AGNESIAN HEALTHCARE | A member of SSMHealth

How to Complete This Power of Attorney for Health Care

Overview

The attached Power of Attorney for Health Care form is a legal document, developed to meet the legal requirements of Wisconsin. This document enables a person to create a Power of Attorney for Health Care that will meet the basic requirements for Wisconsin.

This form allows you to appoint another person(s) to make your health care decisions if you become unable to make these decisions for yourself. The person(s) you appoint is your health care agent. **It does not give your health care agent any authority to make your financial or other business decisions.**

Before completing this Power of Attorney for Health Care form, read it carefully. It is also very important that you discuss your views, values and this document with your health care agent! If you do not closely involve your health care agent and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

Steps To Complete This Document

1. Carefully read and follow instructions for each section
2. Complete the information for "Power of Attorney for Health Care."
3. Part I - **Appointing a Health Care Agent**

   Complete by appointing and listing information about at least one person who will act as your health care agent.
4. Part II - **Authority of the Health Care Agent**

   Complete by indicating your choices in Sections 1, 2 and 3.
5. Part III - **Statement of Desires, Special Provisions or Limitations**
   Complete by indicating your desires, provisions or limitations for care.
6. Part IV - **Making the Document Legal**
   Complete by signing and dating the document in front of two witnesses. Have the witnesses sign the document.

After Completing This Document

After you sign and date the Power of Attorney for Health Care document, keep the original for yourself and make copies for:

- each health care agent appointed in the document
- your physician and then have a discussion about your wishes
- each person in your family who may come if you are seriously ill and does not live with you
- sharing with others as you wish (loved ones, your minister/clergy/rabbi or your attorney)

A photo or fax copy is as legally valid as an original.

Donating Your Body To Science

If you wish to donate your body to medical science after death, you should contact the closest medical school in the state and make arrangements through that school. Here are some places to contact:

Medical College of Wisconsin, Milwaukee: (414) 955-8261

University of Wisconsin-Madison Medical School: (608) 262-2888

Need Assistance?

If you need assistance to complete this document contact:
Advanced Care Planning: (920) 926-4704
Waupun Memorial Hospital, Care Management: (920) 324-8410
Ripon Medical Center, Care Management: (920) 745-3763

Please send completed documents to:
St. Agnes Hospital, Care Management
Attn: Advanced Care Planning
430 E. Division Street, Fond du Lac, WI 54935

On the second Wednesday of each month, help is available to complete the Power of Attorney for Health Care form in the Fond du Lac Regional Clinic lobby from 9 a.m. to 2 p.m.

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Power of Attorney for Health Care for:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Copies of this document have been given to:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Power of Attorney for Health Care Document

Notice to the 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 concern if you become physically or mentally unable to make decisions about your health care.

In order to avoid this issue, 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 particular health care decisions, he or she is required to determine what would be in your best interests in making the decision.

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

Do not sign this document unless you clearly understand it.

It is suggested that you keep a copy of this document on file with your physician.

For purposes of this document, incapacity exists if two physicians, or one physician and one advanced practice clinician, which means a licensed psychologist, certified nurse practitioner or licensed physician assistant who have personally examined me sign a statement that specifically expresses their opinion 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 this statement must be attached to this document.

Part I – Appointing A Health Care Agent

If I am no longer able to make my own health care decisions, I can choose a person to make these choices for me. This person will be my health care agent. This person will make my health care decisions, as provided under state law, when I am determined to be incapable to make those decisions.

Instructions for completing Part I:

When selecting someone to be your health care agent, pick someone who knows you well, whom you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Make sure that you pick someone who will closely follow what you want and will be a good advocate for you. Whatever you do, take time to discuss this document and your views with the person(s) you pick to be your agent.

Your health care agent must be at least 18 years or older and should not be one of your health care providers or an employee of your health care provider or employee of a health care facility in which an individual is a patient or resides, or a spouse of any of those providers or employees, unless he or she is a close relative. Space has been provided for a second and third alternative health care agent.

The person I choose as my health care agent is:

Name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

If this health care agent is unable or unwilling to make these choices, then my next choice for a health care agent is:

Second choice:

Name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

If this health care agent is unable or unwilling to make these choices, then my next choice for a health care agent is:

Third choice:

Name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Part II – Authority of the Health Care Agent

I reserve the right to participate in decision-making even if I become incapacitated and even if my current wishes differ from my previously stated wishes. If I am unable to participate, I want my health care agent to be able to make an informed decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat the principal's physical or mental condition.

- Make choices for me about my medical care or services, such as tests, medicine and surgery. If treatment has already started, my health care agent can keep it going or have it stopped depending upon my stated instructions or my best interest.
- Interpret any instruction I have given in this form or given in other discussions according to my health care agent's understanding of my wishes and values.
- Review and release my medical records and personal files as needed for my medical care.
- Determine which health professionals and organizations should provide my medical treatment.
- Request, review and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.
- Execute on my behalf any documents that may be required in order to obtain this information.
- Consent to the disclosure of this information.

Limitations on Mental Health Treatment

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

Instructions for completing Part II: Directions for My Care

If you do not check any box in a section and make no clear choice, the statute in Wisconsin says your choice is considered to be "no." This means if you do not indicate a choice, in Wisconsin, only a court may make such a decision and not your health care agent. (Please check the box/boxes that express your wishes.)

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

   ❑ Yes, my health care agent has authority, if necessary, to admit me to a nursing home for a long-term stay, subject to any limits I have set forth in this document.

   ❑ Yes, my health care agent has authority, if necessary, to admit me to a community-based residential facility for a long-term stay, subject to any limitations I have set forth in this document.

   ❑ No, my health care agent does not have authority to admit me to a nursing home or a community-based residential facility for a long-term stay. If I check "no" I cannot be admitted to a Wisconsin long-term care facility without a court order.

2. **Agent authority to order the withholding or withdrawal of feeding tube and IV hydration.**

   ❑ Yes, my health care agent has authority to have a feeding tube withheld or withdrawn from me subject to any limits I have set forth in this document.

   ❑ Yes, my health care agent has authority to have IV hydration withheld or withdrawn from me subject to any limits I have set forth in this document.

   ❑ No, my health care agent does not have authority to have a feeding tube or IV hydration withheld or withdrawn from me. If I check "no" feeding tubes or IV hydration cannot be withheld or withdrawn in Wisconsin without a court order.

3. **Agent authority to make decisions if I am pregnant.**

   ❑ Yes, my health care agent has authority to make decisions for me if I am pregnant, subject to any limits I have set forth in this document.

   ❑ No, my health care agent does not have authority to make decisions for me if I am pregnant. If I check "no" health care decisions cannot be made for me without a court order during my pregnancy.

   ❑ Not applicable.

Part III – Statement of Desires, Special Provisions or Limitations

My health care agent shall make decisions consistent with my stated desires and is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my health care agent and/or physician providing my medical care. If I require treatment in a state that does not recognize this Power of Attorney for Health Care, or my health care agent cannot be contacted, I want the instructions, unless otherwise expressed by me, to be followed based on my common law and constitutional right to direct my own health care.

Instructions for completing Part III:

You are not required to provide any written instructions or make any selections in Part III.

If you choose not to provide any instructions, your health care agent will make decisions based on your oral instructions or what is considered your best interest.

Stopping attempts of life-prolonging treatments: (Please check the box/boxes that express your wishes.)

❑ If I reach a point when it is reasonably certain that I will not recover my ability to interact meaningfully with myself, my family, friends and environment, I want to stop or withhold all treatments that might be used to prolong my existence. Treatments I would not want if I were to reach this point include tube feedings, IV hydration, respirator/ventilator, CPR, antibiotics or blood products.

Pain and symptom control:

❑ If I reach a point when efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable.

Cardiopulmonary Resuscitation (CPR):

My CPR choice listed below may be considered by my health care agent in light of my own other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency personnel from attempting CPR in an emergency. Other documents may be needed to control the actions of emergency personnel. (Please check the box that expresses your wishes.)

❑ I want cardiopulmonary resuscitation (CPR) attempted if my heart stops.

❑ I do not want CPR attempted if my heart stops.

❑ I want cardiopulmonary resuscitation attempted unless my physician determines one of the following:

- I have an incurable illness or injury and am dying;

OR

- I have no reasonable chance of survival if my heart stops;

OR

- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.

Donation of my organs or tissue (optional):

(Please check the box that expresses your wishes.)

❑ I want to donate only the following organs or parts if possible (name the specific organs or tissue): _____

_____

_____

_____

_____

❑ I want to donate any organs or tissue if I am a candidate.

❑ I do not want to donate any organ or tissue.

Part IV – Instructions for completing Part IV: Making the Document Legal

- The person creating this document must have it signed and dated in the presence of two witnesses.
- The signing of this document revokes all previous Powers of Attorney for Health Care documents.

My signature: _____ Date: _____

Statement of Witness

I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not a health care agent appointed by the person signing this document.
- Not related to the person signing this document by blood, marriage or adoption.
- Not directly financially responsible for that person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness No. One:

Signature: _____ Date: _____

Print name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Witness No. Two:

Signature: _____ Date: _____

Print name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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 is 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: _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Alternate's signature: _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Alternate's signature: _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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 health care decisions.

Optional (not legally binding)

I would like my health care agent to include the following people in my health care decisions if there is time:

Other instructions or limitations I want my health care agent to follow:

If I am nearing my death, I want the following (list what would make dying more meaningful for you):

If I am nearing my death and cannot speak, I want my friends and family to know:

AGNESIAN HEALTHCARE
A member of SSM Health

Advance Directive/ Power of Attorney for Health Care Receipt

Name: _____

Advance Directive/Power of Attorney for Health Care Receipt

This letter is sent to acknowledge receipt of your Advance Directive/Power of Attorney for Health Care document, according to Wisconsin Chapter 154 Advance Directive and Chapter 155 Health Care Power of Attorney.

Thank you,

_____ _____

Name/Department
Agnesian HealthCare - a member of SSM Health

Date