

## DO-IT-YOURSELF CONSUMER PACKET

### PLANNING FOR FUTURE HEALTH CARE DECISION-MAKING

### POWER OF ATTORNEY FOR HEALTH CARE

updated 3/2017

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 the Power of Attorney for Health Care to assist adults in making future health care decisions. This packet provides instructions and additional information to assist you in planning for future health care decisions.

This packet contains five pieces, plus this cover sheet:

1. **An eight-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. **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.

If you have questions about completing a Power of Attorney of Health Care, please contact the Guardianship Support Center at 1-855-409-9410 or email [guardian@gwaar.org](mailto:guardian@gwaar.org).



# POWER OF ATTORNEY FOR HEALTH CARE: AN OVERVIEW

## 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.

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 only provides 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, and you can provide additional clarification and instructions to your agent about your wishes. Living wills are frequently executed when one does not have an available person to act as the agent, there are significant concerns the agent might predecease the principal or become incapacitated or there is a significant fear the HCPOA will be inadvertently revoked by the principal. 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 typically activated upon a determination by two physicians or one physician and one psychologist who have personally examined you and have determined that you are 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." Wis. Stat. § 155.01(8). 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 a principal 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 the two disinterested witnesses, 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.

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 for 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

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:

**by phone: (855) 409-9410 or**  
**by email: [guardian@gwaar.org](mailto:guardian@gwaar.org)**

Copies of the packet are also available on the Internet at: [www.gwaar.org](http://www.gwaar.org).

## **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 to 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. You may name multiple alternate agents. There is no requirement providing that only one alternate agent be named. The order each named alternate agent is listed will designate who will serve as the next agent.



#### **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 choose 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.” Wis. Stat. § 155.01(2m). 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 the 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. Note, a POA-HC agent will not be able to make financial decisions for you unless the agent is also the POA-Finances agent. 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. 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.

Note: A POA-HC may be revoked at any time, even after the individual is determined to be incapacitated.

## **XXIII. Who Can I Contact If I Have Questions?**

The Wisconsin Guardianship Support Center is operated by the Elder Law and Advocacy Center of the Greater Wisconsin Agency on Aging Resources, Inc. to answer questions about Powers of Attorney.

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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 you 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?



## **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 zidovudine (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 as 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.

## **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 the Guardianship Support Center at 1-855-409-9410 or [guardian@gwaar.org](mailto:guardian@gwaar.org). You can also read “Power of Attorney for Health Care: An Overview” included in this packet.

**STEP 1: BEFORE FILLING 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 For Your Power of Attorney For Health Care Document” 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 bottom center 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 and 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 phone number of the individual you have selected as ALTERNATE AGENT. Remember, you may only appoint ONE individual as Agent.

Under **ADMISSION TO NURSING HOMES 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 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 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.

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

**See Comparison of Wisconsin’s Living Will and Power of Attorney for Health Care below**



# COMPARISON OF WISCONSIN'S LIVING WILL AND POWER OF ATTORNEY FOR HEALTH CARE

03/2011, updated 12/2014

## LIVING WILL (DECLARATION TO PHYSICIANS) *Ch. 154, Wis. Stats.*

## POWER OF ATTORNEY FOR HEALTH CARE *Ch. 155, Wis. Stats.*

<b>What it is</b>	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.
<b>When it becomes effective</b>	When two physicians personally examine patient and sign statement that he or she is "terminal" and death is imminent, <u>or</u> 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).
<b>Conditions under which document is effective</b>	<ul style="list-style-type: none"> <li>• "Terminal" and death imminent; or</li> <li>• "Persistent vegetative state."</li> </ul>	Anytime incapacitated. <b>A Power of Attorney is more comprehensive than a Living Will because it covers more situations.</b>
<b>Procedures covered</b>	<ul style="list-style-type: none"> <li>• "Life-sustaining" procedures to be used or withheld/withdrawn if in "persistent vegetative state."</li> <li>• Feeding tubes to be used or withheld/withdrawn if "terminal" or in "persistent vegetative state."</li> </ul>	Almost anything. Agent may consent to or decline procedure. <i>Authority must be specifically authorized for:</i> <ul style="list-style-type: none"> <li>• Long-term nursing home/CBRF admissions;</li> <li>• Tube feeding withholding/withdrawal; and</li> <li>• Continued effect during pregnancy.</li> </ul>
<b>Does not apply</b>	<ul style="list-style-type: none"> <li>• Neither "terminal" nor in "persistent vegetative state;" or</li> <li>• Terminal but death not imminent; or</li> <li>• Pregnant.</li> </ul>	<ul style="list-style-type: none"> <li>• Electroshock therapy;</li> <li>• Experimental mental health, drugs and treatment; and</li> <li>• Admission to mental facilities, certain treatment facilities, or intermediate care facilities for person with intellectual disabilities.</li> </ul>
<b>Use of alternative Forms</b>	Permitted, but no immunities for health care providers apply.	Permitted, and immunities for health care provider apply.
<b>Individuals who may be agent or alternate agent</b>	<b>NOT APPLICABLE</b>	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.
<b>Witnessing requirements</b>	Two disinterested persons. May <u>not</u> be: relative, person who will inherit or has claim on estate, directly financially responsible for patient's health care, or health care provider/facility employee (except social worker or chaplain).	Two disinterested persons. May <u>not</u> be: relative, person who will inherit or has claim on estate, directly financially responsible for patient's health care, or health care provider/facility employees (except social worker or chaplain).
<b>Distribution and storage</b>	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.
<b>Procedures to revoke document</b>	<ol style="list-style-type: none"> <li>1) Destroy all copies;</li> <li>2) Signed &amp; dated written revocation;</li> <li>3) Oral Revocation with notice to doctor;</li> <li>4) Execute new Declaration; or</li> <li>5) Revoke with POAHC.</li> </ol>	<ol style="list-style-type: none"> <li>1) Destroy all copies;</li> <li>2) Signed &amp; dated written revocation;</li> <li>3) Oral revocation in presence of 2 witnesses; or</li> <li>4) Execute new POAHC.</li> </ol>
<b>Where to Obtain</b>	<a href="http://www.dhs.wisconsin.gov/forms/AdvDirectives/index.htm">http://www.dhs.wisconsin.gov/forms/AdvDirectives/index.htm</a> or for forms with instructions and informational materials, go to <a href="http://www.gwaar.org">www.gwaar.org</a> or call (855) 409-9410.	

