State of Wisconsin

Department of Health Services

# Instructions to Complete the Power of Attorney for Health Care Form

To Whom It May Concern:

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

Be sure to read all six (6) pages of the form carefully and understand it before you complete and sign it. Talk with those you select as your health care agent and the alternate health care agent about your thoughts and beliefs about medical treatment. Neither the health care agent nor the alternate may be your health care provider, an employee of a health care facility in which you are a patient, or a spouse of any of those persons, unless he or she is also your relative.

Two witnesses are required. Witnesses must be at least 18 years of age, not related to you by blood, marriage, domestic partnership, or adoption, and not directly financially responsible for your health care. A witness cannot be a health care provider who is serving you at the time the document is signed or an employee of the health care provider unless the employee is a chaplain or social worker. A witness cannot be an employee of an inpatient health care facility in which you are a patient, unless the employee is a chaplain or social worker. A witness cannot be your health care agent nor have a claim on any portion of your estate. Valid witnesses acting in good faith are immune from civil or criminal liability.

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

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

**Definitions** 'Department' means the Department of Health Services. 'Health Care' means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. 'Health care decision' means an informed decision in the exercise of the right to accept, maintain, discontinue, or refuse health care. 'Health care facility' means a facility, as defined in State Statute 647.01(4), or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, tuberculosis sanatorium or other place licensed or approved by the department under State Statutes 49.70, 49.71, 49.72, 50.02, 50.03, 50.35, 51.08, 51.09, 58.06, 252.073 or 252.076 or a facility under s. 45.365, 51.05, 51.06, 233.40, 233.41. 233.42 or 252.10. 'Health care provider' means a nurse licensed or permitted under State Statute Chapter 441, a chiropractor licensed under Chapter 446, a dentist licensed under Chapter 447, a physician, podiatrist or physical therapist licensed or an occupational therapist or occupational therapy assistant certified under Chapter 448, a person practicing Christian Science treatment, an optometrist licensed under Chapter 449, a psychologist licensed under

POWER OF ATTORNEY FOR HEALTH CARE

FOR

Name:_____

Copies Given to:

1._____ Phone_____

2._____ Phone_____

3._____ Phone_____

4._____ Phone_____

5._____ Phone_____

6._____ Phone_____

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

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

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

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

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

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

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

## POWER OF ATTORNEY FOR HEALTH CARE

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

## CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, _____

_____

_____

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

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

## DESIGNATION OF HEALTH CARE AGENT

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

_____

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

_____

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

## GENERAL STATEMENT OF AUTHORITY GRANTED

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

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

## LIMITATIONS ON MENTAL HEALTH TREATMENT

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

## ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES

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

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

1. A nursing home - - ☐ Yes ☐ No

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

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

## PROVISION OF FEEDING TUBE

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

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

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

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

## HEALTH CARE DECISIONS FOR PREGNANT WOMEN

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

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

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

## STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

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

1. _____

2. _____

3. _____

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

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

(a) Request, review, and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records.

(b) Execute on my behalf any documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

**(The principal and the witnesses all must sign the document at the same time.)**
**SIGNATURE OF PRINCIPAL**
(Person creating the Power of Attorney for Health Care)

Signature _____ Date _____

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

**STATEMENT OF WITNESSES**

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

Witness Number 1
(Print) Name _____ Date _____

Address _____

Signature _____

Witness Number 2
(Print) Name _____ Date _____

Address _____

Signature _____

**STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT**

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

Agent's Signature _____

Address _____

Alternate's Signature _____

Address _____

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

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

## ANATOMICAL GIFTS (optional)

Upon my death:

☐ I wish to donate only the following organs or parts: (specify the organs or parts).

_____

_____

_____

☐ I wish to donate any needed organ or part.

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

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

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

Signature _____ Date _____