How to use the Wisconsin Will to Live Form -- SUGGESTIONS AND REQUIREMENTS:

1. This document is a "Power of Attorney for Health Care" form created in compliance with Wisconsin Statute Chapter 155. **Be sure to read the form carefully and understand it before you complete and sign it.** This document allows you to designate (name) a health care agent who will make health care decisions for you whenever you are unable to make them for yourself. It also allows you to give instructions concerning medical treatment decisions that the health care agent must follow. Any person who is at least 18 years old and of sound mind may voluntarily designate a health care agent through this document. An individual for whom an adjudication of incompetence and appointment of guardian of the person is in effect under Wisconsin Statute Chapter 880 is presumed not to be of sound mind.

2. Your health care agent must be at least 18 years of age. Your health care agent must **not** be your health care provider, an employee of your health care provider, or an employee of a health care facility in which you reside or are a patient, or the spouse of any of these. However, any of these people may be named as your health care agent if that person is also your relative. Talk with the people you select as your health care agents about your thoughts and beliefs about medical treatment.

3. It is helpful to name an alternate health care agent, to take over if your first choice is unable to serve. There is space on the form for you to name two alternate health care agents.

4. In general, your health care agent will not have the authority to admit you to a nursing home unless you specifically authorize that in this document. (You may grant this authority by checking "Yes" in the appropriate place on page 2.) However, even without that authorization, the agent may consent to your admission to a hospital for up to 3 months to recuperate following your discharge from a hospital other than for psychiatric care, and if your health care agent lives with you, the agent may consent to your admission to a nursing home for up to 30 days so that your agent may take a vacation or handle a family emergency. Even <u>with</u> your authorization in this document, your health care agent may not consent to your admission to a nursing home if you are diagnosed as developmentally disabled or as having a mental illness at the time of proposed admission.

5. Your health care agent will not have the authority to consent to experimental mental health research, psychosurgery, electroconvulsive treatment, "or other drastic mental health treatment procedures" for you. Nor will your health care agent have the authority to consent to your inpatient admission to a variety of treatment facilities for mental illness or mental retardation.

6. You must sign and date this document in the presence of two witnesses. If you are unable to sign and date the document yourself, you may direct someone who is at least 18 years old to do it for you in your presence. The two witnesses must sign the document in your presence and in each other's presence.

7. Your two witnesses must each be at least 18 years old. Neither witness can be related to you by blood, marriage or adoption, or have knowledge that he or she is entitled to or has any claim on any portion of your estate, or be directly financially responsible for your health care, or be your health care provider, or be your health care agent.

8. The document will remain in effect until you revoke (cancel) it. The "Notice to Persons Making This Document" at the beginning of the form describes how it may be revoked.

9. You should tell your doctor about this document. You should also ask your doctor to keep the original of this document as a part of your medical health record. Give copies of the signed original to your health care agent, family members, and anyone else you think appropriate. Keep a copy in a safe place that will be easily accessible to others in case of an emergency and tell someone where it is. 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.

10. An individual's power of attorney for health care takes effect upon a finding of incapacity by two physicians or one physician and one licensed psychologist. Mere old age, eccentricity or physical disability are 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.

11. 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.

12. This type of document has been authorized by the Wisconsin Power of Attorney for Health Care Act §§ 155.01 to 155.80.

13. You should periodically review your document to be sure it complies with your wishes. Before making any changes, be aware that it is possible that the statutes controlling this document have changed since this form was prepared. Contact the Will to Live Project by visiting www.nrlc.org (click on "Will to Live") or an attorney to determine if this form can still be used.

14. If you have any questions about this document or want assistance filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit www.nrlc.org
and click on "Will to Live"

form prepared 2001
*clerical changes made 08/05

Wisconsin Will to Live Form

POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT
NOTICE TO PERSON MAKING THE 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 heath care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important 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. If this alternate agent is ever unable or unwilling to do so, I hereby designate

_____

_____

_____

(print name, address, and telephone number)

to be my second 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(s) whom I have designated is my health care provider, an employee of my health care provider or 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 health decision on any health 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 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 other 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 only admit me for short-term stays for recuperative care or respite care.

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, 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:

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care agent to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care agent in fact to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

–all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

The instructions in this document are intended to be followed even if suicide is alleged to be attempted at some point after it is signed.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care agent in fact to follow the above policy, even if I am judged to be incompetent.

During the time I am incompetent, my agent, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

1. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:
(Be as specific as possible; SEE SUGGESTIONS.):

_____
_____
_____
_____
_____
_____

(Cross off any remaining blank lines.)

WHEN I AM TERMINALLY ILL

2. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:
(Be as specific as possible; SEE SUGGESTIONS.):

_____
_____
_____
_____
_____
_____

(Cross off any remaining blank lines.)

3. **OTHER SPECIAL CONDITIONS**:
(Be as specific as possible; SEE SUGGESTIONS.):

_____
_____
_____
_____
_____
_____

(Cross off any remaining blank lines.)

IF I AM PREGNANT

4. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care attorney in fact(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

_____
Signature

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, verbal 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 and 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 employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or 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 to the principal's estate.

Witness No. 1 (print) Name _____ Date _____

Address _____

Signature _____

Witness No.2 (print) Name _____ Date _____

Address _____

Signature _____

STATEMENT OF HEALTH CARE AGENT AND ALTERNATIVE HEALTH CARE AGENTS

I understand that

_____ (name of principal)
has designated me to be his or her health care agent or alternative health care agent if he or she is ever found to have incapacity and unable to make health care decisions regarding 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 _____

Second 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.)

Failure 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 _____

Form prepared 2001
*clerical changes made 08/05