Do-It-Yourself Consumer Packet
Planning for Future Health-Care Decision-Making:
Power of Attorney for Health Care

Updated 08/2024

Who will make decisions for you if you're unable to communicate for yourself? What do you want for end-of-life care? Where you do you want to live and receive care as you grow older? A Power of Attorney for Health Care allows you to put your wishes in writing and choose someone to help carry them out if you are ever unable to make decisions for yourself. Wisconsin provides a standard form you can use; your health care providers may also have forms available.

This packet provides instructions and additional information to help you plan for future health care decisions. It contains five documents in addition to this cover sheet:

1. **An eight-page brochure entitled "Power of Attorney for Health Care: An Overview."** This brochure answers frequently asked questions about Powers of Attorney for Health Care.

2. **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** 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.

Power of Attorney for Health Care: An Overview

1. <u>What is a Power of Attorney for Health Care?</u>

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

2. <u>Why should I have a POA for Health Care?</u>

If you are ever unable to make your own health care decisions for any reason, a POA-HC is a way for you to choose someone to make those decisions for you, in accordance with your previously expressed wishes.

In Wisconsin, a family member is not automatically authorized to make health care decisions for you. You must have a POA-HC authorizing them as your agent.

Without a POA-HC, your family or others may have to go to court and get a temporary or permanent guardian of the person appointed for you. This can be expensive, time-consuming, and emotionally draining for you and your family. And it may result in the appointment of a person you would not have wanted to have decision-making power, or someone who doesn't know your wishes.

3. <u>What is the difference between a Living Will and a POA for Health Care?</u>

A Living Will informs your health care providers of your end-of-life wishes and allows them to carry those wishes out. 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.

In contrast, 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 consistent with your wishes if you ever become incapacitated, no matter what the reason.

See *Comparison of Wisconsin's Living Will and Power of Attorney for Health Care* on the last page of this packet for a more in-depth comparison.

4. <u>Should I have both a Living Will and a POA for Health Care?</u>

There can be benefits to having both. While a POA-HC generally provides more authority to your agent, a Living Will can serve as a backup to inform your health care providers of your wishes in case your agent and alternates are no longer willing or able to make decisions for you.

Make sure your wishes are consistent in the documents if you choose to have both. If the wishes

are inconsistent between the POA-HC and Living Will, the provisions in the valid POA-HC take priority over any that directly conflict with the valid Living Will. Wis. Stat. § 154.70(3).

5. What factors should I think about when selecting an agent?

Your agent should be willing to follow your wishes about your health care decisions and able to act in an emergency if necessary. There are other factors you may want to consider, including:

- Will they 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 they be willing to make decisions consistent with your wishes and not according to their own ideas of what the right decision would be?
- Do they have experience dealing with hospitals, doctors, and stressful health situations? Can they communicate effectively with your providers about your needs and wishes?
- Will they be able to ensure that you are being treated properly?
- Will they ask enough questions about the impact of certain decisions?
- Will they be able to insist that providers keep in contact with details about your treatment, about any change in your condition or medications, or about injuries?
- Are they geographically close? (Note: this is not required, but may be helpful)
- If they aren't nearby, are they comfortable advocating for you by phone or video?

6. Is there anyone who can't serve as my agent?

Your health care providers, their spouses and employees, and employees of facilities where you are receiving care cannot serve as your agent unless they are related to you. For example, if your sibling works at a hospital in which you are receiving care, they may serve as your agent if you wish, but other hospital staff who are not related to you cannot be your agent.

7. Should I name an alternate agent?

It is not required, but it is a good idea to have at least one alternate agent. Your agent could be on vacation, ill, unable to assist you, or deceased when you need help. If the primary agent cannot fulfill their responsibilities, 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; if they are needed, they will be called on in the order in which they are listed.

8. When does the agent's authority start? May I continue to make decisions after completing a document?

An agent has authority when you are declared incapacitated. If you remain able to make your own health care decisions, the agent's authority to make health care decisions doesn't take effect.

"Incapacity" is defined by Wisconsin law as "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." Wis. Stat. § 155.01(8). An assessment for incapacity determines whether you are capable of informed consent for health care at the time you are being asked to make a decision: are you able to understand your options and alternatives for care, choose between them, and express your decision?

Incapacity is determined by two physicians or one physician and one advanced practice clinician (physician assistant, nurse practitioner, or psychologist). They must personally examine you and sign a statement that you are incapacitated. The statement of incapacity must be attached to the POA-HC document. After this has happened, the agent's authority becomes effective.

If you want your document to be activated some other way, you can specify that in the document. Creating the document doesn't cause you to lose any decision-making authority. You continue to handle all your own health care decisions as long as you retain the capacity to make those decisions.

9. What kind of decisions will my agent be able to make?

Your agent will have the authority to make most health care decisions, which include decisions about services and procedures, providers, medications, and care. You may make your POA more specific if you wish. You can add your preferences about where you want to receive care, who you want to treat you, and the types of care you want to receive. you can also limit the types of decisions your agent can make. Your agent will not have the power to make decisions about non-health care issues, including who can visit you, changes to your health insurance, and other similar matters. You may want to complete a Financial Power of Attorney to allow someone to handle insurance and other financial matters.

In Wisconsin, three decisions must have specific authorization in the POA-HC:

1) Admission to a nursing home or community-based residential facility (CBRF) for purposes other than post-hospital rehab or respite (e.g., long-term care),
2) withholding or withdrawing feeding tubes, and
3) health care decisions for a principal who is pregnant.

If you want your agent to be able to make these decisions, you must grant them the authority in your POA document. You may choose to add special instructions or limitations within the document.

In addition, your agent will not be able to admit you to a mental health facility or to a hospital for inpatient mental health treatment.

10. 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 other body opening." Wis. Stat. § 155.01(2m). Feeding tubes 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. That authorization does not *require* your agent to have feeding tubes withheld or withdrawn, but without the authority, they cannot make the decision at all. You may limit that authority in the special instructions if you only want them to be able to make the decision certain circumstances. An agent may never withhold or withdraw orally ingested nutrition or hydration unless there is a medical reason that it may be harmful, e.g., you are at severe risk for choking.

11. Can my agent admit me to a nursing home?

For your agent to have the authority to admit you to a nursing home or Community Based Residential Facility 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 to a nursing home or CBRF for long-term care. Checking "NO" or leaving the box blank on the state form will prohibit your agent from admitting you for long-term care. If you want to give this authority to your agent, you must check the "YES" box on the form.

However, without specific authorization your agent can still admit you for short-term stays:

- For recuperative care for less than three months if admission is directly from the hospital, unless the hospitalization was for psychiatric treatment.
- For respite for less than 30 days if you and your agent live together.

Even if you give your agent authority to admit you for long-term care purposes, you can withdraw the authority by objecting. You don't lose the right to object even if you are considered incapacitated. However, if your condition requires it, a guardianship and protective placement order may then be obtained to keep you in a nursing home or CBRF against your wishes.

12. Whose wishes control after a POA 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 as expressed at any time, even after incapacity.

Because your agent is required to follow your wishes, it is very important that you talk to your agent about your wishes BEFORE you lose capacity. 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 but are still able to express your wishes, your agent is required to follow your current expression of wishes. If your wishes are unknown, your agent must act in your best interests.

13. <u>What should my agent do to advocate for me when making my health care decisions?</u>

Visit or contact you as often as necessary. If you are experiencing rapid medical changes, your agent should be communicating with you and your providers much more often. This is a responsibility that you should discuss with your agent before completing your POA-HC.

Ensure that you are not suffering abuse or neglect in your incapacitated state.

Attend meetings with your care team to discuss your care options and ensure that your wishes are represented and respected when developing care plans.

Provide informed consent or refusal for all your health care needs once your POA-HC document becomes activated. Your agent must be willing to learn about your condition and the proposed treatments and be able to apply your wishes to unforeseen health care decisions.

Some questions you may wish for your agent to consider or ask when making health care decisions:

- Why is this procedure or treatment necessary?
- How will it benefit my care?
- Are there any other reasonable alternatives or options?
- What might happen to me if I do not accept the treatment?
- What can I reasonably expect the outcome to be?
- What are the major risks involved?
- What is likely to be ahead? What are the best and the worst scenarios? What benefit and burden will the treatment offer?
- Will it relieve suffering, restore function, or enhance quality of life?
- Will it prolong the dying process without offering benefit?

For additional information, please see our guide on the Responsibilities of a Health Care Agent.

14. <u>What are the requirements for a valid POA for Health Care?</u>

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

1) be in writing,
2) be voluntarily executed by a principal who is 18 or older and who is of sound mind,
3) be dated and signed by the principal in the presence of two disinterested witnesses,
4) be signed and dated by the two disinterested witnesses, and
5) 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."

"Sound mind" means you understand the purpose of the document and can sign it voluntarily and free of any undue influence or coercion.

"Disinterested" means that your witnesses are not:

- your agent,
- related to you by blood, marriage, or adoption,
- financially responsible for your care,
- expected to inherit from you,
- your health care providers or employees of your providers or an inpatient facility in which you are receiving care (chaplains and social workers may witness, however).

15. <u>What should I do if I cannot physically sign the document?</u>

You may still complete 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 a witness.

16. <u>How can I complete a POA for Health Care?</u>

Both the state Department of Health Services and the Wisconsin Medical Society provide free forms; many hospitals and clinics use one or the other. You can find these online, request them from your clinic or facility staff, or request that DHS mail forms. The Guardianship Support Center has both forms linked from our website as well.

To request forms by mail, send a self-addressed, stamped business-size envelope to:

Division of Public Health
ATTN: POA
P.O. Box 2659
Madison, WI 53701

Please note which forms you would like. You may make copies of the forms.

You may also hire an attorney to draft a document tailored to your specific needs if you wish.

Other forms may be available and acceptable as long as they meet the statutory requirements for a valid POA-HC in Wisconsin noted above.

17. <u>Can I add an addendum to my POA for Health Care?</u>

Yes. If you use the state POA-HC form, you will notice that the space for adding specific instructions to your agent is small. If you have additional instructions, you may write them down in an addendum and attach it to your POA. Make sure to reference the addendum in the special instructions space. Sign,

date, and witness it at the same time as your main POA document.

18. Will completing a POA for Health Care avoid the need for a guardian?

Completing a POA-HC usually prevents needing to have a guardian of the person. However, there are some situations where a guardian of the person may still need to be appointed, including:

- If your agent is unable or unwilling to act and no alternates are available and willing,
- If you did not authorize nursing home or CBRF admission but now need those services,
- 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.

A POA-HC agent will not be able to make *financial* decisions for you unless you have given them authority in a financial Power of Attorney document. Also, there may be decisions that need to be made that are not covered by a POA-HC. A guardian might be appointed to handle those matters.

19. I completed my POA for Health Care in another state. Is it 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. Decisions about nursing home and CBRF admission, withholding or withdrawing of feeding tubes, and care for a pregnant principal must still be specifically authorized in the POA-HC document. 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. The document itself is still valid, but that decision is treated the same as if you had checked "no" on the Wisconsin form.

If you are new to Wisconsin or planning a move, you may want to review your existing POA-HC to make sure it still meets your needs and includes authority you may want your agent to have here. If you frequently travel or spend part of the year in another state, you do not need to have documents in both states – either one will be fine.

20. What should I do once I complete my POA for Health Care?

Once the form is completed, you should make copies or scan the document. Keep the original in an accessible place (not in a safe deposit box, since this document needs to be accessible to work) and distribute copies to your health care providers, your agent, your alternate agents, your hospital, and family members. You can also scan it and send the file to your agent and alternates if you wish. Copies are as valid as the original. For a small fee, you may be able file a copy with the register in probate at the courthouse in your county.

21. When should I review or update my POA for Health Care?

We recommend following "The 5 Ds" as a guideline for when to review or update your POA:

- Decade – Every new decade of your life.
- Death or Dispute – When a loved one or health care agent dies or disagrees with your preferences.
- Divorce – When a divorce occurs.
    - If you have named your spouse or domestic partner as your agent and you divorce or dissolve your domestic partnership, your POA-HC will be automatically revoked. If you would like your former spouse or partner to continue to serve, you must create a new POA-HC naming them after the divorce is final.
- Diagnosis – when you are diagnosed with a serious illness.
- Decline – when your health begins to decline, especially when you are unable to live on your own.

Your views on your health and quality of life will likely change as you age. Your POA-HC should account for those changes and be updated to reflect them. A POA-HC prepared when you were age 25 may or may not still work for you at age 85.

22. How do I revoke a POA for Health Care I may have made before?

All the options below will successfully revoke an existing POA-HC.

- Destroy all the copies of the existing document.
- Sign and date a written revocation.
- Orally revoke the document in the presence of two witnesses.
- Execute a new POA-HC. The POA-HC with the most recent date is the valid one.

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

23. Who can I contact if I have questions?

The Wisconsin Guardianship Support Center can answer questions about Powers of Attorney.

Phone: 1-855-409-9410
Email: guardian@gwaar.org
Website: https://gwaar.org/gsc

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 them before you need them to make decisions for you. We suggest you consider the following questions as a starting point for your discussion. There are no "right" or "wrong" answers. You should consider these questions based on your own beliefs, values, and circumstances, and then convey your wishes to your health care agent so that they can carry out their responsibilities as you would wish.

Always keep your agent informed of changes to your health and any changes in your wishes. 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. How do you feel about signing a legal document that names another person to make health care decisions for you if you are unable to do so? One that says what medical treatments you want and do not want when you are ill or dying?
2. How would you describe your current health status? If you currently have any medical problems, how would you describe them?
3. If you have current medical problems, in what ways, if any, do they affect your ability to function or your daily life?
4. How do you feel about your current health status?
5. What are your current health goals and goals for medical treatment?
    a. Do you want full treatment, with the goal to sustain life at all costs, including ALL life-sustaining measures?
    b. Do you want selective treatment, with the goal to attempt to restore functioning while avoiding intensive care, hospitalization, or long-term care?
    c. Do you want comfort-focused treatment, with the goal to maximize comfort by managing your symptoms?
6. Do you think you would want to have any of the following medical treatments? 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. Ventilator (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)

7. Where do you want to receive care, especially at the end of life?
8. If you have a primary care provider, do you have a good relationship with them? Why or why not? What are your preferences about your providers?
9. If you have irreversible chronic health conditions, such as multiple sclerosis, congestive heart failure, or kidney disease/failure, do you want additional treatments if there are complications or disease progression? How do you feel about treatments such as chemotherapy or radiation treatment for cancer, surgery, life-sustaining measures, or resuscitation efforts if your heart stops or you stop breathing?
10. If you ever have irreversible brain disease such as dementia/Alzheimer's, and are expected to live a long time, what are your wishes for care and treatment? Consider:
    a. Preventive care (dental exam, mammogram, colonoscopy, blood draw, pelvic exam, prostate exam, vaccines)
    b. Where you wish to live
    c. Emergency room visits and hospitalization
    d. Relief from potential suffering (pain, anxiety, breathlessness)
    e. Antibiotics
    f. Comfort feedings, artificial nutrition and hydration (tube feedings, IV fluids)
    g. Palliative care
11. How important are independence and control in your life? If your physical and/or mental abilities decline, how would that affect your attitude toward independence and self-sufficiency?
12. If you have a mental health condition, what are your wishes for care and treatment? Consider:
    a. Medications that work best for you
    b. Assistance during a crisis: objects, people, music, therapies that bring you comfort
    c. Your mental health providers/care plan

    (Please note, however, that your agent may not admit you to a hospital or other facility for mental health treatment.)
13. 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?
14. Do you have any fears regarding health care?
15. What do you think will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?
16. What is your attitude toward death?
17. How do you feel about the use of life-sustaining measures (like feeding tubes and ventilators) in the face of terminal illness?

18. How do you feel about the use of life-sustaining measures if you were in a persistent vegetative state (commonly referred to as "brain-dead")?
19. How do you feel about the use of life-sustaining measures in the face of irreversible chronic illness (e.g., Alzheimer's disease)?
20. What is your minimum acceptable quality of life? What does quality of life mean to you?
21. Do you want to donate parts of your body or your entire body at the time of your death?
22. What is your religious background? How do your religious beliefs affect your attitude toward serious or terminal illness?
23. Does your attitude toward death find support in your religion?
24. How does your faith community view the role of prayer or religious sacraments in an illness?
25. What do you want your agent to ask or consider when acting on your behalf? Some possible questions are
    a. Why is this procedure or treatment necessary?
    b. How will it benefit my care?
    c. Are there any other reasonable alternatives or options?
    d. What might happen to me if I do not accept the treatment?
    e. What can I reasonably expect the outcome to be?
    f. What are the major risks involved?
    g. What is likely to be ahead? What are the best and the worst scenarios? What benefit and burden will the treatment offer?
    h. Will it relieve suffering, restore function, or enhance quality of life?
    i. Will it prolong the dying process without offering benefit?
26. What else do you feel is important for your agent to know?

Suggested Additional Language for your POA-HC

Listed below are examples of language that could be included in the “special provisions” section of the state POA-HC form. Many of the following example provisions use the phrase “life-sustaining procedures.” Many procedures could potentially be considered life-sustaining, including use of a ventilator or feeding tubes, blood transfusions, etc. You may want to consider what types of procedures you personally consider to be life-sustaining (e.g., antibiotics if you have a serious infection) so that your agent will more clearly understand your wishes.

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 maintain or 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.
3. I wish for CPR to be attempted if necessary.

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 have my children/family provide my care.

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 Provider ____________________, 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.
4. I would prefer to die at ______________, if possible.

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.
2. I would like my health care agent to authorize all comfort measures needed to relieve my pain, including narcotics, regardless of the possibility of addiction.

Your Wishes on Religious Preferences

1. I wish to be treated at a (Catholic, Lutheran, etc.) nursing home/hospital if at all possible.
2. My religion is __________and I would like to be treated following its beliefs and norms.
3. I wish to have religious services provided to me once a week, even if I am unable to fully participate.
4. In the event of a terminal or life-threatening situation, I wish to receive my last rites.
5. I wish to be visited by my faith leader 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 family informed of my health care condition.
3. I would like my health care agent and alternate agent(s) to communicate and support each other.

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 was revised in February 2020; previous versions remain effective.

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.

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.
- Select your agent. This should be someone you trust who can handle the responsibility of your health care decisions. 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 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 "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 they will accept the responsibility of acting on your behalf if ever necessary.
- Select an alternative agent and talk with this person about your preferences as well.

COMPLETING THE FORM

Page numbers are at the bottom right of each page of the form and will be referenced throughout the guide.

Page 1

There is no information to fill out, but please fully read the page.

Page 2

WAIT to write the date at the top of the second page until the day you sign it.

PRINT your name and address and date of birth after the "I," at the top of the second page.

PRINT your agent's name, address, and phone number (include the area code), mid-way down the second page, in the first blank under "DESIGNATION OF HEALTH CARE AGENT" If the individual is a relative, indicate the relationship in parentheses, after the name, e.g., "(daughter)." Remember, you may only appoint ONE individual as Agent.

In the next blank, PRINT the name, address, and phone number of the individual you have selected as ALTERNATE AGENT. If you wish to appoint additional alternates, you may write their information down in the special instructions or in an addendum you include with the document.

Page 3

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) for long-term care. Mark the YES or NO box for each.

- 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 designed to protect you and 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. Remember: your Agent must follow your wishes, which means that if you object to admission to a facility, your agent may not admit you, even though you may have checked this box.
- If you check NO or leave the questions 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 for long term care if you are not competent at the time.

Page 4

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 to withdraw or withhold a feeding tube according to any other wishes you may have expressed.
- If you check NO or if you leave it blank, your Agent will have to seek a court order before they can make this decision.

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

If you also complete a Living Will, be sure that your two documents do not conflict.

Under **HEALTH CARE DECISIONS FOR PREGNANT WOMEN** section at the middle of page 4, check whether you want your Agent to have authority to make health care decisions if you are pregnant.

This applies to all health care decisions, not just decisions pertaining to the pregnancy. For example, if you are in a car accident while pregnant and left unconscious, someone must decide whether to set broken bones.

If you are concerned about your Agent making a decision about abortion, you may want to 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.

If you are not capable of becoming pregnant, you may write DOES NOT APPLY.

Under **STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS** on page 4, you may add in any other considerations or wishes you want your Agent to follow. Make sure whatever you include is legible. Some options might be language indicating your beliefs about life support procedures, 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, or circumstances in which your Agent may decide to have feeding tubes withheld or withdrawn. There are other examples of possible language for this section in this packet.

If you have more to insert than fits in the spaces, 1) print "see separate addendum" in this space, 2) use a separate sheet, titled *"Addendum to the Power of Attorney for Health Care of (your name),"* and 3) 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.

SIGNING AND WITNESSING

Page 5

In the presence of both witnesses, you should date the top of page 2 and sign and date the POA on page 5. You and your two witnesses must sign the document at the same time. Insert the same date right after your name. Have your two witnesses then sign, as indicated on the form.

Rules regarding witnesses: A witness MAY NOT be:

1) Your Agent or Alternate Agent(s)
2) A person who is entitled to or has a claim on your estate
3) Related by blood, marriage, or adoption
4) Someone directly financially responsible for your health care
5) Your health care provider
6) An employee of your health care provider
7) An employee of an inpatient health care facility in which you are a patient

For (6) and (7), however, a chaplain or social worker may be a witness.

Page 6

This is where your Agent and Alternate Agent sign to acknowledge this responsibility. It is not a requirement to creating a valid Power of Attorney, but it is encouraged. They do not need to sign at the same time as you.

Insert your own name in the first two blanks under **STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT**.

Have your Agent and Alternative sign and print their address in the appropriate blanks. You can then take or mail the form to your Agent and Alternate Agent for their signatures. No witnesses are required.

The section titled **ANATOMICAL GIFTS** on page 6 is optional. You don't 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 your entire body, 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.

AFTER IT IS COMPLETED

Make several copies of the form or scan it so that it can be printed later. Copies are as valid as the original. Always keep pages 1-6 together. The "To Whom It May Concern" pages can be filed or discarded.

> Remember – this form should be accessible, as it is needed to prove that your Agent is authorized to make decisions.
>
> Don't keep it in a safety deposit box where it cannot be reached.

Give a copy to your primary care provider or clinic and your hospital (if needed) or ask them to scan it into your chart. Discuss with your provider your choice of Agent, as well as your health care preferences, as indicated on the form. Ask your provider to honor your preferences and respect your choice of Agent, if the situation ever arises.

Also give copies of the completed form to your Agent and your Alternate Agent or make a scan available to them. 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, or they may choose to scan it and return it back to you). For a small fee, you may be able file a copy with the Register in Probate at your county courthouse.

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.

Comparison of Wisconsin's Living Will and Power of Attorney for Health Care

	Living Will (Declaration to Health Care Professionals), Ch. 154, Wis. Stats.	Power of Attorney for Health Care, Ch. 155, Wis. Stats.
What it is	**Document signed by a patient giving instructions to attending health care professionals 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 health care professionals, one of who must be a physician, personally examine patient and sign statement that they are "terminal" and death is imminent <u>or</u> they are in a "persistent vegetative state."	When two physicians (or one physician and one advanced practice clinician – a nurse practitioner, physician assistant, or psychologist) personally examine patient and sign statement that they are incapacitated (not able to make health care decisions).
Conditions under which document is effective	• "Terminal" and death imminent; or • "Persistent vegetative state."	Anytime incapacitated. **A Power of Attorney is more comprehensive than a Living Will because it covers more situations.**
Procedures covered	• "Life-sustaining" procedures to be used or withheld/withdrawn if in "persistent vegetative state." • Feeding tubes to be used or withheld/withdrawn if "terminal" or in "persistent vegetative state."	Almost anything. Agent may consent to or decline procedure. *Authority must be specifically authorized for:* • Long-term nursing home/CBRF admissions; • Tube feeding withholding/withdrawal; and • Continued effect during pregnancy.
Does not apply	• Neither "terminal" nor in "persistent vegetative state;" or • Terminal but death not imminent; or • Pregnant.	• Electroshock therapy; • Experimental mental health, drugs and treatment; and • Admission to mental facilities, certain treatment facilities, or intermediate care facilities for persons with intellectual disabilities.
Use of alternative forms	Permitted; not required to use the state form.	Permitted; not required to use the state form.
Individuals who may be agent or alternate agent	**NOT APPLICABLE**	Anyone, other than health care provider, employee of a 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	1) Destroy all copies; 2) Signed & dated written revocation; 3) Oral Revocation with notice to doctor; 4) Execute new Declaration; or 5) Revoke with POAHC.	1) Destroy all copies; 2) Signed & dated written revocation; 3) Oral revocation in presence of 2 witnesses; or 4) Execute new POAHC.
Where to obtain	https://www.dhs.wisconsin.gov/forms/advdirectives/adformspoa.htm or for forms with instructions and informational materials, go to https://gwaar.org/guardianship-resources or call (855) 409-9410.	