WISCONSIN MENTAL HEALTH POWER OF ATTORNEY FORM

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions for you (the principal). Your agent will be able to make decisions and act on your behalf, whether or not you are able to act for yourself.

This power of attorney does not authorize the agent to make health care decisions for you. Such powers are governed by applicable laws for Advance Directives.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

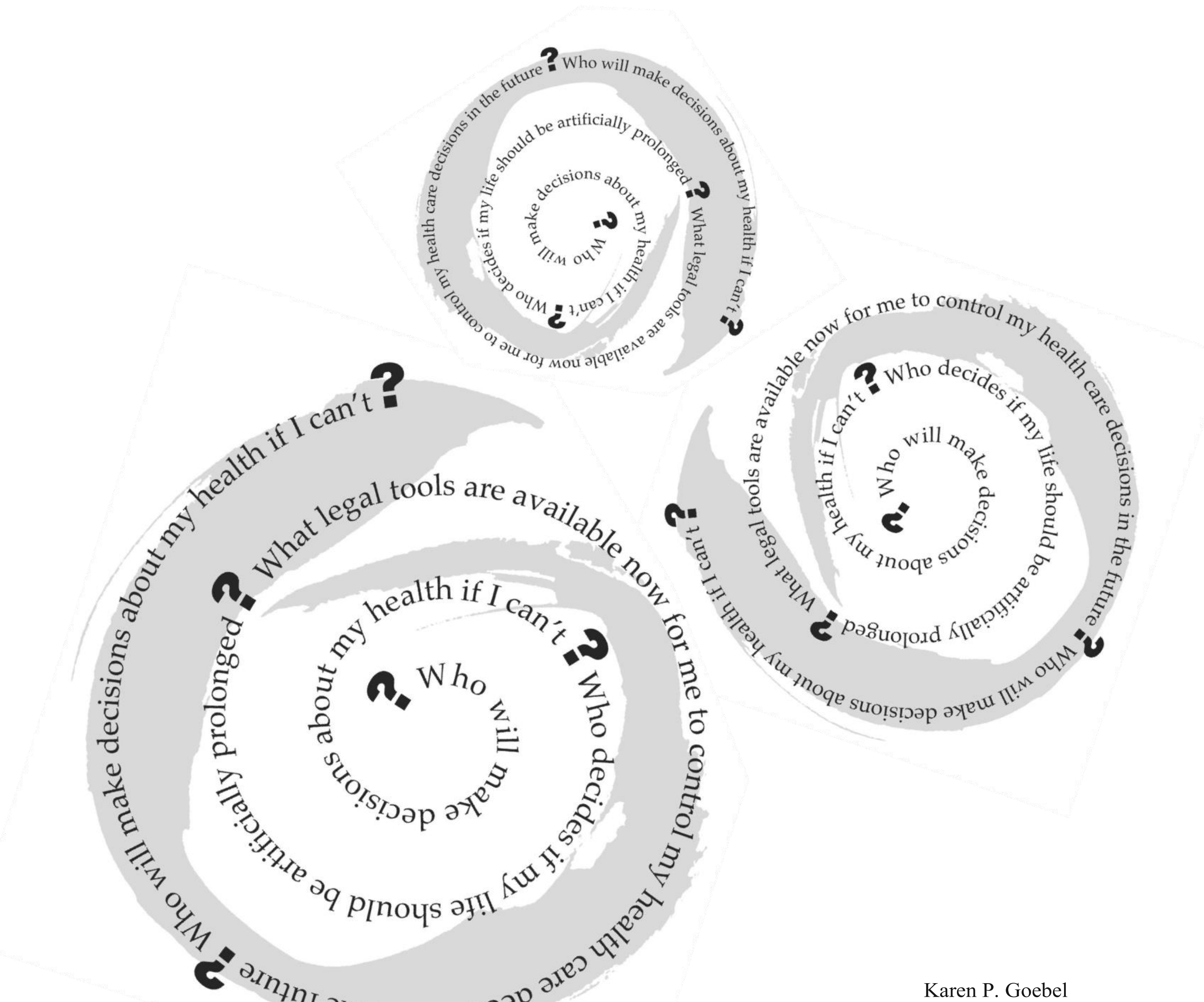
This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

The following forms are available from the National Resource Center on Psychiatric Advance Directives.

Advance Directives for Health Care

Wisconsin Living Will and Power of Attorney for Health Care



Karen P. Goebel
Mary Therese Crave

B3604

Advance Directives for Health Care: *Wisconsin and Power of Attorney for Health Care*

Living Will

Karen P. Goebel
Mary Therese Crave

Contents

This publication introduces laws that affect advance directives for health care in Wisconsin, and pro-vides information about two advance directives documents. It is not intended to substitute for profes-sional advice, nor is it exhaustive.

Statements in this publication reflect legislation in effect in Wisconsin as of January 1, 1994. Otherstates have different laws; some information may not apply outside Wisconsin.

Who decides if my life should be artificially prolonged?

What legal tools are available now for me to control my hdecisions in the future? *ealth care*

This publication explains two **directives** documents — "Declaration to **advance** **living** **will** Physicians," popularly known as a , and **power of attorney for health care** — that can legally provide for health caredecision-making when you are no longerable to do so for yourself.

This booklet answers commonly asked questions and provides a guide and checklist tohelp you discuss health care decision-mak-ing with family members and health carproviders to assure appropriate action.A glossary at the end explains technical andlegal terms you may find in the statutoryforms or in information about advancedirectives, or will notice in bold type on thefollowing pages. e

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e named in an e
decisions

Patient Self-Determination

Sinformation at the time of admission

abouttheir rights:funds — such as

ActAssistancehealth care facilities receiving

federalince December 1991, the U.S.

Who will make decisions about my health care if I can't?

Planning health care decision-making

A fatal.

These advances may be a blessing for many, but they also raise questions about the quality of a life prolonged

PatientSelf-Determination Act has required

that— must give patients written **Medicare** and

Medical n To accept or refuse medical treatment,

and n To formulate advance directives such

as living wills and powers of attorney for health

care.

Many states, including Wisconsin, have enacted legislation to pradvance planning. ovide legal tools for

Separate statutory forms ar Wisconsin residents to make a living will or a power of attorney for health car arthe aid of an attorney. e designed for you to complete without e available for e. These pleted forms when you are unable to make your own health car Your health care provider will use the com-e decisions.

artificially.dvances in medical technology nowenable individuals to survive illnessesand injuries that once would have been

Planning for health care decision-making isnot just an issue for the elderly. No agegror irreversibly ill or injured, or otherwiseincapable of making health care decisions.Cancer and accidents are common causes ofdeath for younger adults. Family membersof all ages should be aware of the need totalk about health care decisions.oup is exempt from becoming terminally

All of us need to make a special effort toindicate in writing who should make deci-sions if we are unable to do so.

not being capable of making their own deci-sions. Many individuals feel it is importantto clarify and discuss their preferences andwishes about health care, but put it off todo…later. It's also easy to assume "It won'thappen to me."Health care decision-making can be stressfulto discuss. Most people avoid thinking aboutincreasing dependency, not being healthy or

Research suggests that many adults wouldprefer family members to make health caredecisions for them. And while family members may be expected to act according to thepatient's wishes, Wisconsin does not have a"next-of-kin" law automatically giving themthe legal right to make decisions for their rel-ative — unless they aradvance directives document.

Situations involving health carcan also lead to conflicts among familymembers, feelings of guilt and being bur-dened by not knowing what the personwould really have wanted.

Living Will ("Declaration to Physicians")

Wisconsin living will (natural death) legislation was enacted in 1983, took effect October 1, 1984, and was expanded in 1991 when the statutory forms were revised. A copy of the statutory form is in the center of this booklet, with informa-tion on how to get more forms.

Legally called "Declaration to Physicians," the living will document makes it possible for a Wisconsin adult to state his or her pref-erences for **tive state life-sustaining procedures** or **persistent vegeta-** and feeding tubes, in the event the person is in a **terminal condition**

Life-sustaining procedures include:

- Assistance with breathing
- Artificial maintenance of heart rate or blood pressure
- Blood transfusion
- Kidney dialysis or other treatment

A living will *cannot* be used:

- To authorize the withholding or with-drawal of any medication or treatment if the physician feels it will cause you pain or reduce your comfort
- If you are pregnant (see

n n n

“Power ofAttorney for Health Care,” page 3)

? Who can be a witness?

The living will document must be signed inthe presence of two witnesses who knowyou (the you to be of sound mind. If you are unableto sign, it must be signed in your name byone of the witnesses or someone else at yourexpress direction — and in your presence.**declarant**) personally, and believe

2

Each witness must be a disinterested personat least 18 years old. A witness *cannot* be: n Related by blood, marriage, or adoption n Entitled to or have claim to any of yourestate

n Your doctor, the doctor’s staff or employee of the hospital, clinic, nursinghome or other facility providing yourcare *except* chaplains and social workers*any* n Directly financially responsible for yourhealth care

? When is a living will effective?

Your completed living will becomes effectivewhen two physicians — one who is theattending physician — have examined anddiagnosed you, and certified in writing thatyou have a terminal condition or are in apersistent vegetative state.

Your physician is required by law to comply with your living will. If the physician refusesor fails to comply with your directives, andrefuses or fails to transfer you to anotherdoctor, the physician may be charged withunprofessional conduct.

If you completed a living will beforeDecember 11, 1991, you may want to reviewor revoke that document in light of legalchanges made since then. To revoke a docu-ment, see page 3: “What If I Change MyMind?”

? What should I do with the document?

ment in a safe, accessible place. Distribute copies, which are as effective as the original.Give your doctor a copy to become part ofyour medical records. Give copies to the hos-pital, your health care agent if you have one,and a family memberSign and keep the original living will docu-

change or revoke the document.one who has a copy, in case you want to.

Keep a list of every**Wisconsin statutory forms** n Power of Attorney for Health Care n Declaration to Physicians (Living Will)

Wisconsin legislators have written

statutoryadvance directives forms that you can use

to give someone power of attorney for health care

and to write a living will. You have thelegal right

to complete one or both docu-ments, but you are not required to do so.

the following pages. You may photocopy orpull out these forms, or

request copies bysending a stamped, self-addressed, business-size

envelope to:These statutory forms, and letters of instruc-tion for

Wisconsin residents, are printed on

Wisconsin Department of Health and Social ServicesDivision of Health — Declaration toPhysicians and POAHCP. O. Box 309Madison, WI 53701-0309

Print or type clearly. Print your name belowyour signature.**Directions**

"Copies are available at:" Name of the clinicor hospital where your medical records arekept that include your advance directives.

Clip this out and carry it with you; keep itwith your other important identificationcards.

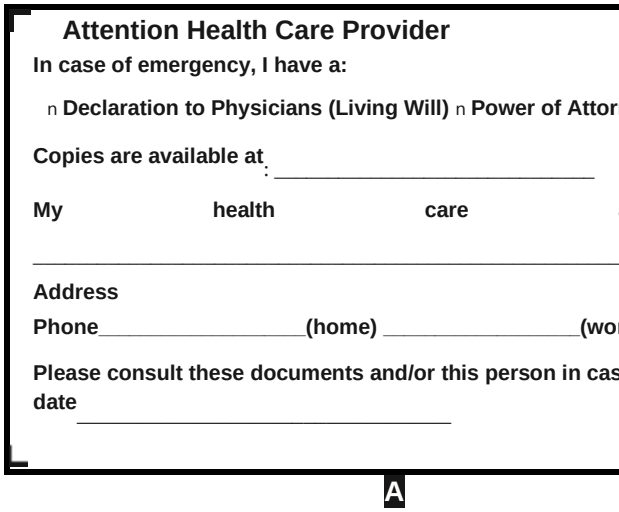
tions and may not be helpful in an emer-gency. If you are admitted to a hospital, itwill inform physicians that you have com-pleted advance directives to guide decisions.*Note:* This card does not give specific direc-

Do not sign these documents unless you clearly understand them.

You may obtain most information you need from this publi-cation, from your health care provider, or from other resources listed.

These forms are not valid until you sign them in the presence of two qualified wit-nesses who know you personally and believe you to be of sound mind.

Laws and statutory forms regarding advance directives vary from state to state. If you travel or live in another state, check with your doctor in that area or local health agency to be sure they will honor the Wisconsin forms.



A

Sample wallet card

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF PUBLIC HEALTH

1 WEST WILSON STREET
P O BOX 2659
MADISON WI 53701-2659

608-266-1251
FAX: 608-267-2832
www.dhfs.state.wi.us

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. DPH 0085A (Rev 6/98)

DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 0085 (Rev. 6/98)

STATE OF WISCONSIN
Chapter 155.30(1),(3)
Effective Date: May 13, 1998
608 266-8475

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 _____

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF PUBLIC HEALTH

1 WEST WILSON STREET
P O BOX 2659
MADISON WI 53701-2659

608-266-1251
FAX: 608-267-2832
www.dhfs.state.wi.us

To Whom It May Concern:

Enclosed is the Declaration to Physicians (Living Will) form, which you requested. This form makes it possible for adults in Wisconsin to state their preferences for life-sustaining procedures and feeding tubes in the event the person is in a terminal condition or persistent vegetative state.

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

The withholding or withdrawal of any medication, life-sustaining procedure or feeding tube may not be made if the attending physician advises that doing so will cause pain or reduce comfort and the pain or discomfort cannot be alleviated through pain relief measures.

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. Witnesses may also not be persons who know they are entitled to or have a claim on any portion of your estate. A witness cannot be a health care provider who is serving you at the time the document is signed, 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 you are a patient. Valid witnesses acting in good faith are immune from civil or criminal liability.

You should make relatives and friends aware that you have signed the document and the location where it is kept. A signed form may be kept in a safe, easily accessible place until needed. 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.

You are responsible for notifying your attending physician of the existence of the declaration. An attending physician who is notified shall make the declaration part of your medical records. A declaration that is in its original form or is a legible photocopy or electronic facsimile copy is presumed to be valid.

If you have both a Declaration to Physicians and a Power of Attorney for Health Care, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Physicians.

Up to four copies of the Declaration to Physicians are available free to anyone to sends a stamped, self-addressed business size envelop to: Living Will, Division of Health, P.O. Box 309, Madison, Wisconsin 53701-0309. You may obtain additional copies of the form by using a photocopy machine or other printing method to reproduce it.

If you have questions about the availability of the Declaration to Physicians (Living Will) form or obtaining larger quantities of the form, you may contact Sherry Kasper-Mohrbacher by writing to the Division of Health or by telephoning 608-266-8475.

INSTRUCTIONS FOR DECLARATION TO PHYSICIANS FORM

A. Definitions

"Declaration" means a written, witnessed document voluntarily executed by the declarant under State Statute 154.03(1), but is not limited in form or substance to that provided in State Statute 154.03(2).

"Department" means department of health and family services.

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

"Terminal condition" means an incurable condition caused by injury or illness that reasonable medical judgement finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

"Persistent vegetative state" means a condition that reasonable medical judgement finds constitutes complete and irreversible loss of all the functions of the cerebral cortex and results in a complete, chronic and irreversible cessation of all cognitive functioning and consciousness and a complete lack of behavioral responses that indicate cognitive functioning, although autonomic functions continue.

"Qualified patient" means a declarant who has been diagnosed and certified in writing to be afflicted with a terminal condition or to be in a persistent vegetative state by 2 physicians, one of whom is the attending physician, who have personally examined the declarant.

"Attending physician" means a physician licensed under State Statute Chapter 448 who has primary responsibility for the treatment and care of the patient.

"Health care professional" means a person licensed, certified or registered under State Statutes Chapters 441, 448 or 455.

"Inpatient health care facility" has the meaning provided under State Statute 50.135(1) and includes community-based residential facilities as defined in State Statute 50.01(1g).

"Life-sustaining procedure" means any medical procedure or intervention that, in the judgement of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient.

"Life-sustaining procedure" includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis and other similar procedures, but does not include (a) The alleviation of pain by administering medication or by performing an medical procedure. (b) The provision of nutrition or hydration.

B. Procedures for signing Declarations

A declaration must be signed by the declarant in the presence of 2 witnesses. If the declarant is physically unable to sign a declaration, the declaration must be signed in the declarant's name by one of the witnesses or some other person at the declarant's express direction and in his or her presence; such a proxy signing shall either take place or be acknowledged by the declarant in the presence of 2 witnesses.

C. Effect of Declaration

The desires of a qualified patient who is competent supersede the effect of the declaration at all times. If a qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures or feeding tubes a declaration executed under this chapter is presumed to be valid.

D. Revocation of Declaration

A declaration may be revoked at any time by the declarant by any of the following methods:

1) By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the declarant or by some person who is directed by the declarant and who acts in the presence of the declarant.
2) By a written revocation of the declarant expressing the intent to revoke signed and dated by the declarant.
3) By a verbal expression by the declarant of his or her intent to revoke the declaration, but only if the declarant or a person acting on behalf of the declarant notifies the attending physician of the revocation.
4) By executing a subsequent declaration.

The attending physician shall record in the declarant's medical records the time, date and place of the revocation and time, date and place, if different, that he or she was notified of the revocation.

E. Liabilities

No physician, inpatient health care facility or health care professional acting under direction of a physician my be held criminally liable or civilly liable, or charged with unprofessional conduct of any of the following:

1) Participating in the withholding or withdrawal of life-sustaining procedures or feeding tubes under ch. 154, subchapter II.
2) Failing to act upon a revocation unless the person or facility has actual knowledge of the revocation.
3) Failing to comply with a declaration, except that failure by a physician to comply with a declaration of a qualified patient constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the patient to another physician who will comply with the declaration.

DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 0060 (Rev. 4/96)

Effective Date
April 6, 1996
S. 154.03(1),(2)

PLEASE BE SURE YOU READ THE FORM CAREFULLY AND UNDERSTAND IT
BEFORE YOU COMPLETE AND SIGN IT

DECLARATION TO PHYSICIANS
(WISCONSIN LIVING WILL)

I, _____, being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a **TERMINAL CONDITION**, as determined by 2 physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

☐ YES, I want feeding tubes used if I have a terminal condition.

☐ NO, I do not want feeding tubes used if I have a terminal condition.

If you have not checked either box, feeding tubes will be used.

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures:

☐ YES, I want life-sustaining procedures used if I am in a persistent vegetative state.

☐ NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

If you have not checked either box, life-sustaining procedures will be used.

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of feeding tubes:

☐ YES, I want feeding tubes used if I am in a persistent vegetative state.

☐ NO, I do not want feeding tubes used if I am in a persistent vegetative state.

If you have not checked either box, feeding tubes will be used.

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

ATTENTION: You and the 2 witnesses must sign the document at the same time.

Signed_____ **Date**_____

Address_____ **Date of Birth**_____

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness Signature _____ **Date Signed** _____

Print Name _____

Witness Signature_____ **Date Signed** _____

Print Name _____

DIRECTIVES TO ATTENDING PHYSICIAN

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when 2 physicians, one of whom is the attending physician, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

2. The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless you believe that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed.

3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

* * * * *

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document:

_____

_____

_____

_____

For a fee, you may file one copy at the regis-ter of probate office (see "Courts, Probate"under county government listings in yourtelephone directory).

Complete and carry a wallet-size card with your other identification cards (see page A).

? What if I change my mind?

Review your living will regularly. Initial anddate the document to reassure others of yourwishes.

You can revoke your living will document atany time for any reason, as long as you arementally competent.

To revoke your living will document:

- Write out a statement revoking your liv-ing will, sign and date it
- Destroy the original document and all copies you made
- Tell your doctor you have revoked your living will

Power of Attorney for Health Care

A power of attorney for health care is alegal document that makes it possiblefor you to authorize anothere decisions on your behalf if you**a health care agent**—to make are not capable of doing so.

The statutory power of attorney for healthcare form became effective in WisconsinApril 28, 1990. An updated copy is in thecenter of this booklet with information onhow to get more (see page 5).

Power of attorney for health carthan a living will because it applies to allhealth care decisions someone is inca-pable of making decisions — in aterminal condition or persistent vegetativestate involving life-prolonging measures. Itmay include, for example, decisions towhether you receive medication, have anoperation, or are moved to or frcare facility.

om a healthe is broader The Wisconsin statutory form allows you to state the breadth and of authority youwant to grant your health care Bychecking yes or no (see pages 3 and 4 of thePower of Attorney for Health Care form), you may not give your agent theauthority to:

when not just as limits agent. may or

- Admit you to a nursing home or **community-based residential facility** for long-term care
- Withhold or withdraw non-oral **nutrition and hydration** (feeding tubes)
- Make decisions if you are pregnant

In the section "Statement of Desires, SpecialProvisions or Limitations," you may:

- Modify any of the issues covered in the three checkoffs
- Specify

treatments you want or do

not want

n State other wishes, such as naming yourpreferred nursing home or instructingyour health care agent to talk to a familymember in a distant city

Your agent can consent to or

decline almostany procedure for

you except: n Electroshock

therapy

n Experimental mental health

drugs and treatment n Admission

to a mental health facility

Your health care agent might confront. To guide your agent, explain in detail what factors and conditions aryou accept. Describe what elements aremeaningful for you to retain, what consti-tutes reasonable quality of life.ou can never fore important to you, or thatesee all the choices your

Communicating your critical to assuring

place. Discussions especiallyyour thepower of attorney effectively. OwnPreferences" and Desires" on your discussions.

wishes, preferences and values is that your agent can act in your withyour doctor, family, friends and health care agent are key to making for health care documentwork "Knowing and Discussing Your and "Consider Your Beliefs,Values page 6 may be usefulin guiding

? Who may be a health care agent?

Designating a health care agent —

and an alternate agent who will

serve if your prima-ry agent is unable or unwilling to serve — isa big decision.

The health care agent you appoint should besomeone you trust, such as a friend or fami-ly member. An assertive person who sharesvalues similar to yours and lives near youwill be in a good position to actively monitoryour health care, ask the right questions andensure that your wishes are followed.

provider, or an employee or spouse of yourhealth care provider—This person *your relative.* *cannot* be your health care *unless they are also*

? Who can be a witness?

Like a living will, the power of attorney forhealth care document must be signed in thepresence of two witnesses who know youpersonally and believe you to be of soundmind. If you are unable to sign, it must besigned in your name by one of the witnessesor someone else at your express direction —and in your presence.

Each witness must be a disinterat least 18 years old. A witness *cannot* ested personbe: n Related by blood, marriage, or adoption n Entitled to or have claim to any of yourestate

n Your doctor, the doctor's staff or employee of the hospital, clinic, nursinghome or other facility providing yourcare *except* chaplains and social workers *any* n Directly financially responsible for yourhealth care

? When is power of attorney for health care effective?

With your completed power of attorney for health care, the person you designate as your agent has the legal authority to makemedical decisions on your behalf any timetwo physicians — or a physician and a psy-chologist — state that you are **incapacitated**.

? What should I do with the document?

health care agent and alternate agent eachneed a copy. Sign and keep the original power of attorney for health care document in a safe, accessibleplace. Distribute copies, which are as effec-tive as the original. Give your doctor a copyto become part of your medical records. The

You may also choose to give copies to familymembers, your attorney and the person whoholds durable power of attorney for yourfinancial matters. Keep a list of everyonewho has a copy, in case you want to changeor revoke the document.

For a fee, you may file one copy at your county register of probate office (see "Courts,Probate" under county government listingsin your telephone directory).

Complete and carry a wallet-size card with your other identification cards (see page A).

? What if I change my mind?

frequent changes can occur in medical prac-tices, in your health or in your family.You can change or revoke your power ofattorney for health cartime for any reason, as long as you are men-tally competent. In fact, it's suggested thatyou review the document re document at anyegularly, since

To revoke a power of attorney for health caredocument: n and

date itWrite out a statement revoking yourpower of attorney

for health care, sign

n Destrcopies you madeoy the original document and all n

Execute a new power of attorney for health care

Common questions about advance directives for health care

? Do I need both a living will and a power of attorney for

In Wisconsin, a power of attorney for healthcare document supersedes or replaces a liv-ing will if the two documents conflict—unless the living will was completed beforeDecember 11, 1991.

? health care?

nancy issues. In that case, it is possible thatneither would be honored.If you completed a living will before December 11, 1991, and also complete a power of attorney for health care, be sure thedirectives to your health care agent do notcontradict the living will. Your living willand power of attorney for health care canconflict over nutrition, hydration and preg-

Generally, the power of attorney for healthcare is the recommended document if youhave someone you trust as agent to makeyour health care decisions. The living willmay clarify your wishes and guide yourhealth care agent.

? Where do I get advance directives forms?

You may photocopy or pull out the "Power of Attorney for Health Car" "Declaration to Physicians (Living Will)" statutory forms from the center of this book-let. Or you can request copies by sending astamped, self-addressed, business-size enve-lope to: e" and

Wisconsin Department of Health and Social ServicesDivision of Health — Declaration toPhysicians and POAHCP. O. Box 309Madison, WI 53701-0309

? Can anyone be liable for carrying my wishes?

In carrying out your wishes through a statutory power of attorney for health care document, a health care agent acting in good faithdoes not incur criminal or civil liability fordecisions made for you when you are notcapable of doing so.

Your health care agent is not liable for thefinancial costs resulting from medical caredecisions unless the agent is your spouse.

If you complete the statutory Declaration to Physicians (Living Will) form, it guarantees certain legal protections for doctors. And aspointed out on page 2 ("When Is a LivingWill Effective?"), it helps assure that yourwishes will be followed.

? Should I have advance directives for health care?

Only you can make that decision after think-ing about your values and beliefs aboutmedical care. The "Consider Your Beliefs,Values and Desires" section on page 6 isdesigned to help you do this.

Share your thoughts and actions with yourdoctor, family, friends and others who maybe involved in making decisions for or withyou.

When you document your wishes before a medical crisis occurs, you minimize familymisunderstandings and disagreements. Youcan also be assured that your family knowswhat kind of care you want.

Knowing and discussing

Planning for life and death decisions involves sorting out preferences based on individual beliefs and values. The more aware or conscious you and your health care agent are of what is important to you, the better decisions and plans you can make and they can follow.

your own preferences

doctor.

Consider your beliefs, values and desires

Your overall attitude toward your

How would you describe your currenthealth status? If you currently have anymedical problems, how would you describethem? Do they affect your ability to function? If so, how?**health**

How do you relate to your doctor? Whatrole should you

doctor have: Make finaldecisions about medical treatment

youmight need? **Role of doctor and caregivers***Or* mak

recommendations for face of your health care agent o

family to consider?

How important are independence and self-sufficiency in your life? How much physi-cal and mental independence

n n n

ar**Independence and control**ing to give up? When? Under what circum-stances? e you will- that af

Spend some time reflecting and writinganswers for the following questions. Thendiscuss these beliefs with your health careagent so they can carry out their responsibil-ities. You may also want to share your wish-es with other family members and your

Do you expect that your friends, familyand/or others will support your decisionsrnow or in the future? Who do you wantand trwhen you are unable to do so? Are therepeople yo do **Personal relationships**health care decisions for you?egarding medical treatment you may needust to make decisions on your behalf*not* want involved in making death?

Do you worry about having enough moneyto provide for your care? Should the cost**Attitude concerning finances**involved and who would have to pay beconsidered in deciding your care? In what way?

Adapted with permission from *Values History Form,*

Attitude toward terminal/irreversible

ness? In the face of permanent coma? In theHow do you feel about the use of life-sus-taining measures in the face of terminal ill-**illness or injury**Alzheimer's Disease?**irreversible chronic illness** such as

Religious background or spiritual

Do you have religious or spiritual beliefs**beliefs**terminal illness or injury? Explain your beliefs and how they affect your attitude.fect your attitude toward serious or

What will be important to you when youare dying in terms of physical comfort,pain, family members prof life or other considerations? Wherewould you prtude toward terminal condition, dying, and**Attitude toward death and dying**efer to die? What is your atti-esent, age, quality

Do you want to donate your organs tosomeone else at the time of your death?Have you signed an organ donor card?**Organ donation**

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n n n

Checklist for preparing advance directives for health care

I have: n Carefully considered my values anddesires regarding terminal condition anddeath. nn

document(s) in a safe, accessible place,and given copies to family members.Discussed document(s)

and wishes withmy primary physician and placed a copyof the document(s) in my official med-ical

file.Filed original signed advance directives n Talked with family members, closefriends and my

doctor about what

would be important to me if I become

or otherwise incapable of making healthterminally or irreversibly ill or injured,care decisions. n Given copies of the document(s) to my

nnn

nnnnn (tory form(s).power of attorney for health care statu-Asked someone I trspouse, parSelected an alternate health care agent incase my agent is unable to serve whenneeded.Carefully completed a living willHad two qualified witnesses watch mesign my document(s).Informed close family members —near me to be my health care agent, andwho my health care agent is.understand how I feel so they can act onmy behalf, and have agreed to serve asmy agent.discussed my wishes with them.

They"Declaration to Physicians") and/orents, childrust and who livesen, siblings — n providers, close friends, clergy or spiritual leader, or any other individuals whohealth care agent, other health caremade a list of who has copies.might be involved in caring for me, andMade plans to review the advance direc-confirm preferences and directions.tives document(s) regularly to update or

Glossary

advance directives—which competent individuals can retain some control over decisions made on their behalf in the event they are no longer able todo so for themselves. Advance directives forhealth care, such as living will and power ofattorney for health care documents, autho-rize medical decisions. Others, such as livingtrusts and durable power of attorney forfinancial matters documents, authorizefinancial decisions. Legal documents in

artificial feeding—by inserting a tube into a vein, the nose orstomach when a person is unable to swallowor eat well enough to sustain life; feedingtubes. *See nutrition and hydration.* Providing liquid nutrition

brain death—vous system.No activity of the central ner-

community-based residential facility(for five or more unrelated adults who need some daily personal care or supervision, butdon't need skilled nursing care. For informa-tion, contact a Department of Health andSocial Services Division of CommunityServices regional licensing specialist (understate government listings in your telephonedirectory).**CBRF)—** Licensed Wisconsin group home

competent—mation about a medical problem and consequences of the treatment decision.Can understand relevant infor- **declarant—**living will (Declaration to Physicians)advance

directives form.Person or patient

completing a

do not resuscitate (DNR)—diopulmonary resuscitation (CPR) not be initiated because it may only serve to pro-long the dying process. DNR is stated in thepatient's medical charts when the patientand agent, in consultation with a physician,have requested such an order. Such an ordercan be reversed at any time and should bereviewed regularly. Request that car-

guardian—petent person and his or her estate.the care, custody and control of the incomPerson the court appoints to have **health care agent—** for health care document, the person legallyauthorized to make health care decisions onbehalf of another person who is incapable ofdoing so. In a power of attorney

incapacitated—health care document, when two physicians —or one physician and a psychologist —find a person unable to receive and evaluateinformation effectively, to communicatedecisions or to manage health care deci-sions. In a power of attorney for

incompetent—designate a person found by a court to be"substantially incapable of managing his [orher] property or caring for himself [or her-self] by reason of infirmities." Note that aphysical disability without mental incapaci-ty is not sufficient to establish incompetence.Legal term to be used only to

irreversible chronic illness—term illness that worsens over time and can-not be cured. Persons may be capable men-tally and/or physically. Examples includeAlzheimer's Disease and rheumatoid arthritis. Usually a long-

life-sustaining procedures—procedure or intervention that would serveonly to prolong the dying process whenthere is no significant hope of functionalrecovery. Examples include assistance withbreathing, artificial maintenance of bloodpressure and heart rate, and kidney dialysis.Any medical pos

medically contraindicated—not medically advisable because it would domore harm than good. A procedure is

Medicare and Medical Assistance—Medicare is a program under the SocialSecurity Administration that provides med-ical care for disabled or older adults.Medical Assistance — the Wisconsin form ofMedicaid — is a program funded jointly bythe state and federal government to providemedical aid to those of any age who cannototherwise afford to pay for it.

living trust—ing a person's lifetime, not to be confusedwith a living will. Living trust creators assign their assets — real estate, bank accounts, stock, mutual funds or other property — to a trustee to hold and manage fortheir beneficiaries. They control their ownassets until they are incapacitated or die,when the trustee manages or disposes of theassets as they direct. Financial trust established dur*See trust.*

next-of-kin law—— or if no spouse, gives parents or adult children — power of attorney for health carewhen an agent has not been named. Whenno next-of-kin law exists, as in Wisconsin,and no health care agent has been named,the court must appoint a guardian for thoseunable to make their own decisions.Automatically gives spouse

living will—sible for a person to state his or her prefer-ences for life-sustaining procedures in theevent the person is in a terminal conditionor persistent vegetative state. Also called"Declaration to Physicians" in Wisconsin.Legal document that makes it

nutrition and hydration—calories, minerals, vitamins and fluids need-ed to maintain body weight and properfunctioning of organs. *See artificial feeding.*

permanent coma—Daily required that is expected to continue, frequently relat-ed to a head injury or lack of oxygen to thebrain. State of unconsciousness

persistent vegetative state—which the heart beats and breathing continues, but there is no consciousness or abilityto communicate.

power of attorney—Condition in another's behalf in areas such as manage-ment of property and finances, or medicaldecisions. Legal right to act on

power of attorney for health care—document that makes it possible for a person to authorize another individual — ahealth care agent — to make health caredecisions on his or her behalf in times ofincapacity. Legal

principal—ney for health care document.Person creating the

power of attor**proxy—**sions for another, also known as surrogatedecision-maker. For example, the health careagent, who makes a person's medical deci-sions based on what that person wrote intheir power of attorney for health care, is aproxy.Person legally named to make deci-

respirator—that assist a patient's breathing when he or she is partially or totally unable to do so alone; also called a ventilator. The patient isconnected to the machine with a tube direct-ly through the windpipe or through the noseto the windpipe. This provides volumes ofair and oxygen adequate to support life.Mechanical breathing machines

substituted judgment—treatment decisions that the person wouldmake if competent. Commonly interpretedas a decision in the person's "best interest,"it may not be what the person would havewanted. Process of making **terminal condition—**caused by injury or illness that reasonablemedical judgment finds would causedeath imminently, so that the applicationof life-

sustaining procedures serves onlyto postpone the moment of death.Incurable condition **trust—**ty title is held by a "trustee" — an individ-ual or corporate fiduciary — who has theduty to administer the trust for the benefitof the people named as beneficiaries of thetrust.Form of ownership where the proper-**will—**tion of a person's property and assetsupon death. This does not involve healthcare decisions.Legal statement directing the distribu-

Adapted with permission from Marlene S. Stum and Minnesota Extension Service, from Glossary,*Taking Control of Life and Death Health Care Decisions*(Science, UniversityMcNeal Hall, St. Paul, MN 55108. 1991.NCR398). St. Paul, Minn.: Department of Family Socialof Minnesota Extension Service, 275

AARP is a membership

n n n

organization for people over age 50. It offers publications and volunteer-run programs on economic, social, health and housing issues, and videos on advance directives.

AARP 601 Washington, DC 20049 (888) 687-2277 www.aarp.org E. Stree NW

Resources

tives, aging, elderly housing options, finan-cial management, health care, estate plan-ning, more. University of Wisconsin-Extension (see county government listings in your tele-phone directory). Provides educational information and programs on advance direc-

U.S. Patient Self-Determination Act of 1991 To see federal laws, ask your local library for *United States Code*.

Elder Law Center is a public interest legal services program. Its goal is to provide accu-rate, up-to-date legal information, education, and services. Most services are provided at no charge.

Elder Law Center 2850 Madison, WI 53718-6751 (608) 224-0660 Dairy Drive, Suite 100

local library). Living will (natural death, Wisconsin Act 202 of 1983) legislation is found in Chapter 154 of the Wisconsin Statutes; Power of Attorney for Health Care is found in Chapter 155. *Wisconsin State Statutes* (available at your

Portions of this publication were adapted with permission from:

Acknowledgments

Dicks, Helen Marks and Betsy Abramson. *Planning for Future Health Care Decisions— Powers of Attorney for Health Care and Living Wills.* Public Representation. 3rd Edition, 1992. Center for

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1991 Science, University of Minnesota Extension Service, St. Paul, MN 55108.

Values History Form and Ethics, Institute of Public Law, School of Law, University of New Mexico, Albuquerque, NM 87131. · Center for Health Law

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