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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 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 wish 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 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.

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 August 3, 2009 and was revised in May 2019.

If you have questions about how to complete this form, contact the Guardianship Support Center at 1-855-409-9410 or 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 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 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). For a small fee, you may 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

	LIVING WILL (DECLARATION TO PHYSICIANS) <i>Ch. 154, Wis. Stats.</i>	POWER OF ATTORNEY FOR HEALTH CARE <i>Ch. 155, Wis. Stats.</i>
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, <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).
Conditions under which document is effective	<ul style="list-style-type: none"> • "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	<ul style="list-style-type: none"> • "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. <i>Authority must be specifically authorized for:</i> <ul style="list-style-type: none"> • Long-term nursing home/CBRF admissions; • Tube feeding withholding/withdrawal; and • Continued effect during pregnancy.
Does not apply	<ul style="list-style-type: none"> • Neither "terminal" nor in "persistent vegetative state;" or • Terminal but death not imminent; or • Pregnant. 	<ul style="list-style-type: none"> • Electroshock therapy; • Experimental mental health, drugs and treatment; and • Admission to mental facilities, certain treatment facilities, or intermediate care facilities for persons with intellectual disabilities.
Use of alternative Forms	Permitted, but no immunities for health care providers apply.	Permitted, and immunities for health care providers 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 <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).
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	<ol style="list-style-type: none"> 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. 	<ol style="list-style-type: none"> 1) Destroy all copies; 2) Signed & dated written revocation; 3) Oral revocation in presences of 2 witnesses; or 4) Execute new POAHC.
Where to Obtain	http://www.dhs.wisconsin.gov/forms/AdvDirectives/index.htm or for forms with instructions and informational materials, go to www.gwaar.org or call (855) 409-9410.	