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"A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." - *Federal Patient Self Determination Act*

Power of Attorney for Healthcare (POA-HC): This document authorizes another person to make health care decisions for you if you are unable to make health care decisions due to accident or illness.

3

3

- ☑ Because we all have the right to our own choices, and have those choices honored
- ☑ Wisconsin law treats family members, including spouses, as strangers for decision-making purposes. Wisconsin is NOT a "next of kin" or "family consent" state for adults.
- ☑ Because the people who care about you will be very grateful to know what you would have wanted if its ever needed.
- ☑ Because doing it later could be too late.

4

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WHO needs a POA-HC?

EVERYONE!!

WHEN should a POA-HC be done?

NOW or soon after turning 18

NOW WHAT ?

1. Choose a decision-maker (health care agent).
2. Think about your goals in the event of a severe accident or sudden illness.
3. Start the conversation.
4. Complete the document and share with doctor, agent, others.

Step 1

Things to think about when choosing a health care agent (decision-maker)

Responsibilities of a health care agent include – making choices about medical care, reviewing and releasing medical records, arranging for medical care and treatment, making decisions on living situation, deciding which providers can provide treatment

Consider choosing a person

- Who is age 18 or older and can make difficult decisions under pressure or in emotional situations.
- Who understands your preferences, values and goals
- Who you know and trust to follow your preferences, even if they are different from their own

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7

Step 2

Have you thought about what experiences or activities are most important for you to live well?

8

8

Step 2

Explore religious, cultural or personal beliefs

- What helps you when you face serious challenges in your life?
- Do you have beliefs that might influence your preferences for using life-sustaining treatment interventions?
- Do you need to discuss these beliefs or clarify any concerns with others?

9

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Step 3

Talk with your agent about:

- Specific treatment if you are facing a life limiting circumstance (CPR, ventilator, etc.)
- Your values and beliefs
- What you want to avoid (pain, emotional distress, etc.)

Keep talking.

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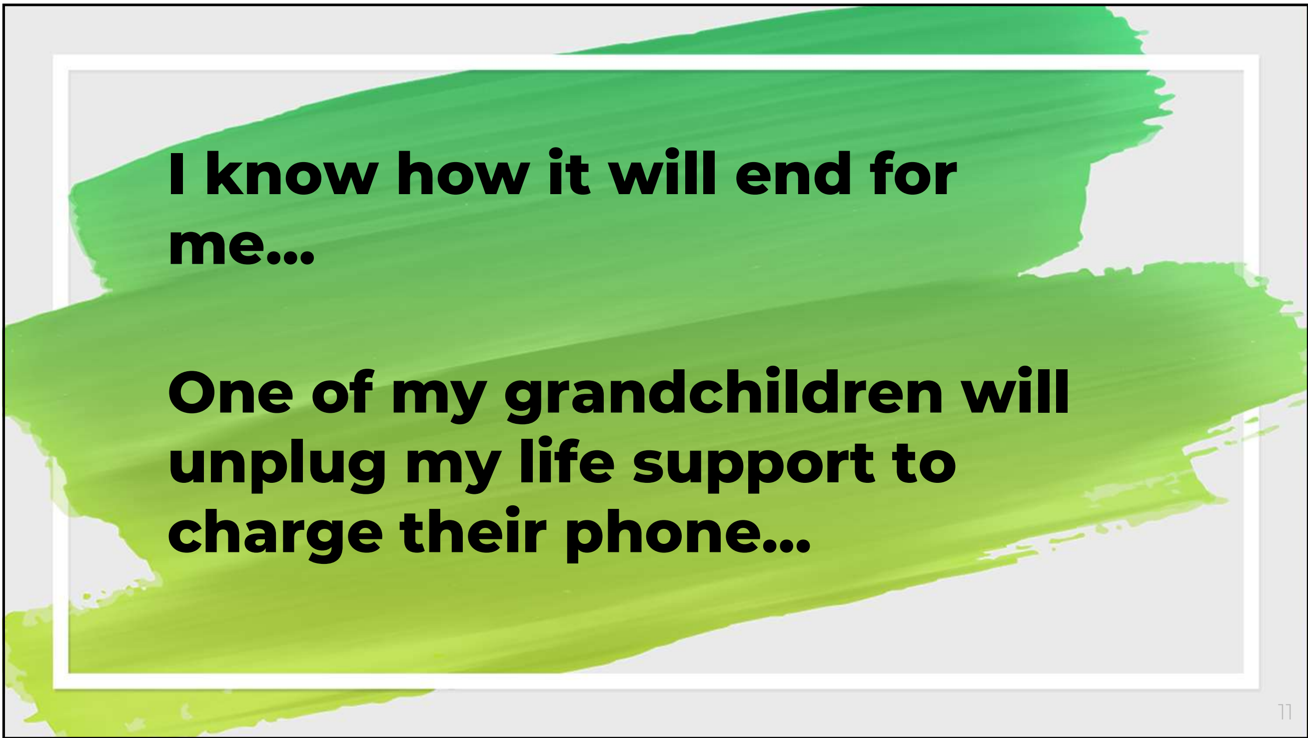

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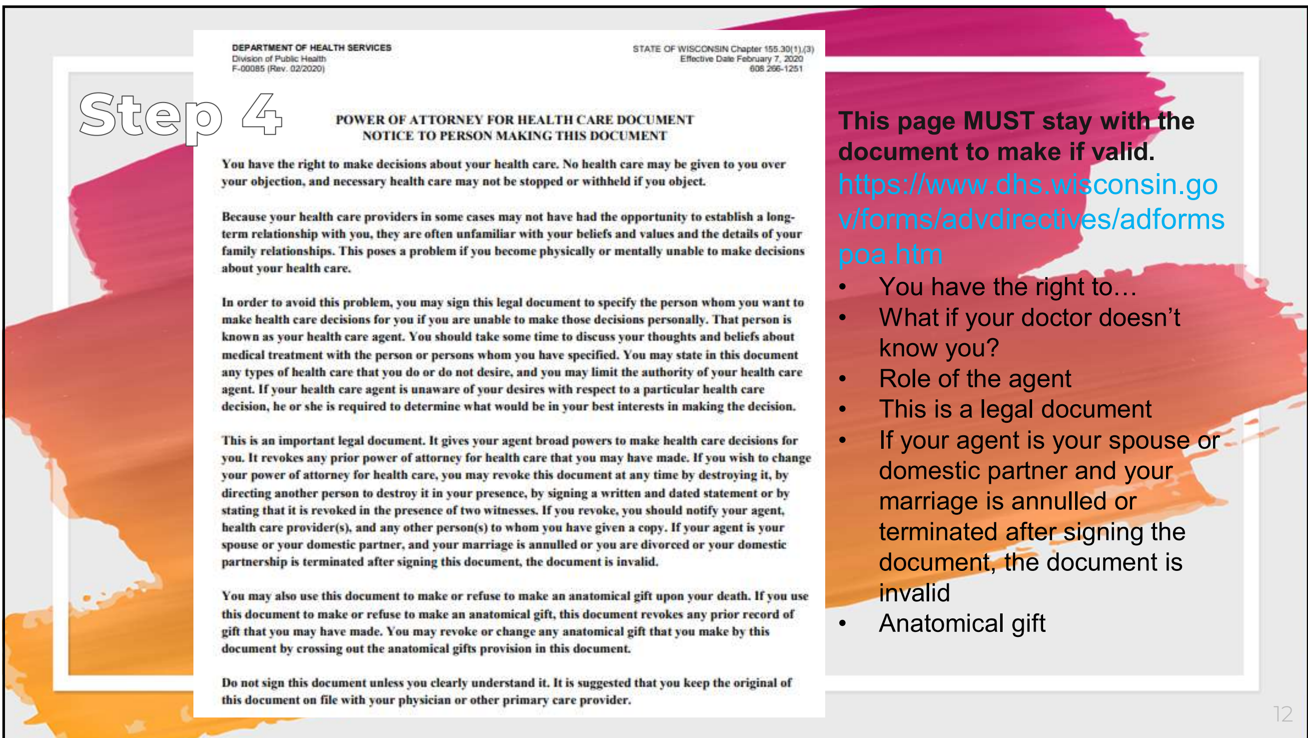

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-00085 (Rev. 02/2020)

STATE OF WISCONSIN Chapter 155.30(1),(3)
Effective Date February 7, 2020
608 266-1251

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 or other primary care provider.

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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, nurse practitioner, or physician assistant 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.

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- Being of sound mind…
- Voluntary
- Fully informed and allowed to participate

AGENT
- Primary and alternate
- **Not** my health care provider
- **Not** an employee of my health care provider
- **Not** an employee or their spouse of a health care facility in which I am a patient
- Unless he or she is also my relative

- Due to "incapacity"

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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 mental retardation, 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.

General Statement of Authority
- Health care provider and agent - do what you're supposed to do – follow my wishes and involve me as much as possible

CANNOT
- Health care agents may not admit to a institute for mental diseases (IMD) or consent to experimental or drastic mental health treatment

CAN
- Admit to a NH or CBRF if you say so.
- If you say "no" which is your right, your health care agent would need to pursue a guardianship if this level of care was needed.

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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.

FEEDING TUBE
Yes = withhold or withdrawal
No = Cannot withhold or withdrawal

PREGNANCY
Yes = may make decisions even if my agent knows I am pregnant
No = may not make decisions if my agent knows I am pregnant
or "NA"

STATEMENT OF DESIRES
Whatever you want to say...

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(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, domestic partnership, or adoption, 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 ______

TWO witnesses:

- 18 years of age or older
- **Not** related by blood, marriage, domestic partnership or adoption
- **Not** a health care provider unless a Chaplain or Social Worker
- **Not** employed by a an inpatient health care facility unless a Chaplain or Social Worker
- **Not** your agent or anyone who has claim on any portion of your estate
- "Valid witnesses acting in good faith are immune from civil or criminal liability."

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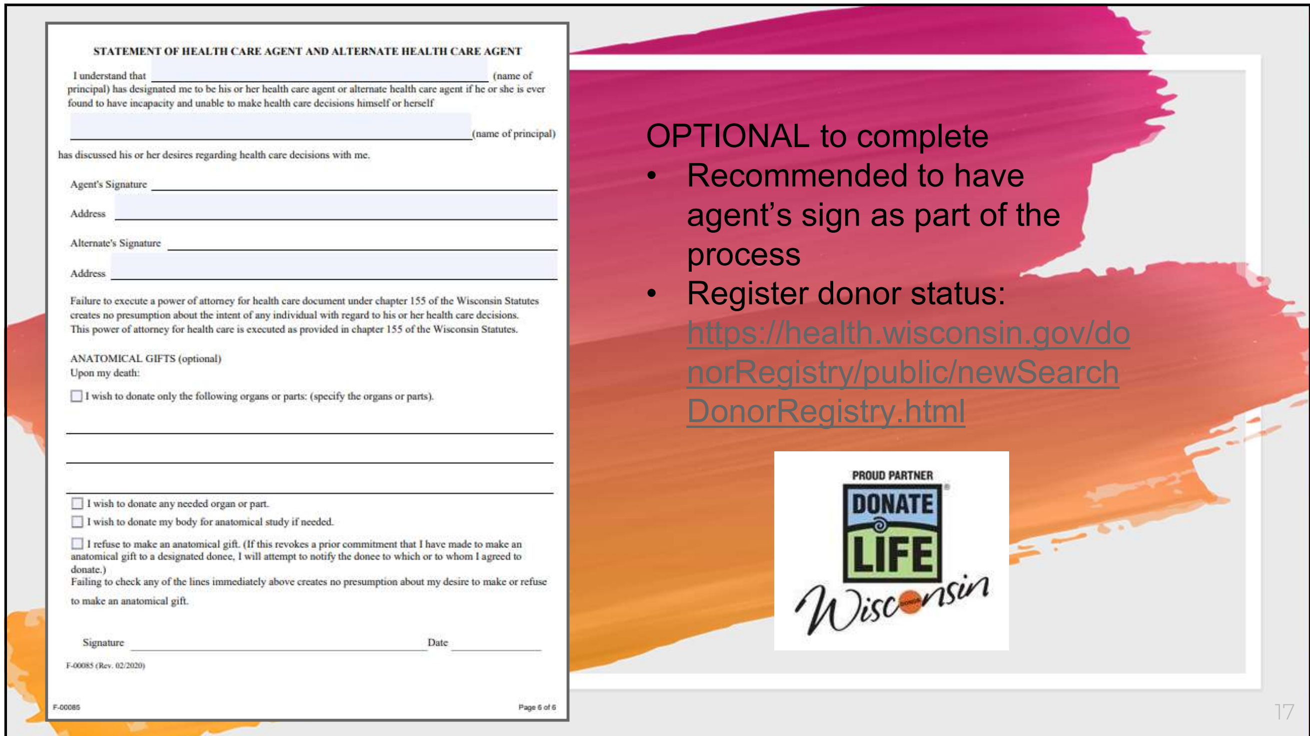

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

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 ____________

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Useful Links

Wisconsin Power of Attorney for Health Care
www.wisconsin.gov
Search Power of Attorney for Health Care for forms and more

Conversation Starter Kit
www.theconversationproject.org
The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care.

Death over Dinner
www.deathoverdinner.org
Gather friends and family to fill a table and bring a difficult conversation into one of engagement and insight.

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Kramer's Coma

While *Seinfeld* had a knack for putting a humorous slant on an otherwise sensitive subject, statistics show that incapacity planning is no laughing matter. According to a 2012 New York Times Editorial which highlights a 2006 Pew Research Center poll, only "one-third of Americans had a living will and even fewer have taken the more legally enforceable measure of appointing a health care proxy to act on their behalf if they cannot act for themselves."

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Local Help

ADVANCE HEALTH CARE PLANNING

You know the importance of planning.

You understand completing the process ensures your future health care wishes will be respected.

You've been wanting to finish your power of attorney for health care but you're not sure how to start.

We're here to help!

Trained staff are available, free of charge, to guide you through the paperwork and talk with you about your specific wishes and concerns.

Appointments are available for Kenosha County residents on **Wednesday mornings, 9 a.m. – noon**.
8600 Sheridan Road, Kenosha, WI 53143 (Entrance D)
To schedule call:
262-605-6646 or **1-800-472-8008**

Appointments are available for Froedtert South patients. To schedule, call and ask to speak to a chaplain: **262-656-2011**

Appointments are available for the public. To schedule, call **262-652-4400**
A receptionist will take your information and one of our Social Workers will call you back to set-up an appointment.

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