

# POWER OF ATTORNEY

FOR HEALTH CARE



PROHEALTH CARE

## 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 for the State of Wisconsin. It may not satisfy the legal requirements in other states.

This Power of Attorney for Health Care form allows you to appoint another person to make health care decisions for you if you become unable to make these decisions for yourself. The person you appoint is your Health Care Agent. This document gives your Health Care Agent authority to make health care decisions on your behalf only when you have been determined by your physician(s) to be incapable of making your own health care decisions. This document does not give your Health Care Agent any authority to make your financial or other business decisions. In addition, it does not give your Health Care Agent authority to make certain decisions about your mental health treatment.

Before completing this Power of Attorney for Health Care form, take time to read it carefully. It is also 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, your views and values may not be fully respected because they may not be understood.

### **Steps to Complete This Document**

1. Carefully read and follow instructions for each part.
2. Complete the information on page 1.
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: General Authority of the Health Care Agent—Complete by indicating your choices.
5. Part III: Statement of Desires, Special Provisions or Limitations
6. Part IV: Making the Document Legal
  - Sign and date the document on page 7 with witnesses present;
  - Have the witnesses sign the document in your presence.
7. Part V: Statement of Desires—Complete by indicating any special instructions or desires (optional).

### **After Completing This Document**

After you complete the document, it is suggested that you:

1. Keep the original in a safe place that you can access easily.
2. Make copies to be given out as follows:
  - one copy for each Health Care Agent appointed in the document;
  - one copy for your record at your physician's office
  - one copy for you to provide to any hospital to which you are admitted or go for emergency treatment;
  - extra copies to share with others if you wish (loved ones, your minister/clergy/rabbi, and/or your attorney).

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

**MY POWER OF ATTORNEY FOR HEALTH CARE**

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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Address \_\_\_\_\_

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City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Telephone \_\_\_\_\_

**I know that this Health Care Power of Attorney will not be in force until two physicians or a physician and psychologist personally examine me and sign a statement that:**

- 1. I am unable to receive and evaluate information effectively or**
- 2. I am unable to communicate decisions to such an extent that I lack the capacity to manage my own health care decisions.**

**Copies of this document have been given to:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## 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 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 by completing page 10. Using this document to indicate your choice about an anatomical gift will revoke any prior anatomical gift documentation. If, after this document is completed, you decide to change your choices about anatomical gifts, you may revoke this documentation by crossing out the anatomical gifts provision on page 10.

- **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.**
- **Keep this page with your completed Power of Attorney for Health Care document.**

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### WOULD YOU LIKE ASSISTANCE?

<b>Waukesha Memorial Hospital Social Work</b>	<b>(262) 928-2300</b>
<b>Oconomowoc Memorial Hospital</b>	<b>(262) 569-0273</b>
<b>ProHealth Home Care and Hospice</b>	<b>(262) 928-7444</b>

## **PART I – Appointing a Person to Make My Health Care Decisions When I Cannot Make My Own Health Care Decisions**

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my Health Care Agent. This person will make my health care decisions when I am determined to be incapable to make health care decisions as provided under Wisconsin law. I understand that it is important for my Health Care Agent and me to have ongoing discussions about my health and health care choices.

### **Instructions for Completing Part I**

When selecting someone to be your Health Care Agent, choose 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. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person you choose to be your Health Care Agent.

Your Health Care Agent should be at least 18 years old and must not be one of your health care providers or an employee (or the spouse of an employee) of your health care provider or facility unless they are a close relative. Space has been provided for a second 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 for me, **then my next choice for a Health Care Agent is:**

#### **Second choice:**

Name: \_\_\_\_\_

Day phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand my Health Care Agent makes the decisions concerning my care; however, if there is time, I would like my agent to include the following people in the decision process.

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## **PART II – General Authority of the Health Care Agent**

Unless I have specified otherwise in this document, I want my Health Care Agent to be able to do the following:

- To make choices for me about my medical care or services, e.g., tests, medicine and surgery, in accordance with my stated instructions or desires and/or my philosophy regarding the health care decisions I would make if I were able.
- To 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.
- If I have not expressed a health care choice about the health care in question and communication cannot be made with me, to make choices for me based on what my Health Care Agent believes to be in my best interest.
- To review and release my medical records and personal files as needed for my medical care.
- To move me to another state if needed.
- To determine which health care professionals and organizations provide my medical treatment.

**Limitations on Mental Health Treatment:** I know that 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.

### **Instructions for Completing Part II** (Check or initial applicable boxes in the following six sections)

Due to limits in Wisconsin law, if you do not select any box in a section and do not make a clear choice, your Health Care Agent may not have the authority to make the decision about the treatment discussed in section 1 through 6, and it may be necessary to go to court to obtain a decision about your treatment. (Questions 1-3 are required for a valid Advance Directive under Wisconsin law. Questions 4-6 provide additional guidance.)

#### **1. 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 or respite care.

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

*(Check or initial one box) Additional guidance may be added at #7.*

Yes, my Health Care 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 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 nursing home or community-based residential facility for purposes of a long-term stay without court involvement.

## 2. Withholding or withdrawal of feeding tube

(Check or initial one box) Additional guidance may be added at #7.

Yes, my Health Care Agent has authority to have a feeding tube withheld or withdrawn from me, unless my attending physician advises that, in his or her professional judgment, the withholding or withdrawing will cause me pain or reduced comfort.

No, my Health Care Agent does not have authority to have a feeding tube withheld or withdrawn from me. *I am aware that if I check no, court involvement may be required for decisions to withhold or withdraw a feeding tube.*

Under Wisconsin law, my Health Care Agent may not consent to the withholding or withdrawal of orally ingested nutrition or hydration unless the provision of such nutrition or hydration is medically contraindicated.

## 3. Decisions during pregnancy

(Check or initial one box) Additional guidance may be added at #7.

Yes, my Health Care 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 Health Care Agent does not have authority to make decisions for me if I am pregnant. I am aware that if I check no, court involvement may be required for health care decision making 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 on page 6. 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 below to be followed based on my 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; however, completing these questions will provide your agent with additional guidance.

If you choose **not** to provide any instructions, your Health Care Agent will make decisions based on your instructions or what is considered your best interest.

## 4. Stopping attempts of life-prolonging treatment

(Check or initial the box if it applies) Additional guidance may be added at #7.

If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with my family, friends and my environment, or if my suffering is intense, irreversible and uncontrollable, even if I do not have a terminal illness, I want my health care provider to stop or withhold all treatments that might be used to prolong my life. Treatments I would not want if I were to reach this point include, but are not limited to: respirator/ventilator; administration of blood products and antibiotics; medications and interventions that I have received for chronic medical conditions; or other medications unless the withholding or withdrawal of these treatments would cause me pain or discomfort.

**5. Pain and symptom control**

*(Check or Initial the box if it applies) Additional guidance may be added at # 7.*

I want medical treatment and nursing care to continue to address my pain needs and symptom control and to make me comfortable, even if this may entail risks of my dying sooner, and even when life-sustaining treatment may be withheld or withdrawn.

**6. Cardiopulmonary resuscitation (CPR)**

CPR has been shown to be of limited benefit for certain patient populations, and it is important to talk to your physician about your specific concerns regarding CPR.

If you do not want CPR attempted and prefer to allow natural death (AND) to occur, your physician should be made aware of this choice. However, in the absence of other documents, this choice, in itself, may not stop emergency personnel from attempting CPR in an emergency. If you have a serious, incurable illness and want to ensure that emergency personnel do not perform CPR, you will need to obtain a **Do Not Resuscitate (DNR)** bracelet from your physician.

*(Check or initial one box) Additional guidance may be added at #7.*

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

I want cardiopulmonary resuscitation (CPR) attempted unless my physician determines one of the following:

- I have a serious, incurable illness; 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 do not want cardiopulmonary resuscitation (CPR) attempted if my heart stops, but rather want to allow natural death (AND) to occur.

If I want my doctor and Health Care Agent to know any other thoughts I have about CPR, I will write them below in Section 7.

**7. My additional guidance to the choices in sections 1 through 6 is written below. If any of the guidance I have written below directly conflicts with my choices selected in sections 1 through 6, I want my choices in the above sections to control the decision to be made. The comments below should be used to interpret and clarify my choices in sections 1 through 6.**

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## **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 Attorney for Health Care documents.

*I am thinking clearly and intend to create a Power of Attorney for Health Care. I do this willingly. I expect to be fully informed about and allowed to participate in any health care decisions for me to the extent I am able. This includes eye blinking if I am not able to communicate verbally.*

**My signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### **Statement of Witnesses**

I personally know the person who signed this 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 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 Number 1**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

### **Witness Number 2**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

## Statement of Agent and Alternate Agent

(Signature of agents are recommended but not required)

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 to be incapable of making his or her own health care decisions.

\_\_\_\_\_ (name of principal) has discussed his or her desires regarding health care decisions with me.

Signature of Agent \_\_\_\_\_

Print name of Agent \_\_\_\_\_

Signature of First Alternate Agent \_\_\_\_\_

Print name of First Alternate Agent \_\_\_\_\_

Signature of Second Alternate Agent \_\_\_\_\_

Print name of Second Alternate Agent \_\_\_\_\_

**PART V – Statement of Desires If My Condition Is Likely to Result in Death**

(This section is optional)

**Religion:**

If I am nearing my death,

I want my pastor / spiritual leader notified of my medical condition.

I want a representative of my place of worship with me as I prepare for my death.

I am of the \_\_\_\_\_ faith, and am a member of the \_\_\_\_\_ congregation or worship group.

Phone number of congregation or worship group (if known): \_\_\_\_\_

*The following are matters that you may wish to address. If you are not comfortable with this information being in your medical record, you can record it elsewhere.*

**If I am nearing my death, I want the following: (List things that would make dying more meaningful for you.)**

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

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**Upon My Death**

Upon my death, the following are my instructions. If my Health Care Agent does not have the authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

**Donation of My Organs or Tissue for Transplantation** *(Initial one box)*

I wish to donate my organs and tissue for transplantation.

I wish to donate only the following organs and tissue (name the specific organs or tissue) for transplantation: \_\_\_\_\_

I do not want to donate any organ or tissue for transplantation.

**Donation of My Organs or Tissue for Medical Research** *(Initial one box)*

*(If you wish to donate your body for medical research after death, you should contact a medical school to make arrangements.)*

In accordance with my selection above, I wish to donate my organs and tissue for transplantation and the remainder of my body, organs and tissue for medical research.

I wish to donate my entire body, organs and tissue for medical research.

I do not want to donate any part of my body, organs or tissue for medical research.

**Autopsy** *(Initial any boxes that apply)*

I do not object to an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future health care decisions.

I do not object to an autopsy if it can help the advancement of medicine or medical education.

I do not want an autopsy performed on me.

Pages 9 and 10 are intended to provide my Health Care Agent with information about my wishes and desires in addition to those expressed in my Power of Attorney for Health Care. These pages are not intended to replace my Power of Attorney for Health Care. If any of the guidance I have written on pages 9 and 10 conflicts directly with my Power of Attorney for Health Care, I want my wishes and desires expressed in my Power of Attorney for Health Care to control the decisions to be made.

Signature

Date

Print name

## SUGGESTED TOPICS TO DISCUSS WITH YOUR HEALTH CARE AGENT

Completing your HCPOA is an important step in advance care planning. The completed document will allow someone you trust to make decisions on your behalf when your physician can no longer communicate with you.

You remain in charge of your health care decisions if you are not mentally incapacitated. If you are no longer able to make health care decisions, your agent must act in good faith consistent with your wishes. Because your agent is required to follow your wishes, it is important that you talk to your agent about your wishes in advance of your possible incapacity.

Following is a list of topics and questions that can help you think and talk about your choices. Your notes and responses will help your agent better understand your wishes.

**Quality of life.** *Take time to talk with your agent about what quality of life means for you. Consider the following circumstances and how these conditions would affect your desire to receive care.*

- If you could no longer eat, would you want to be fed by a tube? If so, for how long?
- What would your health care preferences be if you could no longer recognize or interact with loved ones? For example, if you had a severe stroke, head injury or advanced Alzheimer's Disease. How would you feel about life-sustaining procedures in the face of a terminal illness or permanent coma?
- What if you were no longer able to physically care for yourself?
- Discuss your preferences for where you would want to be when you are in the last stages of dying. Would you want home hospice? If you could no longer remain at home, what are your thoughts about assisted living, a nursing home, a group home or residential hospice?
- Are there circumstances under which you would refuse or discontinue treatment that might prolong your life? If so, describe those circumstances.
- Under what circumstances would dying naturally be preferable to being kept alive?

### **Procedures and treatments.**

- Discuss your preferences for tissue and/or organ donation.
- Are there any treatments or procedures you would not want?
- How important is pain management? For example, would you want to be sedated if it meant controlling your pain better?

**Religious and spiritual concerns.** *Be sure your agent knows how this should factor into your care.*

- Are there spiritual or religious beliefs that should be taken into consideration when making medical decisions on your behalf?
- What would make you comfortable as you near death? Do you prefer the company of friends and loved ones, or would you prefer privacy and quiet? Would you want to pray with a member of the clergy?
- What important needs would you want to be addressed if you were dying?
- What fears or concerns do you have about the end of your life?

Completing your HCPOA is an important step in advance care planning. As your life circumstances and health change, your views on what you would want in health care may also change. It is important to keep your Health Care Agent and physician updated on how you wish to be treated. How well your Health Care Agent makes decisions for you depends upon on how well you prepare them.



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**WOULD YOU LIKE ASSISTANCE?**

Waukesha Memorial Hospital Social Work	(262) 928-2300
Oconomowoc Memorial Hospital	(262) 569-0273
ProHealth Home Care and Hospice	(262) 928-7444



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