AGNESIAN HEALTHCARE

# How to Complete This Power of Attorney for Healthcare

## Overview

The attached Power of Attorney for Healthcare 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 healthcare 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 Healthcare form, read it carefully. It is also very important that you discuss your views, values and this document with your healthcare 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.

If you want to document your views about future health care, but do not want to or cannot use this Power of Attorney for Healthcare form, ask your healthcare organization or attorney about alternatives.

## Steps To Complete This Document

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

   Complete by appointing and listing information about at least one person who will act as your healthcare agent.
4. Part II - **Authority of the Healthcare 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 Healthcare 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) 259-3666 or (800) 272-3666

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

## Need Assistance?

If you need assistance to complete this document contact:
St. Agnes Hospital, Care Management - (920) 926-4750
Waupun Memorial Hospital, Care Management - (920) 324-5581
Ripon Medical Center - (920) 748-9134

AGNESIAN HEALTHCARE

# Power of Attorney for Healthcare for:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Copies of this document have been given to:

_____

_____

_____

_____

_____

_____

_____

_____

_____

AGNESIAN HEALTHCARE

# Power of Attorney for Healthcare Document

## Notice to the person making this document:

You have the right to make decisions about your healthcare. 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 healthcare 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 healthcare decisions for you if you are unable to make those decisions personally. That person is known as your healthcare 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 healthcare that you do or do not desire, and you may limit the authority of your healthcare 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 healthcare decisions for you. It revokes any prior power of attorney for healthcare that you may have made. If you wish to change your Power of Attorney for Healthcare, you make 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 healthcare 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 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 healthcare 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 healthcare decisions, I can choose a person to make these choices for me. This person will be my healthcare agent. This person will make my healthcare 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 healthcare 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 healthcare agent must be at least 18 years or older and should not be one of your healthcare providers or an employee of your healthcare provider or employee of a healthcare 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 healthcare agent.

## The person I choose as my healthcare agent is:

Name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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

## Second choice:

Name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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

## Third choice:

Name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

## Part II – Authority of the Healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare agent. (Please check the box/boxes that express your wishes.)

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

   ❑ Yes, my healthcare 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 healthcare 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 healthcare agent does not have authority to admit me to a nursing home or a community-based residential 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 I.V. hydration.**

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

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

   ❑ Yes, my healthcare 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 healthcare agent does not have authority to make decisions for me if I am pregnant. If I check "no" healthcare 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 healthcare 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 healthcare agent and/or physician providing my medical care. If I require treatment in a state that does not recognize this Power of Attorney for Healthcare, 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 healthcare 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, I.V. 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 healthcare 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 – Making the Document Legal Instructions for completing Part IV:

- 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 Attorneys for Healthcare 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 healthcare 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 healthcare.
- not a healthcare provider directly serving the person at this time.
- not an employee (other than a social worker or chaplain) of a healthcare 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. 1:**

Signature: _____ Date: _____

Print name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

**Witness No. 2:**

Signature: _____ Date: _____

Print name: _____

Day phone: _____ Evening phone: _____

Address: _____

City: _____ State: _____ Zip: _____

## Statement of Healthcare Agent and Alternate Healthcare Agent

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

_____(name of principal) has discussed his or her desires regarding healthcare decisions with me.

Agent's signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Alternate's signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Alternate's signature: _____

Address: _____

City: _____ State: _____ Zip: _____

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

## Optional (not legally binding)

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

_____

_____

Other instructions or limitations I want my healthcare 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:

_____

_____

_____

_____

_____

_____