Advance Directives for Health Care

Wisconsin Living Will and
Power of Attorney for Health Care

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Advance Directives for Health Care:
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Power of Attorney for Health Care
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This publication introduces laws that affect advance directives for health care in Wisconsin, and provides information about two advance directives documents. It is not intended to substitute for professional advice, nor is it exhaustive.

Statements in this publication reflect legislation in effect in Wisconsin as of January 1, 1994. Other states have different laws; some information may not apply outside Wisconsin.
Planning health care decision-making

Advances in medical technology now enable individuals to survive illnesses and injuries that once would have been fatal. These advances may be a blessing for many, but they also raise questions about the quality of a life prolonged artificially.

Planning for health care decision-making is not just an issue for the elderly. No age group is exempt from becoming terminally or irreversibly ill or injured, or otherwise incapable of making health care decisions. Cancer and accidents are common causes of death for younger adults. Family members of all ages should be aware of the need to talk about health care decisions.

All of us need to make a special effort to indicate in writing who should make decisions if we are unable to do so.

Health care decision-making can be stressful to discuss. Most people avoid thinking about increasing dependency, not being healthy or not being capable of making their own decisions. Many individuals feel it is important to clarify and discuss their preferences and wishes about health care, but put it off to do...later. It’s also easy to assume “It won’t happen to me.”

Research suggests that many adults would prefer family members to make health care decisions for them. And while family members may be expected to act according to the patient’s wishes, Wisconsin does not have a “next-of-kin” law automatically giving them the legal right to make decisions for their relative — unless they are named in an advance directives document.

Situations involving health care decisions can also lead to conflicts among family members, feelings of guilt and being burdened by not knowing what the person would really have wanted.

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

This booklet answers commonly asked questions and provides a guide and checklist to help you discuss health care decision-making with family members and health care providers to assure appropriate action.

A glossary at the end explains technical and legal terms you may find in the statutory forms or in information about advance directives, or will notice in bold type on the following pages.

Patient Self-Determination Act

Since December 1991, the U.S. Patient Self-Determination Act has required that health care facilities receiving federal funds — such as Medicare and Medical Assistance — must give patients written information at the time of admission about their rights:

- To accept or refuse medical treatment, and
- To formulate advance directives such as living wills and powers of attorney for health care.

Many states, including Wisconsin, have enacted legislation to provide legal tools for advance planning.

Separate statutory forms are available for Wisconsin residents to make a living will or a power of attorney for health care. These are designed for you to complete without the aid of an attorney.

Your health care provider will use the completed forms when you are unable to make your own health care decisions.
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 information 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 preferences for life-sustaining procedures and feeding tubes, in the event the person is in a terminal condition or persistent vegetative state.

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 withdrawal of any medication or treatment if the physician feels it will cause you pain or reduce your comfort
- If you are pregnant (see “Power of Attorney for Health Care,” page 3)

Who can be a witness?
The living will document must be signed in the presence of two witnesses who know you (the declarant) personally, and believe you to be of sound mind. If you are unable to sign, it must be signed in your name by one of the witnesses or someone else at your express direction — and in your presence.

Each witness must be a disinterested person at least 18 years old. A witness cannot be:
- Related by blood, marriage, or adoption
- Entitled to or have claim to any of your estate
- Your doctor, the doctor’s staff or any employee of the hospital, clinic, nursing home or other facility providing your care except chaplains and social workers
- Directly financially responsible for your health care

When is a living will effective?
Your completed living will becomes effective when two physicians — one who is the attending physician — have examined and diagnosed you, and certified in writing that you have a terminal condition or are in a persistent vegetative state.

Your physician is required by law to comply with your living will. If the physician refuses or fails to comply with your directives, and refuses or fails to transfer you to another doctor, the physician may be charged with unprofessional conduct.

If you completed a living will before December 11, 1991, you may want to review or revoke that document in light of legal changes made since then. To revoke a document, see page 3: “What If I Change My Mind?”

What should I do with the document?
Sign and keep the original living will document in a safe, accessible place. Distribute copies, which are as effective as the original. Give your doctor a copy to become part of your medical records. Give copies to the hospital, your health care agent if you have one, and a family member. Keep a list of everyone who has a copy, in case you want to change or revoke the document.
Wisconsin statutory forms

- Power of Attorney for Health Care
- Declaration to Physicians (Living Will)

Wisconsin legislators have written statutory advance directives forms that you can use to give someone power of attorney for health care and to write a living will. You have the legal right to complete one or both documents, but you are not required to do so.

These statutory forms, and letters of instruction for Wisconsin residents, are printed on the following pages. You may photocopy or pull out these forms, or request copies by sending a stamped, self-addressed, business-size envelope to:

Wisconsin Department of Health and Social Services
   Division of Health — Declaration to Physicians and POAHC
   P. O. Box 309
   Madison, WI 53701-0309

Do not sign these documents unless you clearly understand them. You may obtain most information you need from this publication, 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 witnesses 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.

Directions

Print or type clearly. Print your name below your signature.

“Copies are available at:” Name of the clinic or hospital where your medical records are kept that include your advance directives.

Clip this out and carry it with you; keep it with your other important identification cards.

Note: This card does not give specific directions and may not be helpful in an emergency. If you are admitted to a hospital, it will inform physicians that you have completed advance directives to guide decisions.

Sample wallet card

<table>
<thead>
<tr>
<th>Attention Health Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In case of emergency, I have a:</strong></td>
</tr>
<tr>
<td>□ Declaration to Physicians (Living Will)</td>
</tr>
<tr>
<td>□ Power of Attorney for Health Care</td>
</tr>
<tr>
<td><strong>Copies are available at:</strong> ______________________________</td>
</tr>
<tr>
<td><strong>My health care agent is:</strong> ______________________________</td>
</tr>
<tr>
<td><strong>Name</strong> ______________________________</td>
</tr>
<tr>
<td><strong>Address</strong> ______________________________</td>
</tr>
<tr>
<td><strong>Phone</strong> __________________ (home) __________________ (work)</td>
</tr>
<tr>
<td>Please consult these documents and/or this person in case of medical emergency.</td>
</tr>
<tr>
<td><strong>Signature and date</strong> ______________________________</td>
</tr>
</tbody>
</table>

A
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 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 supersedes any directly conflicting provisions of a valid Declaration to Physicians.

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

If you have any questions about the availability of the Power of Attorney for Health Care form or obtaining larger quantities of the form, you may contact Sherry Kasper-Mohrbacher by telephoning 608-266-8475.

INSTRUCTIONS FOR POWER OF ATTORNEY FOR HEALTH CARE FORM
Definitions
‘Department’ means the department of health and family services.
‘Health Care’ means any care, treatment, service or procedure to maintain, diagnose or treat an individual’s physical or mental condition.
‘Health care decision’ means an informed decision in the exercise of the right to accept, maintain, discontinue or refuse health care.
‘Health care facility’ means a facility, as defined in s. 647.01(4), or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, tuberculosis sanatorium or other place licensed or approved by the department under s. 49.70, 49.71, 49.72, 50.02, 50.03, 50.35, 51.08, 51.09, 58.06, 252.073 or 252.076 or a facility under s. 45.365, 51.05, 51.06, 233.40, 233.41, 233.42 or 252.10.
‘Health care provider’ means a nurse licensed or permitted under ch.441, a chiropractor licensed under ch.446, a dentist licensed under ch. 447, a physician, podiatrist or physical therapist licensed or an occupational therapist or occupational therapy assistant.
certified under ch. 448, a person practicing Christian Science treatment, an optometrist licensed under ch. 449, a psychologist licensed under ch. 455, a partnership thereof, a corporation thereof that provides health care services, an operational cooperative sickness care plan organized under ss. 185.981 to 185.985 that directly provides services through salaried employees in its own facility, or a home health agency, as defined in s. 50.49 (1)(a).

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

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

Who may sign a Power of Attorney for Health Care?

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

Procedures for Signing a Power of Attorney for Health Care

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

When does it take effect?

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

Revocation

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

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

Immunities

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

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

General Provisions

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

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

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

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long-term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOCKS 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 employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the declarant is a patient. I am not the principal’s health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness Number 1
(Print) Name ___________________________ Date ________________
Address ____________________________________________
Signature __________________________________________

Witness Number 2
(Print) Name ___________________________ Date ________________
Address ____________________________________________
Signature __________________________________________

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 ____________
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 who sends a stamped, self-addressed business size envelope 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 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.

DOH0060A (Rev. 4/96)
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:

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
A fee, you may file one copy at the register of probate office (see “Courts, Probate” under county government listings in your telephone 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 and date the document to reassure others of your wishes.

You can revoke your living will document at any time for any reason, as long as you are mentally competent.

To revoke your living will document:

- Write out a statement revoking your living 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

Power of attorney for health care is a legal document that makes it possible for you to authorize another individual—a health care agent—to make health care decisions on your behalf if you are not capable of doing so.

The statutory power of attorney for health care form became effective in Wisconsin April 28, 1990. An updated copy is in the center of this booklet with information on how to get more (see page 5).

Power of attorney for health care is broader than a living will because it applies to all health care decisions when someone is incapable of making decisions — not just in a terminal condition or persistent vegetative state involving life-prolonging measures. It may include, for example, decisions as to whether you receive medication, have an operation, or are moved to or from a health care facility.

The Wisconsin statutory form allows you to state the breadth and limits of authority you want to grant your health care agent. By checking yes or no (see pages 3 and 4 of the Power of Attorney for Health Care form), you may or may not give your agent the authority to:

- 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, Special Provisions or Limitations,” you may:

- Modify any of the issues covered in the three checkoffs
- Specify treatments you want or do not want
- State other wishes, such as naming your preferred nursing home or instructing your health care agent to talk to a family member in a distant city

Your agent can consent to or decline almost any procedure for you except:

- Electroschock therapy
- Experimental mental health drugs and treatment
- Admission to a mental health facility

You can never foresee all the choices your health care agent might confront. To guide your agent, explain in detail what factors and conditions are important to you, or that you accept. Describe what elements are meaningful for you to retain, what constitutes reasonable quality of life.

Communicating your wishes, preferences and values is critical to assuring that your agent can act in your place. Discussions with your doctor, family, friends and especially your health care agent are key to making the power of attorney for health care document work effectively.
“Knowing and Discussing Your Own Preferences” and “Consider Your Beliefs, Values and Desires” on page 6 may be useful in guiding your discussions.

**Who may be a health care agent?**
Designating a health care agent — and an alternate agent who will serve if your primary agent is unable or unwilling to serve — is a big decision.

The health care agent you appoint should be someone you trust, such as a friend or family member. An assertive person who shares values similar to yours and lives near you will be in a good position to actively monitor your health care, ask the right questions and ensure that your wishes are followed.

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

**Who can be a witness?**
Like a living will, the power of attorney for health care document must be signed in the presence of two witnesses who know you personally and believe you to be of sound mind. If you are unable to sign, it must be signed in your name by one of the witnesses or someone else at your express direction — and in your presence.

Each witness must be a disinterested person at least 18 years old. A witness cannot be:

- Related by blood, marriage, or adoption
- Entitled to or have claim to any of your estate
- Your doctor, the doctor’s staff or any employee of the hospital, clinic, nursing home or other facility providing your care except chaplains and social workers
- Directly financially responsible for your health 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 make medical decisions on your behalf any time two physicians — or a physician and a psychologist — state that you are incapacitated.

**What should I do with the document?**
Sign and keep the original power of attorney for health care document in a safe, accessible place. Distribute copies, which are as effective as the original. Give your doctor a copy to become part of your medical records. The health care agent and alternate agent each need a copy.

You may also choose to give copies to family members, your attorney and the person who holds durable power of attorney for your financial matters. Keep a list of everyone who has a copy, in case you want to change or revoke the document.

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

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

**What if I change my mind?**
You can change or revoke your power of attorney for health care document at any time for any reason, as long as you are mentally competent. In fact, it’s suggested that you review the document regularly, since frequent changes can occur in medical practices, in your health or in your family.

To revoke a power of attorney for health care document:

- Write out a statement revoking your power of attorney for health care, sign and date it
- Destroy the original document and all copies you made
- 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 health care?

In Wisconsin, a power of attorney for health care document supersedes or replaces a living will if the two documents conflict—unless the living will was completed before December 11, 1991.

If you completed a living will before December 11, 1991, and also complete a power of attorney for health care, be sure the directives to your health care agent do not contradict the living will. Your living will and power of attorney for health care can conflict over nutrition, hydration and pregnancy issues. In that case, it is possible that neither would be honored.

Generally, the power of attorney for health care is the recommended document if you have someone you trust as agent to make your health care decisions. The living will may clarify your wishes and guide your health care agent.

Where do I get advance directives forms?

You may photocopy or pull out the “Power of Attorney for Health Care” and “Declaration to Physicians (Living Will)” statutory forms from the center of this booklet. Or you can request copies by sending a stamped, self-addressed, business-size envelope to:

Wisconsin Department of Health and Social Services
Division of Health — Declaration to Physicians and POAHC
P. O. Box 309
Madison, WI 53701-0309

Can anyone be liable for carrying out my wishes?

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

Your health care agent is not liable for the financial costs resulting from medical care decisions 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 as pointed out on page 2 (“When Is a Living Will Effective?”), it helps assure that your wishes will be followed.

Should I have advance directives for health care?

Only you can make that decision after thinking about your values and beliefs about medical care. The “Consider Your Beliefs, Values and Desires” section on page 6 is designed to help you do this.

Share your thoughts and actions with your doctor, family, friends and others who may be involved in making decisions for or with you.

When you document your wishes before a medical crisis occurs, you minimize family misunderstandings and disagreements. You can also be assured that your family knows what kind of care you want.
Knowing and discussing your own preferences
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.

Spend some time reflecting and writing answers for the following questions. Then discuss these beliefs with your health care agent so they can carry out their responsibilities. You may also want to share your wishes with other family members and your doctor.

Consider your beliefs, values and desires

Your overall attitude toward your health
How would you describe your current health status? If you currently have any medical problems, how would you describe them? Do they affect your ability to function? If so, how?

Role of doctor and caregivers
How do you relate to your doctor? What role should your doctor have: Make final decisions about medical treatments you might need? Or make recommendations for your health care agent or family to consider?

Independence and control
How important are independence and self-sufficiency in your life? How much physical and mental independence are you willing to give up? When? Under what circumstances?

Personal relationships
Do you expect that your friends, family and/or others will support your decisions regarding medical treatment you may need now or in the future? Who do you want and trust to make decisions on your behalf when you are unable to do so? Are there people you do not want involved in making health care decisions for you?

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

Attitude toward terminal/irreversible illness or injury
How do you feel about the use of life-sustaining measures in the face of terminal illness? In the face of permanent coma? In the face of irreversible chronic illness such as Alzheimer’s Disease?

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

Attitude toward death and dying
What will be important to you when you are dying in terms of physical comfort, pain, family members present, age, quality of life or other considerations? Where would you prefer to die? What is your attitude toward terminal condition, dying, and death?

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

Adapted with permission from Values History Form, published by the Center for Health Law and Ethics, Institute of Public Law, School of Law, University of New Mexico, Albuquerque, NM 87131.
Checklist for preparing advance directives for health care

I have:

☐ Carefully considered my values and desires regarding terminal condition and death.

☐ Talked with family members, close friends and my doctor about what would be important to me if I become terminally or irreversibly ill or injured, or otherwise incapable of making health care decisions.

☐ Asked someone I trust and who lives near me to be my health care agent, and discussed my wishes with them. They understand how I feel so they can act on my behalf, and have agreed to serve as my agent.

☐ Selected an alternate health care agent in case my agent is unable to serve when needed.

☐ Carefully completed a living will (“Declaration to Physicians”) and/or power of attorney for health care statutory form(s).

☐ Had two qualified witnesses watch me sign my document(s).

☐ Informed close family members — spouse, parents, children, siblings — who my health care agent is.

☐ Filed original signed advance directives document(s) in a safe, accessible place, and given copies to family members.

☐ Discussed document(s) and wishes with my primary physician and placed a copy of the document(s) in my official medical file.

☐ Given copies of the document(s) to my health care agent, other health care providers, close friends, clergy or spiritual leader, or any other individuals who might be involved in caring for me, and made a list of who has copies.

☐ Made plans to review the advance directives document(s) regularly to update or confirm preferences and directions.
Glossary

**advance directives**—Legal documents in which competent individuals can retain some control over decisions made on their behalf in the event they are no longer able to do so for themselves. Advance directives for health care, such as living will and power of attorney for health care documents, authorize medical decisions. Others, such as living trusts and durable power of attorney for financial matters documents, authorize financial decisions.

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

**brain death**—No activity of the central nervous system.

**community-based residential facility (CBRF)**—Licensed Wisconsin group home for five or more unrelated adults who need some daily personal care or supervision, but don’t need skilled nursing care. For information, contact a Department of Health and Social Services Division of Community Services regional licensing specialist (under state government listings in your telephone directory).

**competent**—Can understand relevant information about a medical problem and consequences of the treatment decision.

**declarant**—Person or patient completing a living will (Declaration to Physicians) advance directives form.

**do not resuscitate (DNR)**—Request that cardiopulmonary resuscitation (CPR) not be initiated because it may only serve to prolong the dying process. DNR is stated in the patient’s medical charts when the patient and agent, in consultation with a physician, have requested such an order. Such an order can be reversed at any time and should be reviewed regularly.

**guardian**—Person the court appoints to have the care, custody and control of the incompetent person and his or her estate.

**health care agent**—In a power of attorney for health care document, the person legally authorized to make health care decisions on behalf of another person who is incapable of doing so.

**incapacitated**—In a power of attorney for health care document, when two physicians—or one physician and a psychologist—find a person unable to receive and evaluate information effectively, to communicate decisions or to manage health care decisions.

**irreversible chronic illness**—Usually a long-term illness that worsens over time and cannot be cured. Persons may be capable mentally and/or physically. Examples include Alzheimer’s Disease and rheumatoid arthritis.

**life-sustaining procedures**—Any medical procedure or intervention that would serve only to prolong the dying process when there is no significant hope of functional recovery. Examples include assistance with breathing, artificial maintenance of blood pressure and heart rate, and kidney dialysis.

**living trust**—Financial trust established during a person’s lifetime, not to be confused with 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 for their beneficiaries. They control their own assets until they are incapacitated or die, when the trustee manages or disposes of the assets as they direct. See trust.

**living will**—Legal document that makes it possible for a person to state his or her preferences for life-sustaining procedures in the event the person is in a terminal condition or persistent vegetative state. Also called “Declaration to Physicians” in Wisconsin.
medically contraindicated—A procedure is not medically advisable because it would do more harm than good.

**Medicare and Medical Assistance**—Medicare is a program under the Social Security Administration that provides medical care for disabled or older adults. Medical Assistance — the Wisconsin form of Medicaid — is a program funded jointly by the state and federal government to provide medical aid to those of any age who cannot otherwise afford to pay for it.

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

nutrition and hydration—Daily required calories, minerals, vitamins and fluids needed to maintain body weight and proper functioning of organs. See artificial feeding.

permanent coma—State of unconsciousness that is expected to continue, frequently related to a head injury or lack of oxygen to the brain.

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

power of attorney—Legal right to act on another’s behalf in areas such as management of property and finances, or medical decisions.

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

principal—Person creating the power of attorney for health care document.

proxy—Person legally named to make decisions for another, also known as surrogate decision-maker. For example, the health care agent, who makes a person’s medical decisions based on what that person wrote in their power of attorney for health care, is a proxy.

respirator—Mechanical breathing machines 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 is connected to the machine with a tube directly through the windpipe or through the nose to the windpipe. This provides volumes of air and oxygen adequate to support life.

substituted judgment—Process of making treatment decisions that the person would make if competent. Commonly interpreted as a decision in the person’s “best interest,” it may not be what the person would have wanted.

terminal condition—Incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

trust—Form of ownership where the property title is held by a “trustee” — an individual or corporate fiduciary — who has the duty to administer the trust for the benefit of the people named as beneficiaries of the trust.

will—Legal statement directing the distribution of a person’s property and assets upon death. This does not involve health care decisions.

Resources
AARP is a membership 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 E. Street NW
Washington, DC 20049
(888) 687-2277
www.aarp.org

Elder Law Center is a public interest legal services program. Its goal is to provide accurate, up-to-date legal information, education, and services. Most services are provided at no charge.
Elder Law Center
2850 Dairy Drive, Suite 100
Madison, WI 53718-6751
(608) 224-0660

University of Wisconsin-Extension (see county government listings in your telephone directory). Provides educational information and programs on advance directives, aging, elderly housing options, financial management, health care, estate planning, more.

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

Wisconsin State Statutes (available at your 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.

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