



Completing The Power of Attorney for Health Care Document:

Power of Attorney for Health Care documents that are created in Wisconsin must meet the following requirements to be valid:

1. The law requires that you date and sign your Power of Attorney for Healthcare in the presence of two adult witnesses. The two witnesses must sign a statement stating that you are of sound mind and that you signed the Power of Attorney for Healthcare of your own free will. The date you sign and the date your witnesses sign must match.
2. The witnesses **cannot be**:
 - Related to you by blood, marriage or adoption.
 - Persons who know they are entitled to, or have a claim against, any part of your estate.
 - Directly financially responsible for your healthcare.
 - Your healthcare provider.
 - An employee of your health care provider, other than a chaplain or a social worker.
 - An employee of an inpatient healthcare facility in which you are a patient, other than a chaplain or a social worker.
 - Your healthcare agent.

****Note:** You do NOT need to notarize your Wisconsin Power of Attorney for Healthcare Document.

Available Assistance with Completing the Power of Attorney for Health Care Document

- The VMH Patient and Family Services Social Workers can provide you with assistance in completing a document. **To schedule an appointment with a VMH Social Worker call 608-637-4367 or 608-637-4241.**

Power of Attorney for Healthcare for

Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Copies of this document are being or have been given to the following health organizations and people. (Provide copies to your hospital, physician, and health care agents. Copies might also be given to close family, friends and clergy.):

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Power of Attorney for Healthcare Document

Notice to the Person Making This Document:

You have the right to make decisions about your healthcare. No healthcare may be given to you over your objection and necessary healthcare 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 healthcare.

In order to avoid this problem, you may sign this legal document to specify a person who you would want to make healthcare decisions for you if you become unable to make those decisions personally. That person would be known as your healthcare agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons you might specify. You may state in the document any types of healthcare that you do or do not desire, and you may limit the authority of your healthcare agent. If your healthcare agent is unaware of your desires with respect to a particular healthcare decision, he or she is expected 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 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 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 designation of your spouse as healthcare agent shall no longer be valid.

You may also use this document to make or refuse to make any 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 you may have made. You may revoke or change any anatomical gift that you make in this document by crossing out the anatomical gift 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 healthcare provider.

Part I – Appointing a Person to Make My Healthcare Decisions When I Can't Make My Own Healthcare Decisions

If I am no longer able to make my own healthcare decisions, this document names the person I choose to make these choices for me. This person will be my healthcare agent. This person will make my healthcare decisions when I am determined to be incapable to make healthcare decisions as provided under state law.

Instructions for Completing This Part:

When selecting someone to be your healthcare agent, pick someone who knows you well, who 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(s).

Your healthcare agent should be at least 18 years or older and should not be one of your healthcare providers or an employee of your healthcare provider unless they are a close relative. Space has been provided for a second and third alternate healthcare agent.

The person I choose as my Healthcare Agent is:

Name: _____

Day Phone: _____ Evening Phone: _____

Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

If this healthcare agent is unable or unwilling to make these choices for me, or if my spouse is designated as my healthcare agent and our marriage is annulled or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

Second Choice (1st Alternate Agent)

Name: _____

Day Phone: _____ Evening Phone: _____

Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

If this alternate healthcare agent is unable or unwilling to make these choices for me, or if my spouse is designated as my healthcare agent and our marriage is annulled or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

Third Choice (2nd Alternate Agent)

Name: _____

Day Phone: _____ Evening Phone: _____

Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Part II – General Authority of the Healthcare Agent

I want my healthcare agent to be able to do the following (Please cross out anything you do not want your healthcare agent to do that is listed below):

- To make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment has already been started, my healthcare agent can keep it going or have it stopped depending upon my stated instructions or my best interests.
- To interpret any instructions I have given in this form or given in other discussions according to my healthcare agent's understanding of my wishes and values.
- To review and release my medical records and personal files as needed for my medical care.
- To arrange for my medical care and treatment in Wisconsin, Minnesota, and Iowa or any other state, as my healthcare agent thinks appropriate.
- To determine which health professionals and organizations provide my medical treatment.
- To make decisions about organ/tissue or body donation decisions (anatomical gifts) after my death according to my known wishes or values.

Instructions for Completing These Sections:

Put your initial on the line (e.g. DJ) to indicate you have selected “yes,” “no,” or “not applicable” in the next three sections. Draw a line through the statements you do not select (e.g. ~~No, my healthcare . . .~~). If you do not initial any line in a section and make no clear choice, the statute in Wisconsin says your choice is considered to be “no.” This means that if you do not indicate a choice, in Wisconsin only a court may make such a decision and not your healthcare agent.

1. Agent authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care:

_____ **Yes**, my healthcare agent has authority, if necessary to admit me to a nursing home or community based residential facility for a long-term stay, subject to any limits I have set forth in this document.

_____ **No**, my healthcare agent does not have authority, if necessary to admit me to a Wisconsin nursing home or community-based residential facility for a long-term stay. *If I initialed “no,” or leave this section blank, 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/or IV hydration:

_____ **Yes**, my healthcare agent has authority to have a feeding tube or 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 and/or IV hydration withheld and/or withdrawn from me. *If I initialed “no,” or leave this section blank, feeding tubes or IV hydration cannot be withheld or withdrawn from me 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 later set forth in this document.

_____ **No**, my healthcare agent does not have authority to make decisions for me if I am pregnant. *If I initialed “no,” or leave this section blank, healthcare decisions cannot be made for me during my pregnancy without a court order.*

_____ **Not Applicable**, because I am either a male or no longer capable of becoming pregnant.

Part III – Statement of Desires, Special Provisions, or Limitations

My healthcare agent shall make decisions consistent with my stated desires and values 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 there are conflicts among my known values and goals, I want my agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this Power of Attorney for Healthcare, or my healthcare agent cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own healthcare.

Instructions for Completing These Sections:

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 they consider your best interest. If you choose **not** to provide any instructions, it is recommended that you draw a line and write “no instructions” across the page.

Stopping Attempts of Life-Prolonging Treatments:

[Either put your initial (e.g. DJ) on the line next to each statement if you agree or draw a line through the statement if you do not agree.]

_____ If I reach a point where 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** treatment that might be used to prolong my existence. Treatments I would not want if I were to reach this point include but are not limited to tube feedings, IV hydration, respirator/ventilator, CPR, and antibiotics.

Pain and Symptom Control

If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable. The following are important to me for comfort: (If you don't write specific wishes, your physician, and nurses will provide the best standard of care possible.)

Cardiopulmonary Resuscitation (CPR):

My CPR choice listed below may be reconsidered by my healthcare agent in light of my other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my healthcare provider 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.

(Initial one of the following statements and draw a line through the statements that you do not want.)

_____ I want CPR attempted unless my physician determines any 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.

_____ I want CPR attempted if my heart stops.

_____ I do not want CPR attempted if my heart stops, but rather, want to permit a natural death.

Other Instructions or Limitations I want My Healthcare Agent to Follow:

If it is possible, when I am nearing my death and cannot speak, I want my friends and family to know I have the following thoughts and feelings:

If I am nearing my death, I want the following: (List the types of care, ceremonies, etc. that would make dying more meaningful for you.)

Persons I Want My Agent to Include in the Decision Process:

I ask that my healthcare agent make reasonable attempts to include the following persons in my healthcare decisions if there is time:

Religion:

I am of the _____ faith, and am a member of the _____, congregation, synagogue, or worship group. The phone number of the congregation, synagogue, or worship groups (if known): _____.

Please attempt to notify them.

Upon My Death:

After my death the following are my instructions. If my healthcare agent does not have authority to make these decisions, I ask that my next of kin and healthcare provider follow these requests if possible.

Autopsy:

(Initial both the first and second choice, or just one choice, and draw a line through the statements that you do not want.)

_____ I would accept an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future healthcare decisions.

_____ I would accept an autopsy if it can help the advancement of medicine or medical education.

_____ I do not want an autopsy performed on me.

Donation of My Organs or Tissue: (Examples of organs are kidney, liver, heart, lung, and examples of tissues are eye, skin, bone, heart valve.)

(Initial one and draw a line through the statements that you do not want.)

_____ I consent to donate only the following organs or parts if possible (name specific organ and/or tissue: _____).

_____ I consent 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 These Sections:

Wisconsin residents must have this document signed and dated in the presence of two witnesses. Minnesota or Iowa residents may have this document signed and dated in the presence of two witnesses or a notary public.

I am thinking clearly; I agree with everything that is written in this document and I have made this document willingly.

My Signature (or my signature signed by the person named below)

Date

If I cannot sign my name, I can ask someone to sign this document for me.

Signature of the person who I asked to sign this document for me.

Print the name of the person who I asked to sign this document for me.

Statement of Witnesses

I know this person to be the individual identified in the document. I believe him or her to be of sound mind and at least 18 years of age. 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 related to the person signing this document by blood marriage or adoption.**
- Not a healthcare agent appointed by the person signing this document.
- 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 Number 1:

Signature

Date

Print Name

Address

Witness Number 2:

Signature

Date

Print Name

Address

Instructions for Notarization:

Residents of Iowa and Minnesota may have the document signed by a notary public authorized in their state instead of having two witnesses.

Notary Public

In my presence on _____(Date), _____(Name) acknowledged his or her signature on this document or acknowledged that he or she authorized the person signing this document to sign on his or her behalf. I am not named as a healthcare agent or alternate healthcare agent in this document.

(Notary Stamp)

Signature of Notary