

## STEP-BY-STEP INSTRUCTION FOR COMPLETING

### THE WISCONSIN STATUTORY POWER OF ATTORNEY FOR HEALTH CARE

**STEP 1: BEFORE FILLING IT OUT** - Read the entire document carefully. Be sure you understand the authority you are giving to someone else. Think carefully about whom you want to select as your agent. You may not select your doctor, nurse, an employee of your health care facility or spouse of any of these individuals, UNLESS this individual is also a relative. Consider a close family member or friend – someone who knows you well, who lives geographically close to you, who will be a strong advocate for you and will ensure that your preferences, religious beliefs, quality of life concerns, etc. are followed. Ask the individual if he or she will accept this responsibility. Do the same with the individual you select as your alternate.

**STEP 2: FILLING IT OUT** – Don't insert the date at the top of the first page until the day you are ready to sign it. PRINT your name and address and date of birth after the "I," on the first page. Next, under Designation of Health Care Agent, PRINT the name, address and phone number (with area code) of the individual you have selected as your health care agent. If the individual is a relative, indicate the relationship, e.g., (daughter), in parentheses, after the name. In the next blanks, PRINT the name, address and telephone number of the individual you have selected as ALTERNATE AGENT. Remember that you may only appoint ONE individual as agent and ONE as alternate.

Under **ADMISSION TO NURSING HOME OR COMMUNITY-BASED RESIDENTIAL FACILITIES**, decide whether you want your agent to have authority to admit you to a nursing home or community-based residential facility (group home). If you check YES, your agent will be able to do so without going to court. That will save time, money and some emotional anguish for you and your family. On the other hand, the court process is designed as protection for you, to ensure that you really need to be in a nursing home. Decide whether you are comfortable giving that power to your agent. If you check NO or leave the question blank, your agent will not have the authority and a court proceeding will be required before you could be admitted to a nursing home if you are not competent at that time.

Under **PROVISION OF FEEDING TUBE**, decide whether you want your agent to have authority to withhold or withdraw feeding tubes. If you check YES, your agent will have the authority to decide, on a case-by-case basis, whether you would want him or her to withhold or withdraw these feeding tubes. If you check NO or if you leave it blank, your agent would have to get a court order before being able to do so.

The **HEALTH CARE DECISIONS FOR PREGNANT WOMEN** section applies only to women capable of becoming pregnant. If you are a man or a woman who is incapable of becoming pregnant, write NOT APPLICABLE next to the blanks. If you could become pregnant, decide whether you want your agent to have the authority. Keep in mind that there are decisions other than abortion that a health care agent might have to make. For example, if you are in a car accident while pregnant and left unconscious, someone has to decide whether to set broken bones and make other decisions. Even as to the abortion decision, you should consider checking YES, but clarifying your position on abortion (“always,” “never,” “only in certain circumstances,” etc.) in the next section. Again, if you check NO or leave it blank, your agent will not have the authority to make decisions for you if you later become pregnant.

Under **STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS**, you are encouraged to add something to “personalize” the form. Print all inserts. Consider adding in some language indicating your beliefs about life support procedures, organ donations, organ transplants, autopsies, choice of health care provider or facility or any preference to receive long-term care in your own home or in a nursing home. This is also the place to clarify, put limitations on, or further explain any of the earlier “YES” or “NO” questions. For example, you could consider qualifying the nursing home admission by indicating a preference for home care over nursing homes or by indicating what decisions your agent can make if you later become pregnant. Do insert something. If you have more to insert that fits in the spaces use a separate sheet, titled “Addendum to the Power of Attorney for Health Care of (your name).” Then print (or type) your additional provisions. This Addendum should be signed and witnessed exactly like the document itself.

For the signing, you and your two witnesses must be together. The witnesses may not be relatives by blood or marriage, nor your health care provider or an employee of your health care provider or your health care provider’s spouse. (EXCEPTION: Facility social workers may witness these documents). You should then date the form on the front and sign it on the back. Insert the same date right after your name. Have your two witnesses then sign as indicated on the form. You should then take or mail the form to your agent and alternate for their signatures. Insert your own name in the first two blanks under STATEMENT OF HEALTH CARE AGENT and ALTERNATE HEALTH CARE AGENT and your agent and alternate are then ready to sign. (NOTE: If your agent or alternate lives elsewhere, you may mail the document to them for their signatures. No witnesses are required).

**STEP 3: AFTER IT IS COMPLETED** - Make four copies of the form. Give the original to your physician (if you have a regular attending physician, as opposed to a clinic) and discuss with him or her your choice of agent, as well as your health care preference, as indicated on the form. Ask your physician to honor your preferences and respect your choice of agent, if the situation ever arises. Give copies of the completed form to your agent and your alternate agent. Put one copy in a safe place at home and one copy to the hospital. You may also, for a small fee, file a copy with the Register-in-Probate in your county’s Probate Court Office.

Discuss with close family members your choice of agent and your health care preferences. Ask them, too, to respect your choice of agent and your decisions and to honor those decisions, if the situation ever arises.

-Coalition of Wisconsin Aging Groups (Revised)



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**To Whom It May Concern:**

Enclosed is the 'Power of Attorney for Health Care' form which 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 on or after the death of the donor).

Be sure to read the form carefully and understand it before you complete and sign it.

Talk with the persons 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 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 can also not 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 or 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 this 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.

Two copies of the Power of Attorney for Health Care form are available free to anyone who sends a stamped self-addressed business-size envelope to: Power of Attorney, Division of Public Health, P.O. Box 309, Madison, Wisconsin 53701-0309. You may obtain additional copies of the enclosed blank form by using a photocopy machine or other printing method to reproduce it.

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 Sherry Kasper-Mohrbacher by telephoning 608-266-8475.

**INSTRUCTIONS FOR POWER OF ATTORNEY FOR HEALTH CARE FORM**

**Definitions**

'Department' means the department of health and family 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 s. 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 s. 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 ch.441, a chiropractor licensed under ch.446, a dentist licensed under ch. 447, a physician, podiatrist or physical therapist licensed or an occupational therapist or occupational therapy assistant

certified under ch. 448, a person practicing Christian Science treatment, an optometrist licensed under ch.449, a psychologist licensed under ch. 455, a partnership thereof, a corporation thereof that provides health care services, an operational cooperative sickness care plan organized under ss. 185.981 to 185.985 that directly provides services through salaried employees in its own facility, or a home health agency, as defined in s.50.49 (1)(a).

‘Incapacity’ means the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions.

‘Feeding tube’ means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of the declarant.

#### Who may sign a Power of Attorney for Health Care?

An individual who is of sound mind and has attained age 18 may voluntarily execute a power of attorney for health care. An individual for whom an adjudication of incompetence and appointment of a guardian of the person is in effect under State Statute Chapter 880 is presumed not to be of sound mind.

#### Procedures for Signing a Power of Attorney for Health Care

The principal (person creating the Power of Attorney for Health Care) and the witnesses all must sign the form at the same time.

#### When does it take effect?

Unless otherwise specified in the power of attorney for health care instrument (form), an individual’s power of attorney for health care takes effect upon a finding of incapacity by 2 physicians, as defined in s.448.01 (5), or one physician and one licensed psychologist, as defined in s.455.01 (4), who personally examine the principal and sign a statement specifying that the principal has incapacity. Mere old age, eccentricity or physical disability, either singly or together, is insufficient to make a finding of incapacity. Neither of the individuals who make a finding of incapacity may be a relative of the principal or have knowledge that he or she is entitled to or has a claim on any portion of the principal’s estate. A copy of the statement, if made, shall be appended to the power of attorney for health care instrument.

#### Revocation

A principal may revoke his or her power of attorney for health care and invalidate the power of attorney for health care instrument at any time by doing any of the following: canceling, defacing, obliterating, burning, tearing or otherwise destroying the power of attorney for health care instrument or directing another in the presence of the principal to so destroy the power of attorney for health care instrument; executing a statement, in writing, that is signed and dated by the principal, expressing the principal’s intent to revoke the power of attorney for health care; verbally expressing the principal’s intent to revoke the power of attorney for health care, in the presence of 2 witnesses; or, executing a subsequent power of attorney for health care instrument.

The principal’s health care provider shall, upon notification of revocation of the principal’s power of attorney for health care instrument, record in the principal’s medical record the time, date and place of the revocation and the time, date and place, if different, of the notification to the health care provider of the revocation.

#### Immunities

No health care facility or health care provider may be charged with a crime, held civilly liable or charged with unprofessional conduct for any of the following: certifying incapacity under s. 155.05(2), if the certification is made in good faith based on a thorough examination of the principal; failing to comply with a power of attorney for health care instrument or the decision of a health care agent, except that failure of a physician to comply constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the principal to another physician who will comply; complying, in the absence of actual knowledge of a revocation, with the terms of a power of attorney for health care instrument that is in compliance with ch 155; or the decision of a health care agent that is made under a power of attorney for health care that is in compliance with ch. 155; acting contrary to or failing to act on a revocation of a power of attorney for health care, unless the health care facility or health care provider has actual knowledge of the revocation; or, failing to obtain the health care decision for a principal from the principal’s health care agent, if the health care facility or health care provider has made a reasonable attempt to contact the health care agent and obtain the decision but has been unable to do so.

No health care agent may be charged with a crime or held civilly liable for making a decision in good faith under a power of attorney for health care instrument that is in compliance with ch. 155. No health care agent who is not the spouse of the principal may be held personally liable for any goods or services purchased or contracted for under a power of attorney for health care instrument.

#### General Provisions

The making of a health care decision on behalf of a principal under the principal’s power of attorney for health care instrument does not, for any purpose, constitute suicide.

No individual may be required to execute a power of attorney for health care as a condition for receipt of health care or admission to a health care facility.

No insurer may refuse to pay for goods or services covered under a principal’s insurance policy solely because the decision to use the goods or services was made by the principal’s health care agent.

## **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, 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.**

**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 document 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 mentally retarded, 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 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 employe of the health care provider, other than a chaplain or a social worker, or an employe, 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 \_\_\_\_\_