COMBINED LIVING WILL AND ADVANCE HEALTHCARE DIRECTIVE

State of residence: WI **Place of paper signing:** WI **Effective Date:** [DATE]

Wisconsin notice for a health care power of attorney

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 OR DOMESTIC PARTNER AND YOUR MARRIAGE IS ANNULLED OR YOU ARE

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DIVORCED OR THE DOMESTIC PARTNERSHIP IS TERMINATED 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 RECORD 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 OR OTHER PRIMARY CARE PROVIDER.

I, **[DECLARANT NAME]**, born [DATE], residing at [DECLARANT ADDRESS] (the "Declarant," "Principal," or "Patient"), being of sound mind and at least eighteen (18) years of age, voluntarily make this **Combined Advance Healthcare Directive** — comprising a **Living Will** (statement of treatment wishes) and a **Healthcare Power of Attorney** (appointment of a healthcare agent) — under the laws of the State of WI, as a directive to physicians, my healthcare agent, family members, and all other persons concerned with my care.

1. Statement of Capacity and Voluntariness

I am competent to make this directive. I understand its contents and legal effect. I am not acting under duress, fraud, or undue influence. I make this directive freely and voluntarily, after reflection on the medical, personal, moral, and (where applicable) religious implications of the choices expressed herein.

2. Appointment of Healthcare Agent

I hereby appoint the following person as my Healthcare Agent (the "Agent") to make healthcare decisions for me if I lose the capacity to make them myself:

- **Name:** [PRIMARY AGENT FULL LEGAL NAME]
- **Relationship:** [RELATIONSHIP TO YOU]
- **Address:** [PRIMARY AGENT ADDRESS]
- **Phone:** [PRIMARY AGENT PHONE]

First Alternate Agent (serves if the primary Agent is unavailable, unwilling, or unable):

- **Name:** [ALTERNATE AGENT FULL LEGAL NAME RECOMMENDED]
- **Address:** [ALTERNATE AGENT ADDRESS]

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- **Phone:** [ALTERNATE AGENT PHONE]

Second Alternate Agent (serves if both prior Agents are unavailable):

- **Name:** [SECOND ALTERNATE AGENT FULL LEGAL NAME]
- **Phone:** [SECOND ALTERNATE AGENT PHONE]

When authority begins. My Agent's authority begins when a physician determines in writing that I lack the capacity to make or communicate my own healthcare decisions, and ends when I regain capacity.

Scope of authority. My Agent has full authority to make all healthcare decisions I could make if I had capacity, including (without limitation): consenting to, refusing, or withdrawing any medical treatment, service, or procedure; selecting, hiring, and discharging physicians, nurses, therapists, and facilities; authorizing or refusing artificial nutrition, hydration, and life-sustaining treatment (consistent with any explicit instructions in this directive); obtaining medical information relevant to an authorized decision; making decisions about pain management, palliative sedation, hospice, and comfort care; admitting me to or discharging me from hospitals, nursing homes, assisted-living facilities, and hospice programs; authorizing an autopsy; directing disposition of my remains; and making an anatomical gift of my body or parts thereof consistent with any instruction below.

Agent obligation. My Agent shall make decisions consistent with my wishes as stated in this directive. Where my wishes are unknown or do not clearly address a specific circumstance, my Agent shall act in my best interest after consulting with my attending physician and weighing the burdens and benefits of treatment.

Ineligible persons. My Agent is not my attending physician, an employee of my attending physician, or an owner/operator/employee of a residential healthcare facility where I reside (unless related to me by blood, marriage, or adoption).

Nomination of guardian/conservator. If a court proceeding is ever initiated to appoint a guardian or conservator of my person, I nominate my Agent (and the alternates, in order) to serve in that capacity, to the maximum extent permitted by law.

3. Statement of Treatment Wishes (Living Will)

Treatment choices. A blank or unselected item states no preference on that item. It is not consent, refusal or a medical order. Where a specific instruction applies, it takes priority over a general goal. A choice about ventilation does not choose CPR for me.

Overall philosophy. No specific instruction.

Conditions under which this directive applies. This directive takes effect if I am unable to make or communicate healthcare decisions and my attending physician (or, where required, two physicians)

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determines that I am in any of the following conditions:

Specific Treatment Instructions

Artificial Nutrition and Hydration (feeding tubes, IV fluids) — initial _____. No specific instruction.

Cardiopulmonary Resuscitation (CPR). No specific instruction.

Mechanical Ventilation. No specific instruction.

Dialysis. No specific instruction.

Antibiotics. No specific instruction.

Blood Transfusions. No specific instruction.

Emergency care and travel. These are personal instructions, not an emergency medical order. Review emergency orders with an authorized clinician for the setting where I receive care. When I travel or transfer, my care team should check the destination's requirements.

Pregnancy and the place of care

These instructions describe future decisions if I cannot decide for myself. They do not report a diagnosis. The place where care is provided may change which law applies. **Wisconsin living will.** If I am a qualified patient and my attending health care professional diagnoses me as pregnant, my declaration about withholding or withdrawing life-sustaining procedures or feeding tubes has no effect for the duration of that pregnancy under Wis. Stat. § 154.07(2). My wishes while I am competent take precedence.

Wisconsin agent authority during pregnancy. Under Wis. Stat. § 155.20(6), if my agent knows I am pregnant and I cannot decide for myself, the following applies. I make no election granting my agent authority during a known pregnancy. Under this instrument my agent therefore may not make health care decisions for me during that pregnancy.

5. Agent access to decision-related records

When my Agent has legal authority to make a healthcare decision for me, the Agent may obtain information relevant to that authority under 45 C.F.R. § 164.502(g), subject to applicable exceptions. Appointment alone is not blanket permission to disclose my records. Separate consent may be needed for specially protected records.

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9. Preferred Setting for Care

I express no specific preference regarding care setting; my Agent and care team may decide based on the circumstances.

10. Personal Message to My Loved Ones and Caregivers

[PERSONAL MESSAGE TO LOVED ONES AND]

11. Revocation

Revoking my Wisconsin living will. Under Wis. Stat. § 154.05, I may revoke my declaration at any time by destroying or canceling it myself, directing another person to do so in my presence, signing and dating a written statement of my intent to revoke, or executing a later declaration. I may also state my intent to revoke verbally. A verbal revocation takes effect only when I or someone acting on my behalf notifies my attending health care professional. The attending health care professional must record the revocation in my medical record.

Revoking my Wisconsin health care power of attorney. Under Wis. Stat. § 155.40, I may revoke the appointment at any time by destroying or canceling the instrument myself, directing another person to do so in my presence, signing and dating a written statement of my intent to revoke, stating that intent verbally in the presence of two witnesses, or executing a subsequent health care power of attorney. If my named agent is my spouse or registered domestic partner, an annulment or divorce, or termination of that registered domestic partnership after execution, revokes the power and invalidates the instrument. Anyone who knows that the appointment naming them as agent was revoked must tell each of my health care providers they know has a copy. A notified provider must record the revocation in my medical record.

12. Effect of Copy

A copy of this executed directive has the same force and effect as the signed original. I authorize my Agent, physicians, hospitals, and family members to rely on a photocopy, scan, facsimile, or electronic copy of this document.

13. Severability and Governing Law

If any provision of this directive is held invalid or unenforceable, the remaining provisions shall continue in full force and effect. This directive shall be governed by the laws of the State of WI, provided that it shall also be given effect in any other jurisdiction to the extent permitted by that jurisdiction's law.

Patient Self-Determination Act Notice

Under the federal Patient Self-Determination Act of 1990 (42 U.S.C. §§1395cc(f), 1396a(w)), hospitals, nursing homes, home health agencies, hospices, and HMOs participating in Medicare or Medicaid are

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required to ask adult patients whether they have an advance directive, to provide information about advance directives, and to not discriminate in care based on the existence or non-existence of a directive.

Signature of Declarant

I sign this directive knowingly, voluntarily, and after careful consideration.

Declarant

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Paper signing location. WI. If the place of signing and the place of care differ, check the rules for both. The residence entry does not establish where this document was signed.

Statement of Witnesses

Each of the undersigned witnesses attests under penalty of perjury that:

1. The Declarant is personally known to me (or proved identity by satisfactory evidence) and signed or acknowledged this directive in my presence;
2. The Declarant appears to be of sound mind and under no duress, fraud, or undue influence;
3. I am at least eighteen (18) years of age;
4. I am not the person appointed as Agent by this directive;
5. I am not the Declarant's attending physician, an employee of the attending physician, or an operator or employee of a healthcare facility where the Declarant is a patient or resident (unless related to the Declarant);
6. To the best of my knowledge, I am not entitled to any portion of the Declarant's estate upon death under any existing will or by operation of law.

Witness 1

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Witness 2

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

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Distribution

This directive shall be distributed to, at minimum: (a) my primary-care physician; (b) my healthcare Agent and any alternate Agents; (c) the hospital or healthcare facility where I typically receive care; (d) close family members; and (e) if applicable, my state's advance-directive registry.

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