



Coalition of Wisconsin Aging Groups
Advocacy • Membership • Elder Law

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*Securing the present
and protecting
the future.*

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. The current version is effective May 13, 1998.

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 not 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.



DIVISION OF PUBLIC HEALTH

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

State of Wisconsin

Department of Health and Family Services

608-266-1251

FAX: 608-267-2832

dhfs.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 both sides 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 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 copies of the enclosed blank. The form is also available on the Department of Health and Family Services Web page, <http://dhfs.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 FOR POWER OF ATTORNEY FOR HEALTH CARE FORM

Definitions

'Department' means the Department of Health and Family 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; or 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.



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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?



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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.

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.



DIVISION OF PUBLIC HEALTH

1 WEST WILSON STREET
PO BOX 2659
MADISON WI 53701-2659

State of Wisconsin

Department of Health & Family Services

608-266-1251
FAX: 608-267-2832
www.dhfs.state.wi.us

POWER OF ATTORNEY FOR HEALTH CARE
FOR

NAME: _____

COPIES GIVEN TO:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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, your health care providers and any other person to whom you have given a copy. If your agent is your spouse and your marriage is annulled or you are divorced 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 document 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 mentally retarded, 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 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 employee of the health care provider, other than a chaplain or a social worker, or an employee, 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 _____

Address _____

Signature _____ Date _____

Witness Number 2: (Print) Name _____

Address _____

Signature _____ Date _____

**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 _____

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

<p>ATTENTION HEALTH CARE PROVIDERS: I have a: ___ Living Will ___ Power of Attorney-Health Care My agent under my power of attorney is:</p> <hr/> <p><i>Name</i></p> <hr/> <p><i>Address</i></p> <hr/> <p><i>Phone</i></p> <p>Please consult these documents and/or this person in case of an emergency.</p> <hr/> <p><i>Signature</i> Listed on the card back are locations of copies of document(s).</p>

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.

<p>ATTENTION HEALTH CARE PROVIDERS: I have a: ___ Living Will ___ Power of Attorney-Health Care My agent under my power of attorney is:</p> <hr/> <p><i>Name</i></p> <hr/> <p><i>Address</i></p> <hr/> <p><i>Phone</i></p> <p>Please consult these documents and/or this person in case of an emergency.</p> <hr/> <p><i>Signature</i> Listed on the card back are locations of copies of document(s).</p>

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

**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