.

XXII. How do I Revoke an Already Existing Power of Attorney for Health Care?

There are several ways to successfully revoke an existing POA-HC. You may destroy all the copies of the existing document. You may sign and date a written revocation. You may orally revoke the document in the presence of two witnesses. Or you may execute a new POA-HC. All of these actions will effectively revoke an existing POA-HC.

XXIII. Who Can I Contact if I Have Questions?

The Wisconsin Guardianship Support Center is operated by the Elder Law Center of the Coalition of Wisconsin Aging Groups to answer questions about Powers of Attorney.

QUESTIONS? Call the Guardianship Support Center at 1-800-488-2596 ext. 314. Or e-mail at guardian@cwag.org.

2850 Dairy Drive, Suite 100 • Madison, WI 53718-6742 • www.cwag.org
Telephone: (608) 224-0606 • Toll-Free: 1-800-366-2990 • Fax: (608) 224-0607

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RESPONSIBILITIES of a HEALTH CARE AGENT UNDER a WISCONSIN POWER OF ATTORNEY for HEALTH CARE

05/01/2011

I. Introduction

You have been chosen by a loved one or friend (the **principal)**, to serve as **agent** under a power of attorney for health care document. You have undertaken an important responsibility by agreeing to act as agent if the principal is ever unable to advocate for her or himself due to disability. The principal has chosen you as agent because she or he trusts you to implement his or her health care wishes *even if you disagree with those decisions.*

A health care agent makes "health care" decisions on behalf of a principal whenever the principal is not able to make those decisions her or himself because of incapacity. Many health care providers and individuals believe that family members, such as spouses, can legally make health care decisions on behalf of their loved ones. T*his is not the law, however.* In Wisconsin, only a person's legally authorized representative – an agent under a valid power of attorney for health care document or a court-appointed guardian of the person – may provide informed consent to health care treatment on behalf of another adult. The duties of a health care agent are described in Chapter 155 of the Wisconsin Statutes. The following information explains these duties and may assist you in determining how to best fulfill your role.

II. When Does An Agent's Authority To Make Decisions Begin?

Most power of attorney for health care documents provide that the document becomes "activated" when two physicians or one physician and one psychologist personally examine the principal then sign a statement asserting (certifying) that the principal is incapacitated. Incapacity means the principal is not able to "receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions." This certification of incapacity must be attached to the document.

Some individually-tailored power of attorney for health care documents provide for an alternate method of activation. For example, an agent may have authority to make medical decisions on behalf of the principal when the principal has been determined incapacitated by only one

physician. Check your principal's document to determine when your authority to make decisions begins.

III. What Types Of Decisions May an Agent Make?

As agent, you may only make "health care" decisions. "Health care" is defined as "any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental condition." Thus, depending on the exact language of the document, you may choose medical professionals and facilities, and consent to surgical procedures and medications. You may also make certain end-of-life decisions on the principal's behalf **if** the principal has delegated that authority to you. *Please note*: you do not have authority to decide non-medical issues, such as who may visit the principal at a nursing home, or whether the principal may smoke.

Keep in mind that your decision-making authority is not only about end of life decisions. If you are an agent for an individual with a chronic illness or long-term mental disability, you may be the agent for many years.

IV. What Standard Does An Agent Use To Make Health Care Decisions?

As agent, you must act in good faith consistently with the desires of the principal as expressed in the power of attorney for health care document or as otherwise specifically directed by the principal to you **at any time** – even after certification of incapacity. You may not make medical decisions based on your own religious or moral views regarding the particular treatment. The law provides specific guidance on how you make medical decisions on behalf of a principal, as follows:

A. First, you determine what the principal's current wishes are regarding his or her treatment, if the principal is capable of expressing those wishes. You are obligated to follow the treatment wishes of the principal as expressed at any time, *even after the principal has been determined incapacitated.* This is true even if the principal can only express his or her wishes by nodding his or her head or blinking his or her eyes.

B. Second, if the principal is currently unable to express his or her wishes, you may rely on the principal's previously expressed treatment wishes. These wishes may be contained in the power of attorney document itself, or may have been expressed verbally to you or other family and friends.

C. Finally, if the principal has never expressed his or her wishes regarding the treatment, and is currently unable to express those wishes, you may make the medical decision based on what you feel would be in the principal's best interests. You should consider the principal's values and beliefs when making this decision.

If you have not done so already, you should immediately speak with the principal about his or her wishes regarding medical treatment. Determine preferences the principal has in regards to treatment professionals and medication. Discuss end-of-life treatment at length. If the individual has a Living Will, obtain a copy of the Living Will and discuss the decisions the principal made in that document. Learn the person's values and beliefs about various medical treatment options. If

the principal is not able to discuss his or her treatment preferences, ask family and friends if the principal had discussed health care treatment with them at any time.

IV. Are There Medical Decisions an Agent Is Prohibited In Making under Any Circumstances?

Under Wisconsin law, you cannot consent to admission of the principal to an institution for mental diseases, an intermediate care facility for the mentally retarded, to a state treatment facility or a treatment facility. Additionally, you may not consent to experimental mental health research or to psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for the principal.

V. May an Agent make every Health Care Decision?

Not automatically. As agent there are certain health care decisions you may not make unless the principal has given you specific authority in the document itself. These include:

A. Admitting the principal to a community based residential facility or nursing home for long term placement.

B. Consenting to the withholding or withdrawal of feeding tubes.

C. Making health care decisions if you know the principal is pregnant.

If the principal has not given you specific authority to admit her or him to a nursing home or community based residential facility for long term placement, you will need to go to court to be appointed guardian and obtain a protective placement order to have this authority.

VI. What Authority Does an Agent Have To Admit A Principal to A Residential Facility?

As agent, you may admit a principal to a nursing home or community based residential facility for **long term care** only if the principal has given you that specific authority in the power of attorney for health care document, **and** if the principal is <u>not</u> diagnosed as developmentally disabled or as having mental illness at the time of the proposed admission. As agent, you may admit a principal to a nursing home for a **short term stay** (up to 90 days) for recuperative care if the principal is admitted directly from a hospital inpatient unit, unless the hospital admission was for psychiatric care, regardless of whether or not the principal has specifically authorized you to admit the principal for long term care in the principal's document. Also, if you and the principal live together, you may admit the principal to a nursing home or community based residential facility temporarily for up to 30 days to go on vacation or to deal with a family emergency.

All of the above statutory ways to admit a principal to a facility may only be used when the principal is **not objecting** to the admission. If the individual objects, and you still believe it is

necessary to place the individual in a nursing home or community based residential facility, you must go to court to obtain a guardianship and protective placement order.

VII. How Can an Agent Best Advocate for the Principal in Making Medical Decisions?

To assure that the principal is receiving adequate care, an agent should:

A. Prior to admitting an individual to a nursing home or other facility, explore all possible options to determine the best residential setting for the principal that least imposes restrictions on the individual's liberty, and provides as many activities and amenities as possible. Check out staff ratios and qualifications and the facility's general reputation for quality care.

B. Visit the principal as often as possible, but at least once a month, and more often if the principal is experiencing rapidly changing medical conditions. **You may be the only sentinel to protect the individual from abuse or neglect whether the individual lives at home or in a facility.**

C. Attend facility staffings related to medical care for the principal.

D. Become knowledgeable about the principal's medical conditions through resources such as medical dictionaries, medical journals and the Internet. Be advised of and research possible treatment options, risks and benefits of various treatments, and side effects of medication. Review the principal's medical records, and get second medical opinions where appropriate. Release medical records to appropriate professionals.

E. Provide informed consent or refusal for all of the principal's health care needs. Insist that providers contact you with details about any change in the principal's medical condition, adverse medication reactions, and injuries.

F. Become familiar with the resident's rights in the facility where the principal resides. You should be given a copy of these rights when admitting a principal to a facility.

G. If the principal has no guardian of the estate or agent under a power of attorney for finances document, you may apply for government benefits, such as Medical Assistance, on the individual's behalf, and become the individual's representative payee.

VIII. When Do My Duties as Agent Come To an End?

Your duties as agent may come to an end in any one of the following ways:

A. If the **principal dies**, your authority ceases by law.

B. If the **principal revokes** his or her power of attorney for health care document, your authority ceases when you (or your principal's health care providers) receive notice of the revocation. A principal may revoke a Wisconsin power of attorney for health care document **at any time**, even after incapacity, by doing any of the following:

1. Canceling, defacing, obliterating, burning, tearing or otherwise destroying the document, or directing another in his or her presence to so destroy it;
2. Executing a signed and dated written statement, expressing his or her intent to revoke the document;
3. Verbally expressing his or her intent to revoke the document in the presence of two witnesses; or
4. Executing a subsequent power of attorney for health care document.

Additionally, the principal's document is automatically revoked and invalid if you and the principal are married and your marriage is later annulled or you divorce. You are obligated by law to notify all of the principal's health care providers if the principal's document is revoked. The provider must record this revocation in its files.

C. You may become **unwilling or unable to serve as agent** because of death, disability or other reason. If so, the person designated as alternate agent will begin to serve as agent. If there is no alternate agent, the principal will need to have a court-appointed legal guardian.

D. In some cases, as agent under a power of attorney for health care document you **may be removed in judicial proceedings**, such as where a legal guardian has been appointed (see below), or as a result of an interested person petitioning the court to review your performance as agent.

IX, WHAT IS THE ROLE OF THE ALTERNATE AGENT?

The principal may have chosen an alternate agent to serve when the primary agent is unable to serve. Decision making for an incapacitated principal is not joint between an agent and alternate agent, but successive. This means that the alternate agent's authority only begins when the primary agent has died or becomes otherwise unable or unwilling to serve. Having one person at a time serve as agent helps promote continuity of care for the principal through consistent and informed decision making, and avoids family conflict possibly resulting in guardianship.

X. WHAT IS THE RELATIONSHIP BETWEEN GUARDIANSHIP AND A POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT?

One of the most important reasons individuals execute power of attorney for health care documents is to avoid the need for invasive, costly and time-consuming court procedures to appoint a guardian if they become incompetent. Family, friends or other interested persons, however, may seek guardianship of the person and/or estate despite the principal having executed a power of attorney for health care document. For example, a family member of the principal may feel, rightly or wrongly, that the agent is not fulfilling his or her duties as agent and file a petition to become the individual's guardian. Or, a decision may be needed in an area that the power of attorney does not address.

Where a petition for guardianship has been filed, the court must consider appointing the agent named by the principal as guardian of the person, although it need not if it is not in the best interests of the incompetent person. If the court appoints a guardian of the person, the power of

attorney for health care document is revoked and invalid, unless the court finds that the power of attorney for health care should remain in effect. If the court makes this finding, the guardian for the individual may not make health care decisions for the ward that may be made by the health care agent, unless the guardian is also the health care agent.

XI. As a Health Care Agent, When Are You Liable?

You are not personally liable for medical costs incurred by the principal, including the cost of the nursing home or other facility, unless you are the spouse of the principal.

No health care agent may be charged with a crime or held civilly liable for making a decision in good faith under a power of attorney for health care document.

QUESTIONS? Call the Guardianship Support Center at 1-800-488-2596 ext. 314. Or e-mail at guardian@cwag.org.

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25 SUGGESTED TOPICS TO DISCUSS WITH YOUR HEALTH CARE AGENT

Because the health care agent you name in your Power of Attorney for Health Care document is required to follow your wishes, you should discuss your beliefs and wishes with him or her. We suggest you consider the following questions in your discussion. We suggest no particular answers. Each person should answer these questions based on their own beliefs and then convey those beliefs and wishes to their health care agent. Any other wishes or desires that you feel your health care agent should know should also be discussed so that they can carry out their responsibilities as you would wish.

If, over time, your beliefs or attitudes in any area change, you should inform your health care agent. It is also wise to inform your health care agent when there are changes in your health, such as a new diagnosis. If you are informed of a terminal illness, this, as well as the ramifications of it, should be discussed with your agent. How well your health care agent performs depends on how well you have prepared them.

Even if you don't complete a Power of Attorney for Health Care, it is important to discuss these issues with family members and close friends. Without a Power of Attorney, a guardian may need to be appointed to make health care decisions for you. A guardian can follow your wishes, but only if your wishes are known.

1. Do you think it is a good idea to sign a legal document that names another person to make health care decisions for you if are unable to do so? That says what medical treatments you want and do not want when you are ill or dying?

2. Do you think you would want to have any of the following medical treatments performed on you? If so, under what circumstances?

    a. Kidney dialysis (used if your kidneys stop working)

    b. Cardiopulmonary resuscitation, also known as CPR (used if your heart stops beating or you stop breathing)

    c. Respirator (used if you are unable to breathe on your own)

    d. Artificial nutrition (used if you are unable to eat food)

    e. Artificial hydration (used if you are unable to drink fluids)

3. Do you want to donate parts of your body to someone else at the time of your death? (This is called "organ donation.")

4. How would you describe your current health status? If you currently have any medical problems, how would you describe them?

5. If you have current medical problems, in what ways, if any, do they affect your ability to function?

6. How do you feel about your current health status?

7. If you have a doctor, do you like him or her? Why?

8. Do you think your doctor should make the final decision about any medical treatments you might need?

9. How important is independence and self-sufficiency in your life?

10. If your physical and mental abilities were decreased, how would that affect your attitude toward independence and self-sufficiency?

11. Do you wish to make any general comments about the value of independence and control in your life?

12. Do you expect that your friends, family, and/or others will support your decisions regarding medical treatment you may need now or in the future?

13. What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?

14. Where would you prefer to die?

15. What is your attitude toward death?

16. How do you feel about the use of life-sustaining measures in the face of terminal illness?

17. How do you feel about the use of life-sustaining measures in the face of persistent vegetative state?

18. How do you feel about the use of life-sustaining measures in the face of irreversible chronic illness (e.g., Alzheimer's disease)?

19. Do you wish to make any general comments about your attitude toward illness, dying, and death?

20. What is your religious background?

21. How do your religious beliefs affect your attitude toward serious or terminal illness?

22. Does your attitude toward death find support in your religion?

23. How does your faith community, church or synagogue view the role of prayer or religious sacraments in an illness?

24. Do you wish to make any general comments about your religious background and beliefs?

25. What else do you feel is important for your agent to know?

25 Topics - 2

CWAG "Advocating for All Generations"

The Coalition of Wisconsin Aging Groups is a nonprofit, nonpartisan, statewide membership organization that was founded in 1978.

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SUGGESTED ADDITIONAL LANGUAGE FOR YOUR POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT

Listed below are suggested topics to discuss with your health care agent. You can also include your choices in the "Special Provisions" section of the Wisconsin Power of Attorney for Health Care. It is essential that you discuss your choices with your health care agent (and health care providers) while you are competent so that they fully understand what you want them to do.

Even if you don't complete a Power of Attorney for Health Care, it is important to discuss these issues with family members and close friends. Without a Power of Attorney, a guardian may need to be appointed to make health care decisions for you. A guardian can follow your wishes, but only if your wishes are known.

Your Wishes On The Removal Of Life-Sustaining Procedures

1. I do not wish to be kept alive on life-sustaining procedures. My health care agent may determine the timing of the discontinuation of treatment.
2. My health care agent may make any decisions needed about life support procedures, including the decision to discontinue artificial nutrition and hydration and other treatments.
3. I do not wish to be kept alive on artificial life-sustaining equipment, including nutrition or hydration, if these procedures would only serve to prolong the dying process or maintain me in a persistent vegetative state.
4. Do not start or continue life-sustaining procedures if my condition is stable and full independent functional capacity is not expected to return.
5. I do not want my life to be artificially or forcibly prolonged, unless there is some hope that both my physical and mental health may be restored.
6. I wish all artificial nutrition and hydration removed except the kind and amount needed to prevent stressful dehydration of the mouth and skin, so as to maximize comfort and minimize nursing care.

Your Wishes On The Continued Use Of Life-Sustaining Equipment

1. I wish that all life-sustaining equipment and artificial nutrition and hydration be used for as long as possible.

2. I wish that any medical treatment that will prolong my life be used, including chemotherapy, radiation treatment, kidney dialysis and artificial nutrition and hydration.

Your Wishes On Time Constraints

1. If I should be in a coma for at least _____ days and the coma is certified to be irreversible by a physician, I direct that all life-sustaining equipment, including artificial nutrition and hydration, be removed.

Your Wishes On Resuscitation And Other Heroic Measures

1. Do not start or continue life-sustaining procedures if my condition is stable and full independent functional capacity is not expected to return.
2. If death is imminent, I want respiration discontinued and no CPR.

Your Wishes On Organ Donation

1. My agent may not donate any organs under any circumstances.
2. My agent may authorize organ donations and autopsy.
3. I wish to donate my entire body to medical research.

Your Wishes On Nursing Home Placement

1. I would prefer not to be placed in a nursing home (and/or community-based residential facility) unless it is absolutely necessary and all community resources have been exhausted.
2. I prefer to stay in my own home as long as possible.
3. I prefer to go to a nursing home rather than impose on my children.

Your Wishes On Preferred Physician And/Or Long-Term Care Facilities

1. If consistent with my medical treatment, I would prefer to be treated at _____ Hospital.
2. I prefer to be treated by Physician _____, if possible.
3. If it is necessary for me to be placed in a nursing home, I would prefer (or prefer to avoid) _____ Nursing Home.

Your Wishes On Revocation Of Prior Living Wills

1. I revoke any prior executed living will executed on _____ (date if possible). My health care agent can make the decision to withhold or withdraw life-sustaining procedures.
2. I authorize my health care agent to make all decisions not already covered in my living will so as to cover those conditions where I am not terminally ill and/or my death is not imminent, as well as all procedures not covered by my living will.

ADD'L LANGUAGE – 2

Your Wishes On The Use Of Experimental Treatment/Possible Suggestions For Patients Who Are HIV Positive

1. I wish my health care agent to authorize all experimental drugs and treatment available which are supervised by a licensed health care professional.

2. I wish no AZT or other experimental drugs or experimental procedures if these procedures would only serve to prolong the dying process or maintain me in a vegetative state.

3. I authorize my health care agent to disclose my condition and prognosis only to my health care providers and X, Y and Z.

4. I wish my health care agent to authorize all comfort measures, including narcotics, to the extent necessary to alleviate all of my pain, regardless of the possibility of addiction.

Your Wishes On The Alleviation Of Pain

1. My desire is that pain should be alleviated to the extent possible, even though its use may lead to physical damage, addiction or even hasten (but not cause) death.

Your Wishes On Religious Preferences

1. I wish to be treated at a (Catholic, Lutheran, etc.) nursing home/hospital if at all possible.

2. I wish to have religious services provided to me once a week, even if I am unable to fully participate.

3. In the event of a terminal or life threatening situation, I wish to receive my last rites.

4. I wish to be visited by my minister/priest/pastor on a regular basis.

Your Wishes On Visitation

1. I wish that only X, Y and Z be allowed to visit me.

2. I want all visitors to be able to visit me, unless inconsistent with my medical treatment.

Your Wishes Regarding Consultation

1. I would like my health care agent to consult with _____ before making any of my health care decisions.

2. I wish my health care agent to keep my children informed of my health care condition.

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STEP-BY-STEP INSTRUCTIONS FOR COMPLETING THE WISCONSIN STATUTORY POWER OF ATTORNEY FOR HEALTH CARE

These instructions are to be used with the Power of Attorney for Health Care Document, created by the Wisconsin Legislature.

If you have questions about how to complete this form, contact CWAG's Guardianship Support Center at 608-224-0606 or 800-488-2596 or guardian@cwag.org. You can also read "Powers of Attorney for Health Care: An Overview" included in this packet.

STEP 1: BEFORE FILLING IT OUT – Read the "To Whom It May Concern" information that accompanies the form. Read the entire Power of Attorney document carefully, including the notice language on page 1. Be sure you understand the authority you are giving to someone else. Think carefully about who you want to select as your Agent. You may not select your doctor, nurse, an employee of your health care facility or spouse of any of these individuals, UNLESS this individual is also a relative. Consider a close family member or friend – someone who knows you well, who lives close to you, who will be a strong advocate for you and will ensure that your preferences are honored. Talk to this person about your health care preferences, religious beliefs, quality of life concerns, etc., using the enclosed "25 Suggested Topics To Discuss With Your Health Care Agent" and "Suggested Additional Language" as a guide. Ask the individual if he or she will accept this responsibility. Do the same with the individual you select as your alternate agent.

STEP 2: FILLING IT OUT – DON'T insert the date at the top of the second page until the day you sign it. (Note that page numbers are at the top left of the page.) PRINT your name and address and date of birth after the "I," at the top of the second page. Then, mid-way down the second page, in the blanks, PRINT the name, address and phone number (with area code) of the individual you have selected as your health care Agent. If the individual is a relative, indicate the relationship in parentheses, after the name, e.g., "(daughter)." In the next blanks, PRINT the name, address and telephone number of the individual you have selected as ALTERNATE AGENT. Remember, you may only appoint ONE individual as Agent.

Under **ADMISSION TO NURSING HOME OR COMMUNITY-BASED RESIDENTIAL FACILITIES** on page 3, decide whether you want your Agent to have authority to admit

you to a nursing home or community-based residential facility (CBRF). If you check YES, your Agent will be able to do so without going to court. That will save time, money and some emotional anguish for you and your family. On the other hand, the court process is designated as protection for you, to ensure that you really need to be in a nursing home or community-based residential facility. Decide whether you are comfortable giving that power to your Agent. If you check NO or leave the question blank, your Agent will not have that authority. A court proceeding will be required before you could be admitted to a nursing home or community-based residential facility if you are not competent at the time.

Under **PROVISION OF FEEDING TUBE** on page 4, decide whether you want your Agent to have authority to withhold or withdraw feeding tubes. If you check YES, your Agent will have the authority to decide, on a case-by-case basis, whether you would want him or her to withhold or withdraw feeding tubes. If you check NO or if you leave it blank, your Agent will have to seek a court order before being able to do so.

If you also complete the statutory Living Will, be sure that your two documents do not conflict. For example, if in your Living Will you direct that feeding tubes be withheld, be sure to check YES on this question in your Power of Attorney for Health Care.

Note that a feeding tube is a "medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth, or any other body opening." It is important to understand that a "feeding tube" can be used to administer both nutrition and hydration.

The **HEALTH CARE DECISIONS FOR PREGNANT WOMEN** section at the middle of page 4 applies only to women capable of becoming pregnant. If you are a man, or a woman who is incapable of becoming pregnant, write DOES NOT APPLY next to the blanks. If you could become pregnant, decide whether you want your Agent to have that authority. Keep in mind that there are decisions other than abortion that a health care Agent might have to make. For example, if you are in a car accident while pregnant and left unconscious, someone has to decide whether to set broken bones and make other decisions. Even as to the abortion decision, you should consider checking YES but clarifying your position on abortion ("always," "never," "only in certain circumstances," etc.) in the next section. Again, if you check NO or leave it blank, your Agent will <u>not</u> have the authority to make any decisions for you if you later become pregnant, whether related to the pregnancy or not.

Under **STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS** on page 4, you are encouraged to add something to "personalize" the form. Print whatever you include. Consider adding some language indicating your beliefs about life support procedures, organ donations, organ transplants, autopsies, choice of health care provider or facility or any preference to receive long-term care in your own home or in a nursing home. This is also the place to clarify, put limitations on, or further explain any of the earlier "YES" or "NO" questions. For example, you could consider qualifying the nursing home admission by indicating a preference for home care over nursing homes. Or you could use this space to indicate what decisions your Agent can make if you later become pregnant. There are other examples of possible language for this section in this packet. If you have more to insert than fits in the spaces, a) print "see separate addendum" in this space b) use a separate sheet, titled *"Addendum to the Power of*

Attorney for Health Care of (your name)," and c) print (or type) your additional provisions. This Addendum should be dated the same date as the Power of Attorney document, and signed and witnessed exactly like the Power of Attorney.

STEP 3: SIGNING and WITNESSING For the signing on page 5, you and your two witnesses must be together. A witness may not be: (1) your Agent or Alternate Agent, (2) a person entitled to or has a claim on your estate, (3) a relative, (4) someone directly financially responsible for your health care, (5) your health care provider, (6) an employee of your health care provider, or (7) an employee of an inpatient health care facility in which you are a patient. For (6) and (7), however, a person employed as a chaplain or social worker may be a witness. In the presence of both witnesses, you should then date the top of page 2 and sign it on the page 5. Insert the same date right after your name. Have your two witnesses then sign, as indicated on the form.

It is preferred that you have your Agent and Alternate Agent sign the document so that they know that you have selected them and so that you know they agree to accept this responsibility. However, their signatures are not required. To get their signatures, insert your own name in the first two blanks under STATEMENT OF HEALTH CARE AGENT and ALTERNATE HEALTH CARE AGENT. You can then take or mail the form to your Agent and Alternate Agent for their signatures. Your Agent and Alternate Agent are then ready to sign. No witnesses are required.

The section titled **ANATOMICAL GIFTS** on page 6 is optional. You do not have to complete this section for your Power of Attorney for Health Care to be valid. If you are interested in donating certain organs or parts of your body, or all of them, or your entire body for anatomical study, or if you want to clarify that you want to make no anatomical gift, you may use this section to do so. Or, you may leave it blank, which does not create any presumptions about your preferences.

STEP 4: AFTER IT IS COMPLETED – Make several copies of the form (the "To Whom It May Concern" page can be filed or discarded, and does not need to be attached to the completed form). Give a copy to your physician or your clinic, and your hospital. Discuss with your doctor your choice of Agent, as well as your health care preferences, as indicated on the form. Ask your physician to honor your preferences and respect your choice of Agent, if the situation ever arises. Give copies of the completed form to your Agent and your Alternate Agent. Put the original in a safe place at home (ignore the comment on the state form that says you should give the original to your doctor – you should keep the original and you should give a copy to your doctor). You may for a small fee, file a copy with the Register in Probate in your county's Probate Court office.

Discuss with close family members your choice of Agent and your health care preferences. Ask them, too, to respect your choice of Agent and your decisions and to honor those decisions, if the situation ever arises.

Complete the wallet card (on last page of this packet) and put it in your wallet. If possible, have it laminated.

Congratulations! You have now completed your Power of Attorney for Health Care.

08/11

CWAG

Coalition of Wisconsin Aging Groups
Advocacy ▪ Membership ▪ Elder Law

2850 Dairy Drive
Suite 100
Madison, WI 53718-6751
608-224-0606
800-488-2596 toll free
608-224-0607 fax
guardian@cwag.org
www.cwag.org

Securing the present and protecting the future.

Obtain the Wisconsin Statutory Power of Attorney for Health Care form (6 pages), along with the "To Whom it May Concern" letter (2 pages) from:

http://dhfs.wisconsin.gov/forms/AdvDirectives/index.htm

See also following pages →

Scott Walker
Governor

Dennis G. Smith
Secretary

State of Wisconsin

Department of Health Services

DIVISION OF PUBLIC HEALTH

1 WEST WILSON STREET
P O BOX 2659
MADISON WI 53701-2659

608-266-1251
FAX: 608-267-2832
TTY: 888-701-1253
dhs.wisconsin.gov

To Whom It May Concern:

Enclosed is the Power of Attorney for Health Care form you requested. The Power of Attorney for Health Care form makes it possible for adults in Wisconsin to authorize other individuals (called health care agents) to make health care decisions on their behalf should they become incapacitated. It may also be used to make or refuse to make an anatomical gift (donation of all or part of the human body to take effect upon the death of the donor).

Be sure to read all three (3) pages of the form carefully and understand it before you complete and sign it. Talk with those you select as your health care agent and the alternate health care agent about your thoughts and beliefs about medical treatment. Neither the health care agent nor the alternate may be your health care provider, an employee of a health care facility in which you are a patient, or a spouse of any of those persons, unless he or she is also your relative.

Two witnesses are required. Witnesses must be at least 18 years of age, not related to you by blood, marriage, domestic partnership or adoption, and not directly financially responsible for your health care. A witness cannot be a health care provider who is serving you at the time the document is signed or an employee of the health care provider unless the employee is a chaplain or social worker. A witness cannot be an employee of an inpatient health care facility in which you are a patient, unless the employee is a chaplain or social worker. A witness cannot be your health care agent or have a claim on any portion of your estate. Valid witnesses acting in good faith are immune from civil or criminal liability.

An original signed form may be kept on file with your physician. A signed Power of Attorney for Health Care form may also be kept in a safe, easily accessible place until needed. You should make relatives and friends aware that you have created a Power of Attorney for Health Care and the location where it is kept. Relatives and friends should also be told whom you select as the health care agent and the alternate. The document may, but is not required to be, filed for safekeeping, for a fee, with the Register in Probate of your county of residence. The fee for filing with the Register in Probate has been set by State Statute at $8.00. A Power of Attorney for Health Care that is an original signed form or is a legible photocopy or electronic facsimile copy is presumed to be valid. If you have both a Power of Attorney for Health Care and a Declaration to Physicians, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Physicians.

One copy of the Power of Attorney for Health Care form is available free to anyone who sends a stamped, self-addressed, business-size envelope to: Power of Attorney, Division of Public Health, P.O. Box 2659, Madison, Wisconsin 53701-2659. You may make additional blank copies of the form you receive from the Division of Public Health. The form is also available on the Department of Health Services Web page, http://dhs.wisconsin.gov/forms/DPHnum.asp. If you have any questions about the availability of the Power of Attorney for Health Care form or obtaining larger quantities of the form, you may contact the Division of Public Health by telephoning 608-266-1251.

Instructions to Complete the Power of Attorney for Health Care Form

Definitions. 'Department' means the Department of Health Services. 'Health Care' means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. 'Health care decision' means an informed decision in the exercise of the right to accept, maintain, discontinue, or refuse health care. 'Health care facility' means a facility, as defined in State Statute 647.01(4), or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, tuberculosis sanatorium or other place licensed or approved by the department under State Statutes 49.70, 49.71, 49.72, 50.02, 50.03, 50.35, 51.08, 51.09, 58.06, 252.073 or 252.076 or a facility under s. 45.365, 51.05, 51.06, 233.40, 233.41, 233.42 or 252.10. 'Health care provider' means a nurse licensed or permitted under State Statute Chapter 441, a chiropractor licensed under Chapter 446, a dentist licensed under Chapter 447, a physician, podiatrist or physical therapist licensed or an occupational therapist or occupational therapy assistant certified under Chapter 448, a person practicing Christian Science treatment, an optometrist licensed under Chapter 449, a psychologist licensed under Chapter 455, a partnership thereof, a corporation thereof that provides health care services, an operational cooperative sickness care plan organized under State Statute 185.981 to 185.985 that directly provides services through salaried employees in its own facility, or a home health agency, as defined in State Statute 50.49 (1) (a). 'Incapacity' means the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions. 'Feeding tube' means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of the declarant.

Who may sign a Power of Attorney for Health Care? An individual who is of sound mind and has attained age 18 may voluntarily execute a Power of Attorney for Health Care. An individual for whom an adjudication of incompetence and appointment of a guardian of the person is in effect under State Statute Chapter 880 is presumed not to be of sound mind.

Procedures for signing a Power of Attorney for Health Care. The principal (person creating the Power of Attorney for Health Care) and the witnesses all must sign the form at the same time.

When does it take effect? Unless otherwise specified in the Power of Attorney for Health Care instrument (form), an individual's Power of Attorney for Health Care takes effect upon a finding of incapacity by 2 physicians, as defined in State Statute 448.01 (5), or one physician and one licensed psychologist, as defined in State Statute.455.01 (4), who personally examine the principal and sign a statement specifying that the principal has incapacity. Mere old age, eccentricity, or physical disability, either singly or together, is insufficient to make a finding of incapacity. Neither of the individuals who make a finding of incapacity may be a relative of the principal or have knowledge that he or she is entitled to or has a claim on any portion of the principal's estate. A copy of the statement, if made, shall be appended to the Power of Attorney for Health Care instrument.

Revocation. A principal may revoke his or her Power of Attorney for Health Care and invalidate the Power of Attorney for Health Care instrument at any time by doing any of the following: canceling, defacing, obliterating, burning, tearing or otherwise destroying the Power of Attorney for Health Care instrument or directing another in the presence of the principal to so destroy the Power of Attorney for Health Care instrument; executing a statement, in writing, that is signed and dated by the principal, expressing the principal's intent to revoke the Power of Attorney for Health Care; verbally expressing the principal's intent to revoke the Power of Attorney for Health Care in the presence of 2 witnesses; or, executing a subsequent Power of Attorney for Health Care instrument. The principal's health care provider shall, upon notification of revocation of the principal's Power of Attorney for Health Care instrument, record in the principal's medical record the time, date and place of the revocation and the time, date and place, if different, of the notification to the health care provider of the revocation.

Immunities. No health care facility or health care provider may be charged with a crime, held civilly liable, or charged with unprofessional conduct for any of the following: certifying incapacity under State Statute 155.05 (2), if the certification is made in good faith based on a thorough examination of the principal; failing to comply with a Power of Attorney for Health Care instrument or the decision of a health care agent, except that failure of a physician to comply constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the principal to another physician who will comply; complying, in the absence of actual knowledge of a revocation, with the terms of a Power of Attorney for Health Care instrument that is in compliance with Chapter 155; complying with the decision of a health care agent that is made under a Power of Attorney for Health Care that is in compliance with Chapter 155; acting contrary to or failing to act on a revocation of a Power of Attorney for Health Care, unless the health care facility or health care provider has actual knowledge of the revocation; or, failing to obtain the health care decision for a principal from the principal's health care agent, if the health care facility or health care provider has made a reasonable attempt to contact the health care agent and obtain the decision but has been unable to do so. No health care agent may be charged with a crime or held civilly liable for making a decision in good faith under a Power of Attorney for Health Care instrument that is in compliance with Chapter 155. No health care agent who is not the spouse of the principal may be held personally liable for any goods or services purchased or contracted for under a Power of Attorney for Health Care instrument.

General provisions. The making of a health care decision on behalf of a principal under the principal's Power of Attorney for Health Care instrument does not, for any purpose, constitute suicide. No individual may be required to execute a Power of Attorney for Health Care as a condition for receipt of health care or admission to a health care facility. No insurer may refuse to pay for goods or services covered under a principal's insurance policy solely because the decision to use the goods or services was made by the principal's health care agent.

F-00085A (Rev. 06/11)

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-00085 (Rev. 06/11)

STATE OF WISCONSIN
Chapter 155.30(1),(3)
Effective Date: August 3, 2009
608 266-1251

POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT
NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make health care decisions for you. It revokes any prior power of attorney for health care that you may have made. If you wish to change your power of attorney for health care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, health care provider, and any other person(s) to whom you have given a copy. If your agent is your spouse or your domestic partner and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document on file with your physician.

POWER OF ATTORNEY FOR HEALTH CARE

Document made this_____day of_____(month),_____(year).

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I,_____

_____

_____

(print name, address, and date of birth), being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate_____

_____

print name, address and telephone number) to be my health care agent for the purpose of making health care decisions on my behalf. If he or she is ever unable or unwilling to do so, I hereby designate_____

_____

(print name, address and telephone number) to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions.

A copy of that statement must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the persons with mental retardation, a state treatment facility, or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

1. A nursing home - - ☐ Yes ☐ No

2. A community-based residential facility - - ☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may admit me only for short-term stays for recuperative care or respite care.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube - - ☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withdrawn from me.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant - - ☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions or limitations that I wish to state (add more items if needed):

1. _____

2. _____

3. _____

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

(a) Request, review and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records.
(b) Execute on my behalf any documents that may be required in order to obtain this information.
(c) Consent to the disclosure of this information.

(The principal and the witnesses all must sign the document at the same time.)

SIGNATURE OF PRINCIPAL

(Person creating the Power of Attorney for Health Care)

Signature_____ Date_____

(The signing of this document by the principal revokes all previous powers of attorney for health care documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, domestic partnership under Wisconsin Statutes chapter 770, or adoption, and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employe of the health care provider, other than a chaplain or a social worker, or an employe, other than a chaplain or a social worker, of an inpatient health care facility in which the declarant is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness Number 1

(Print) Name _____ Date _____

Address_____

Signature _____

Witness Number 2

(Print) Name_____ Date _____

Address_____

Signature _____

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

I understand that_____ (name of principal) has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself._____ (name of principal) has discussed his or her desires regarding health care decisions with me.

Agent's Signature_____

Address_____

Alternate's Signature _____

Address_____

Failure to execute a power of attorney for health care document under chapter 155 of the Wisconsin Statutes creates no presumption about the intent of any individual with regard to his or her health care decisions.

This power of attorney for health care is executed as provided in chapter 155 of the Wisconsin Statutes.

ANATOMICAL GIFTS (optional)

Upon my death:

☐ I wish to donate only the following organs or parts: _____

_____

(specify the organs or parts).

_____

☐ I wish to donate any needed organ or part.

☐ I wish to donate my body for anatomical study if needed.

☐ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failing to check any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift.

Signature _____ Date _____

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Coalition of Wisconsin Aging Groups
Intergenerational Leadership Development ▪ Education ▪ Advocacy ▪ Elder Law Center

STEP-BY-STEP INSTRUCTIONS FOR COMPLETING THE WISCONSIN STATUTORY LIVING WILL (DECLARATION TO PHYSICIANS)

These instructions are to be used with the Living Will (officially called a Declaration to Physicians), created by the Wisconsin legislature.

If you have questions, contact CWAG's Guardianship Support Center at 608-224-0606 ext. 314 or 800-488-2596 or guardian@cwag.org. You can also read "Comparison of Wisconsin's Living Will and Power of Attorney for Health Care" included in this packet.

STEP 1: BEFORE FILLING IT OUT - Read the "To Whom It May Concern" information that accompanies the form - note the definitions of "feeding tube," "terminal condition" and "persistent vegetative state." Read the entire form carefully. Be sure that you understand and are comfortable with its language. If you have a Power of Attorney for Health Care, consider whether you need a Living Will since these same issues could be addressed in the Power of Attorney for Health Care and discussed with your health care agent. If you determine you need or want a Living Will, proceed to Step 2.

STEP 2: FILLING IT OUT - Print your name in the first blank and then proceed to the check-offs. Item 1 addresses the use of feeding tubes if you have a terminal condition. Item 2 addresses the use of life-sustaining procedures if you are in a persistent vegetative state. Item 3 addresses the use of feeding tubes if you are in a persistent vegetative state.

STEP 3: SIGNING and WITNESSING - You and your two witnesses must be together. The witnesses may not be relatives by blood, marriage or adoption, someone who is entitled to or has a claim on your estate, directly financially responsible for your health care, your health care provider, an employee of your provider or an employee of an inpatient facility where you are a patient. (EXCEPTION: Social workers and chaplains may witness these documents). Be sure all dates are identical.

STEP 4: AFTER IT IS COMPLETED – Make several copies of the form (the "To Whom It May Concern" page can be filed or discarded, and does not need to be attached to the completed Living Will form). Give a copy to your physician or your clinic, discuss your choices, and ask him or her to honor them if the situations ever arise. Give a copy to your hospital. Discuss and consider giving copies of the document to family members and close friends and ask them to honor your choices. Put the original in a safe place at home (not in a locked bank box). You may also, for a small fee, file a copy with the Register in Probate in your county's Probate Court office. Complete the wallet card (on last page of this packet) and put it in your wallet. If possible, have it laminated.

Congratulations! You have completed your Living Will.

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CWAG INSTRUCTIONS
LIVING WILL

CWAG

Coalition of Wisconsin Aging Groups
Advocacy ▪ Membership ▪ Elder Law

2850 Dairy Drive
Suite 100
Madison, WI 53718-6751
608-224-0606
800-488-2596 toll free
608-224-0607 fax
guardian@cwag.org
www.cwag.org

Securing the present and protecting the future.

Obtain the Wisconsin Living Will (Declaration to Physicians) form (2 pages), along with the "To Whom it May Concern" letter (2 pages), from:

http://dhfs.wisconsin.gov/forms/AdvDirectives/index.htm

See also following pages →

Scott Walker
Governor

Dennis G. Smith
Secretary

State of Wisconsin

Department of Health Services

DIVISION OF PUBLIC HEALTH

1 WEST WILSON STREET
P O BOX 2659
MADISON WI 53701-2659

608-266-1251
FAX: 608-267-2832
TTY: 888-701-1253
dhs.wisconsin.gov

To Whom It May Concern:

Enclosed is the Declaration to Physicians (Living Will) form you requested. This form makes it possible for adults in Wisconsin to state their preferences for life-sustaining procedures and feeding tubes in the event the person is in a terminal condition or persistent vegetative state.

Be sure to read both sides of the form carefully and understand it before you complete and sign it.

The withholding or withdrawal of any medication, life-sustaining procedure or feeding tube may not be made if the attending physician advises that doing so will cause pain or reduce comfort, and the pain or discomfort cannot be alleviated through pain relief measures.

Two witnesses are required. Witnesses must be at least 18 years of age, not related to you by blood, marriage or adoption, and not directly financially responsible for your health care. Witnesses may not be persons who know they are entitled to or have a claim on any portion of your estate. A witness cannot be a health care provider who is serving you at the time the document is signed, an employee of the health care provider, other than a chaplain or a social worker, or an employee other than a chaplain or social worker of an inpatient health care facility in which you are a patient. Valid witnesses acting in good faith are immune from civil or criminal liability.

You should make relatives and friends aware that you have signed the document and the location where it is kept. A signed form may be kept in a safe, easily accessible place until needed. The document may be filed for safekeeping for a fee with the Register in Probate of your county of residence, but it is not required that it be filed. The fee for filing with the Register in Probate has been set by State Statute at $8.00.

You are responsible for notifying your attending physician of the existence of the Declaration. An attending physician who is notified shall make the Declaration part of your medical records. A Declaration that is in its original form or is a legible photocopy or electronic facsimile copy is presumed to be valid.

If you have both a Declaration to Physicians and a Power of Attorney for Health Care, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Physicians.

Up to four copies of the Declaration to Physicians are available free to anyone who sends a stamped, self-addressed, business-size envelope to: Living Will, Division of Public Health, P.O. Box 2659, Madison, Wisconsin 53701-2659. You may make additional copies of the enclosed blank form. The form is also available on the Department of Health Services Web page http://dhs.wisconsin.gov/forms/DPHnum.asp .

If you have questions about the availability of the Declaration to Physicians (Living Will) form or obtaining larger quantities of the form, you may contact the Division of Public Health at (608) 266-1251.

INSTRUCTIONS FOR DECLARATION TO PHYSICIANS FORM

Definitions

"Declaration" means a written, witnessed document voluntarily executed by the declarant under State Statute 154.03 (1), but is not limited in form or substance to that provided in State Statute 154.03 (2).

"Department" means the Department of Health Services.

"Feeding tube" means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of a qualified patient.

DHS INSTRUCTIONS
LIVING WILL - 1

"Terminal condition" means an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

"Persistent vegetative state" means a condition that reasonable, medical judgment finds constitutes complete and irreversible loss of all the functions of the cerebral cortex and results in a complete, chronic and irreversible cessation of all cognitive functioning and consciousness and a complete lack of behavioral responses that indicate cognitive functioning, although autonomic functions continue.

"Qualified patient" means a declarant who has been diagnosed and certified in writing to be afflicted with a terminal condition or to be in a persistent vegetative state by two physicians, one of whom is the attending physician, who have personally examined the declarant.

"Attending physician" means a physician licensed under State Statute Chapter 448 who has primary responsibility for the treatment and care of the patient.

"Health care professional" means a person licensed, certified or registered under State Statutes Chapters 441, 448 or 455.

"Inpatient health care facility" has the meaning provided under State Statute 50.135 (1) and includes community-based residential facilities as defined in State Statute 50.01 (1g).

"Life-sustaining procedure" means any medical procedure or intervention that, in the judgment of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient.

"Life-sustaining procedure" includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis and other similar procedures, but does not include (a) the alleviation of pain by administering medication or by performing an medical procedure; or (b) the provision of nutrition or hydration.

Procedures for signing Declarations

A Declaration must be signed by the declarant in the presence of two witnesses. If the declarant is physically unable to sign a Declaration, the Declaration must be signed in the declarant's name by one of the witnesses or some other person at the declarant's express direction and in his or her presence; such a proxy signing shall either take place or be acknowledged by the declarant in the presence of two witnesses.

Effect of Declaration

The desires of a qualified patient who is competent supersede the effect of the Declaration at all times. If a qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures or feeding tubes, a Declaration executed under this chapter is presumed to be valid.

Revocation of Declaration

A Declaration may be revoked at any time by the declarant by any of the following methods:

1) By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the declarant or by some person who is directed by the declarant and who acts in the presence of the declarant.
2) By a written revocation, signed and dated by the declarant expressing the intent to revoke.
3) By a verbal expression by the declarant of his or her intent to revoke the Declaration, but only if the declarant or a person acting on behalf of the declarant notifies the attending physician of the revocation.
4) By executing a subsequent Declaration.

The attending physician shall record in the declarant's medical records the time, date and place of the revocation and time, date and place, if different, that he or she was notified of the revocation.

Liabilities

No physician, inpatient health care facility or health care professional acting under direction of a physician may be held criminally or civilly liable, or charged with unprofessional conduct of any of the following:

1) Participating in the withholding or withdrawal of life-sustaining procedures or feeding tubes under Chapter 154, subchapter II.
2) Failing to act upon a revocation unless the person or facility has actual knowledge of the revocation.
3) Failing to comply with a Declaration, except that failure by a physician to comply with a Declaration of a qualified patient constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the patient to another physician who will comply with the Declaration.

DHS INSTRUCTIONS
LIVING WILL -2

Effective Date
April 6, 1996
S. 154.03(1),(2)

PLEASE BE SURE YOU READ THE FORM CAREFULLY AND UNDERSTAND IT BEFORE YOU COMPLETE AND SIGN IT

DECLARATION TO PHYSICIANS (WISCONSIN LIVING WILL)

I, _____

being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a **TERMINAL CONDITION**, as determined by 2 physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

☐ YES, I want feeding tubes used if I have a terminal condition.

☐ NO, I do not want feeding tubes used if I have a terminal condition.

If you have not checked either box, feeding tubes will be used.

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures:

☐ YES, I want life-sustaining procedures used if I am in a persistent vegetative state .

☐ NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

If you have not checked either box, life-sustaining procedures will be used.

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of feeding tubes:

☐ YES, I want feeding tubes used if I am in a persistent vegetative state.

☐ NO, I do not want feeding tubes used if I am in a persistent vegetative state.

If you have not checked either box, feeding tubes will be used.

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

LIVING WILL FORM -1

ATTENTION: You and the 2 witnesses must sign the document at the same time.

Signed _____ **Date** _____

Address _____ **Date of Birth** _____

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness Signature _____ **Date Signed** _____

Print Name _____

Witness Signature _____ **Date Signed** _____

Print Name _____

DIRECTIVES TO ATTENDING PHYSICIAN

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when 2 physicians, one of whom is the attending physician, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

2. The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless you believe that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed.

3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

* * * * *

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document:

_____

_____

_____

_____

_____

CWAG "Advocating for All Generations"

Coalition of Wisconsin Aging Groups
Intergenerational Leadership Development • Education • Advocacy • Elder Law Center

The Coalition of Wisconsin Aging Groups is a nonprofit, nonpartisan, statewide membership organization that was founded in 1978.

COMPARISON of WISCONSIN'S LIVING WILL and POWER OF ATTORNEY FOR HEALTH CARE

	LIVING WILL (DECLARATION TO PHYSICIANS) *Ch. 154, Wis. Stats.*	POWER OF ATTORNEY FOR HEALTH CARE *Ch. 155, Wis. Stats.*
What it is	**Document signed by a patient giving instructions to physicians under certain circumstances.**	**Document signed by a "principal" appointing another individual as "agent" to make health care decisions for principal.**
When it becomes effective	When two physicians personally examine patient and sign statement that he or she is "terminal" and death is imminent, or is in a "persistent vegetative state."	When two physicians (or one physician and one psychologist) personally examine patient and sign statement that he or she is incapacitated (not able to make health care decisions).
Conditions under which document is effective	• "Terminal" and death imminent; or • "Persistent vegetative state."	Anytime incapacitated. **A Power of Attorney is more comprehensive than a Living Will because it covers more situations.**
Procedures covered	• "Life-sustaining" procedures to be used or withheld/withdrawn if in "persistent vegetative state." • Feeding tubes to be used or withheld/withdrawn if "terminal" or in "persistent vegetative state."	Almost anything. Agent may consent to or decline procedure. *Authority must be specifically authorized for:* • Long-term nursing home/CBRF admissions; • Tube feeding withholding/withdrawal; and • Continued effect during pregnancy.
Does not apply	• Neither "terminal" nor in "persistent vegetative state;" or • Terminal but death not imminent; or • Pregnant.	• Electroshock therapy; • Experimental mental health, drugs and treatment; and • Admission to mental facilities.
Use of alternative forms	Permitted, but no immunities for health care providers apply.	Permitted, and immunities for health care provider apply.
Individuals who may be agent or alternate agent	NOT APPLICABLE	Anyone, other than health care provider, employee of provider or facility where patient or resident, or spouse of provider/employee, unless also a relative. Usually a family member or close friend.
Witnessing requirements	Two disinterested persons. May not be: relative, person who will inherit or has claim on estate, directly responsible for patient's health care, or health care provider/facility employee (except social worker or chaplain).	Two disinterested persons. May not be: relative, person who will inherit or has claim on estate, directly responsible for patient's health care, or health care provider/facility employees (except social worker or chaplain).
Distribution and storage	Sign one original and make several copies. Copies to doctor/clinic, hospital, a family member. Original at safe place at home; may file with Register in Probate for small fee. Complete wallet card.	Sign one original and make several copies. Copies to doctor/clinic, hospital, agent, alternate agent, family member. Original at safe place at home; may file with Register in Probate for small fee. Complete wallet card.
Procedures to revoke document	1) Destroy all copies; 2) Signed & dated written revocation; 3) Oral Revocation with notice to doctor; 4) Execute new Declaration; or 5) Revoke with POAHC.	1) Destroy all copies; 2) Signed & dated written revocation; 3) Oral revocation in presence of 2 witnesses; or 4) Execute new POAHC.
Where to Obtain	http://www.dhs.wisconsin.gov/forms/AdvDirectives/index.htm *or* Division of Public Health, P.O. Box 2659, Madison, WI 53701-2659 *or* for forms with instructions and informational materials, send a voluntary $2 cash or check to: CWAG/POA, 2850 Dairy Drive, Suite 100, Madison, WI 53718-6751.	

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LIVING WILL vs POAHC

OPTIONS UNDER WISCONSIN LIVING WILL

	Do you want:	
Are you in:	**Life Sustaining Treatment?**	**Feeding Tube?**
Terminal Condition	*No treatment*	*Treatment Optional*
Persistent Vegetative State	*Treatment Optional*	*Treatment Optional*

Complete this WALLET CARD, clip it and place it in your wallet near your insurance cards. If possible, have it laminated.

ATTENTION HEALTH CARE PROVIDERS:
I have a: ___ Living Will ___ Power of Attorney-Health Care
My agent under my power of attorney is:

_____
Name

_____
Address

_____
Phone

Please consult these documents and/or this person in case of an emergency.

_____
Signature
Listed on the card back are locations of copies of document(s).

Now, RELAX and enjoy the peace of mind
that comes from knowing you have taken care of this important business!

Complete this WALLET CARD, clip it and place it in your wallet near your insurance cards. If possible, have it laminated.

ATTENTION HEALTH CARE PROVIDERS:
I have a: ___ Living Will ___ Power of Attorney-Health Care
My agent under my power of attorney is:

_____
Name

_____
Address

_____
Phone

Please consult these documents and/or this person in case of an emergency.

_____
Signature
Listed on the card back are locations of copies of document(s).

Now, RELAX and enjoy the peace of mind
that comes from knowing you have taken care of this important business!

WALLET CARDS

ATTENTION HEALTH CARE PROVIDERS:
Copies of my Living Will/Power of Attorney-Health Care documents may be found at the following locations:

#1 Name

#1 Address

#1 Phone

#2 Name

#2 Address

#2 Phone

ATTENTION HEALTH CARE PROVIDERS:
Copies of my Living Will/Power of Attorney-Health Care documents may be found at the following locations:

#1 Name

#1 Address

#1 Phone

#2 Name

#2 Address

#2 Phone

WALLET CARDS - LIVING WILL