



Triage Cancer Estate Planning Toolkit: Wisconsin

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Wisconsin probate courts accept written and statutory wills. To make a valid written will in Wisconsin:

1. You need to be in the right state of mind to create a will. This means you need to be:
 - At least 18 years old
 - Of “sound mind” (meaning you know what you’re doing)
2. You need to sign the will or authorize someone to do so for you, in front of two witnesses who have watched you sign or authorize someone else to sign the will, and understand what they are signing.
3. Your will does not need to be notarized to be legal in Wisconsin, but you might want to make your will “self-proving,” or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign an affidavit affirming the will in front of a notary.

Wisconsin state legislature created the statutory will form to make this process more accessible. With this free will form, you can execute your will by filling in the blanks and signing it in front of two witnesses (who meet the same requirements for a written will).

The benefits of this statutory will are that it is free to complete, and you can complete it on your own, without hiring an attorney. The downsides of a statutory will are that they cannot be customized. Therefore, statutory wills are best for very simple estates. Part III of this toolkit includes a sample form.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Wisconsin’s statutory form for power of attorney allows you to choose someone to manage your finances, including assets like your property, taxes, and government benefits. You can also choose one or more alternate agents, who will take charge separately if the first person cannot act, or can oversee your finances jointly if you indicate this preference in the “special instructions” section. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the “special instructions” section, this document takes effect immediately after you sign it, and will remain in effect if you become incapacitated. This document will remain in effect until you die, unless you revoke your power of attorney.

If you nominate your spouse or domestic partner as your agent, this will automatically be revoked if your marriage or partnership dissolves.

Part III of this toolkit includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. The **Wisconsin Advance Directive** includes the following:

Wisconsin Power of Attorney for Health Care: This form lets you choose someone (your “health care agent”) to make medical decisions for you any time you cannot make them yourself, including decisions about life-sustaining care and organ donation. You can also choose an alternate person to make these decisions if the first person you chose isn’t available. You can include detailed instructions for these decisions, including whether to keep them in place if you are pregnant when this document goes into effect. If there are other directions you want your proxy to follow, you can share those in the “other directions” section.

The Power of Attorney for Health Care takes effect if your doctor determines you are unable to make or communicate health care decisions, and confirms this with another doctor.

Declaration to Physicians: This is also called a living will. This is where you state your wishes about life-sustaining care in advance, in case you become unconscious or unable to make them due to a terminal condition. This includes decisions about what procedures (like artificial nutrition or hydration) you would like, and under what circumstances (terminal condition or vegetative state).

Signature and Witnessing Provisions: You must sign your advance health care directive in front of two adult witnesses. Your witnesses cannot be:

- Your agent
- Related to you by marriage, blood, domestic partnership, or adoption
- Entitled to, or have a claim against, any portion of your assets
- Directly financially responsible for your health care
- Your health care provider or their employee, unless they are a chaplain or social worker
- An employee of your inpatient health care facility, unless they are a chaplain or social worker

You can change the directions in your AHCD at any time, by destroying the document, creating a dated and signed revocation, creating a new directive, or orally revoking this document in front of two witnesses.

Part III of this toolkit includes a sample form.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Wisconsin, this document is called a physician order for scope of treatment (POST). The POST does not replace an advance directive. You can complete a POST form with your doctor.

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a “Do not resuscitate,” or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition and hydration, or food and fluids offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

You can find this form in Part III of this toolkit.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

A **Wisconsin Authorization for Final Disposition** form allows you to designate a trusted person (your “representative”) to carry out your funeral plan, or create one for you, and provide instructions for the disposal of your remains. You can also choose an alternate person if the first person you choose is not available. This could include whether you would like to be cremated or buried, and if there are any religious traditions you would like to be honored.

Part III includes a sample form.

State Laws About Death with Dignity

“Death with Dignity” laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Wisconsin does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care through an advance health care directive.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent’s access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent’s authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information:

www.cdc.gov/phlp/publications/topic/hipaa.html.



Triage Cancer Estate Planning Toolkit: Wisconsin

Part III: Your State's Estate Planning Forms

- Statutory Will
- Power of Attorney for Financial Affairs
- Wisconsin Power of Attorney for Health Care
- Wisconsin Declaration to Physicians
- Physician Order for Scope of Treatment (POST)
- Wisconsin Authorization for Final Disposition
- HIPAA Authorization form



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Statutory Will

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

4. The mandatory clauses under s. 853.60.

(3) The Wisconsin basic will with trust includes all of the following:

(a) The contents of the form for the Wisconsin basic will with trust under s. 853.56.

(b) The full texts of each of the following:

1. The definitions under s. 853.50.

2. The clause under s. 853.57.

3. The property disposition clause under s. 853.59.

4. The mandatory clauses under ss. 853.60 and 853.61.

(4) Any person who prints forms for the Wisconsin basic will or basic will with trust shall place a signature line on each page of the printed document. A testator shall sign on each such line. Failure to comply with this subsection does not affect the validity of the will.

History: 1983 a. 376; 1993 a. 304.

853.53 Selection of property disposition clause. If

more than one property disposition clause is selected or if none is selected, the residuary property of a testator who signs a Wisconsin basic will or basic will with trust shall be distributed to the testator's heirs as if the testator did not make a will.

History: 1983 a. 376.

853.54 Revocation or revision. (1) A Wisconsin basic will or a basic will with trust may be revoked and may be amended in the same manner as other wills.

(2) Any additions to or deletions from the face of the form of the Wisconsin basic will or basic will with trust, other than in accordance with the instructions, shall be ineffective and shall be disregarded.

(3) Notwithstanding sub. (2), any failure to print in the proper places, provide the full name of a person or charity to receive a gift, include residences or use the phrase “not used” where applicable does not affect the validity of a Wisconsin basic will or basic will with trust.

History: 1983 a. 376.

853.55 Wisconsin basic will. The following is the form for the Wisconsin basic will:

NOTICE TO THE PERSON WHO SIGNS THIS WILL:

1. THIS WILL DOES NOT DISPOSE OF PROPERTY WHICH PASSES ON YOUR DEATH TO ANY PERSON BY OPERATION OF LAW OR BY ANY CONTRACT. FOR EXAMPLE, THE WILL DOES NOT DISPOSE OF JOINT TENANCY ASSETS, AND IT DOES NOT NORMALLY APPLY TO PROCEEDS OF LIFE INSURANCE ON YOUR LIFE OR YOUR RETIREMENT PLAN BENEFITS.

2. THIS WILL IS NOT DESIGNED TO REDUCE TAXES. YOU SHOULD DISCUSS THE TAX RESULTS OF YOUR DECISIONS WITH A COMPETENT TAX ADVISER.

3. THIS WILL MAY NOT WORK WELL IF YOU HAVE CHILDREN BY A PREVIOUS MARRIAGE OR IF YOU HAVE BUSINESS PROPERTY, PARTICULARLY IF THE BUSINESS IS UNINCORPORATED.

4. YOU CANNOT CHANGE, DELETE OR ADD WORDS TO THE FACE OF THIS WISCONSIN BASIC WILL. YOU MAY REVOKE THIS WISCONSIN BASIC WILL, AND YOU MAY CHANGE IT BY SIGNING A NEW WILL.

5. THE FULL TEXT OF THIS WISCONSIN BASIC WILL, THE DEFINITIONS, THE PROPERTY DISPOSITION CLAUSES AND THE MANDATORY CLAUSES FOLLOW THE END OF THIS WILL AND ARE CONTAINED IN THE PROBATE CODE OF WISCONSIN (CHAPTERS 851 TO 882 OF THE WISCONSIN STATUTES).

6. THE WITNESSES TO THIS WILL SHOULD NOT BE PEOPLE WHO MAY RECEIVE PROPERTY UNDER THIS WILL. YOU SHOULD READ AND CAREFULLY FOLLOW THE WITNESSING PROCEDURE DESCRIBED AT THE END OF THIS WILL.

7. YOU SHOULD KEEP THIS WILL IN YOUR SAFE–DEPOSIT BOX OR OTHER SAFE PLACE.

8. IF YOU MARRY OR DIVORCE AFTER YOU SIGN THIS WILL, YOU SHOULD MAKE AND SIGN A NEW WILL.

9. THIS WILL TREATS ADOPTED CHILDREN AS IF THEY ARE BIRTH CHILDREN.

10. IF YOU HAVE CHILDREN UNDER 21 YEARS OF AGE, YOU MAY WISH TO USE THE WISCONSIN BASIC WILL WITH TRUST OR ANOTHER TYPE OF WILL.

11. IF THIS WISCONSIN BASIC WILL DOES NOT FIT YOUR NEEDS, YOU MAY WANT TO CONSULT WITH A LAWYER.

[A printed form for a Wisconsin basic will shall set forth the above notice in 10–point boldface type.]

WISCONSIN BASIC WILL OF

.....
(Insert Your Name)

Article 1. Declaration

This is my will and I revoke any prior wills and codicils (additions to prior wills).

Article 2. Disposition of My Property

2.1. **PERSONAL, RECREATIONAL AND HOUSEHOLD ITEMS.** Except as provided in paragraph 2.2, I give all my furniture, furnishings, household items, recreational equipment, personal automobiles and personal effects to my spouse, if living; otherwise they shall be divided equally among my children who survive me.

2.2. **GIFTS TO PERSONS OR CHARITIES.** I make the following gifts to the persons or charities in the cash amount stated in words (.... Dollars) and figures (\$....) or of the property described. I SIGN IN EACH BOX USED. I WRITE THE WORDS “NOT USED” IN THE REMAINING BOXES. If I fail to sign opposite any gift, then no gift is made. If the person mentioned does not survive me or if the charity does not accept the gift, then no gift is made.

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
--	---	-------------------------------------

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
--	---	-------------------------------------

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
--	---	-------------------------------------

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
--	---	-------------------------------------

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
--	---	-------------------------------------

2.3. **ALL OTHER ASSETS (MY “RESIDUARY ESTATE”).** I adopt only one Property Disposition Clause in this paragraph by writing my signature on the line next to the title of the Property Disposition Clause I wish to adopt. I SIGN ON ONLY ONE LINE. I WRITE THE WORDS “NOT USED” ON THE REMAINING LINE. If I sign on more than one line or if I fail to sign on any line, the property will go under Property Disposition Clause (b) and I realize that means the property will be distributed as if I did not make a will in accordance with Chapter 852 of the Wisconsin Statutes.

PROPERTY DISPOSITION CLAUSES (Select one.)

- (a) TO MY SPOUSE IF LIVING, IF NOT LIVING,
THEN TO MY CHILDREN AND THE
DESCENDANTS OF ANY DECEASED
CHILD BY RIGHT OF REPRESENTATION
- (b) TO BE DISTRIBUTED AS IF I DID NOT
HAVE A WILL.

Article 3. Nominations of Personal Representative and Guardian

3.1. PERSONAL REPRESENTATIVE. (Name at least one.)

I nominate the person or institution named in the first box of this paragraph to serve as my personal representative. If that person or institution does not serve, then I nominate the others to serve in the order I list them in the other boxes. I confer upon my personal representative the authority to do and perform any act which he or she determines is in the best interest of the estate, with no limitations. This provision shall be given the broadest possible construction. This authority includes, but is not limited to, the power to borrow money, pledge assets, vote stocks and participate in reorganizations, to sell or exchange real or personal property, and to invest funds and retain securities without any limitation by law for investments by fiduciaries.

FIRST PERSONAL REPRESENTATIVE

SECOND PERSONAL REPRESENTATIVE

THIRD PERSONAL REPRESENTATIVE

3.2. GUARDIAN. (If you have a child under 18 years of age, you should name at least one guardian of the child.)

If my spouse dies before I do or if for any other reason a guardian is needed for any child of mine, then I nominate the person named in the first box of this paragraph to serve as guardian of the person and estate of that child. If the person does not serve, then I nominate the person named in the second box of this paragraph to serve as guardian of that child.

FIRST GUARDIAN

SECOND GUARDIAN

3.3. BOND.

My signature in this box means I request that a bond, as set by law, be required for each individual personal representative or guardian named in this will. IF I DO NOT SIGN IN THIS BOX, I REQUEST THAT A BOND NOT BE REQUIRED FOR ANY OF THOSE PERSONS.

I sign my name to this Wisconsin Basic Will on (date), at (city), (state).

Signature of Testator.

STATEMENT OF WITNESSES (You must use two witnesses, who should be adults.)

I declare that the testator signed the will in front of me, acknowledged to me that this document was his or her will *or* acknowledged to me that the signature above is his or her signature. The testator appears to me to be of sound mind and not under undue influence.

Signature Residence Address:

Print Name Here: Date Signed:

I declare that the testator signed the will in front of me, acknowledged to me that this document was his or her will *or* acknowledged to me that the signature above is his or her signature. The testator appears to me to be of sound mind and not under undue influence.

Signature Residence Address:

Print Name Here: Date Signed:

History: 1983 a. 376; 1997 a. 188.

853.56 Wisconsin basic will with trust. The following is the form for the Wisconsin basic will with trust:

2019–20 Wisconsin Statutes updated through 2021 Wis. Act 72 and through all Supreme Court and Controlled Substances Board Orders filed before and in effect on July 23, 2021. Published and certified under s. 35.18. Changes effective after July 23, 2021, are designated by NOTES. (Published 7–23–21)

NOTICE TO THE PERSON WHO SIGNS THIS WILL:

1. THIS FORM CONTAINS A TRUST FOR YOUR FAMILY. IF YOU DO NOT WANT TO CREATE A TRUST, DO NOT USE THIS FORM.
2. THIS WILL DOES NOT DISPOSE OF PROPERTY WHICH PASSES ON YOUR DEATH TO ANY PERSON BY OPERATION OF LAW OR BY ANY CONTRACT. FOR EXAMPLE, THE WILL DOES NOT DISPOSE OF JOINT TENANCY ASSETS, AND IT DOES NOT NORMALLY APPLY TO PROCEEDS OF LIFE INSURANCE ON YOUR LIFE OR YOUR RETIREMENT PLAN BENEFITS.
3. THIS WILL IS NOT DESIGNED TO REDUCE TAXES. YOU SHOULD DISCUSS THE TAX RESULTS OF YOUR DECISIONS WITH A COMPETENT TAX ADVISER.
4. THIS WILL MAY NOT WORK WELL IF YOU HAVE CHILDREN BY A PREVIOUS MARRIAGE OR IF YOU HAVE BUSINESS PROPERTY, PARTICULARLY IF THE BUSINESS IS UNINCORPORATED.
5. YOU CANNOT CHANGE, DELETE OR ADD WORDS TO THE FACE OF THIS WISCONSIN BASIC WILL WITH TRUST. YOU MAY REVOKE THIS WISCONSIN BASIC WILL WITH TRUST, AND YOU MAY CHANGE IT BY SIGNING A NEW WILL.
6. THE FULL TEXT OF THIS WISCONSIN BASIC WILL WITH TRUST, THE DEFINITIONS, THE PROPERTY DISPOSITION CLAUSES AND THE MANDATORY CLAUSES FOLLOW THE END OF THIS WILL AND ARE CONTAINED IN THE PROBATE CODE OF WISCONSIN (CHAPTERS 851 TO 882 OF THE WISCONSIN STATUTES).
7. THE WITNESSES TO THIS WILL SHOULD NOT BE PEOPLE WHO MAY RECEIVE PROPERTY UNDER THIS WILL. YOU SHOULD READ AND CAREFULLY FOLLOW THE WITNESSING PROCEDURE DESCRIBED AT THE END OF THIS WILL.
8. YOU SHOULD KEEP THIS WILL IN YOUR SAFE–DEPOSIT BOX OR OTHER SAFE PLACE.
9. THIS WILL TREATS ADOPTED CHILDREN AS IF THEY ARE BIRTH CHILDREN.
10. IF YOU MARRY OR DIVORCE AFTER YOU SIGN THIS WILL, YOU SHOULD MAKE AND SIGN A NEW WILL.
11. IF THIS WISCONSIN BASIC WILL WITH TRUST DOES NOT FIT YOUR NEEDS, YOU MAY WANT TO CONSULT WITH A LAWYER.

[A printed form for a Wisconsin basic will with trust shall
set forth the above notice in 10–point boldface type.]

WISCONSIN BASIC WILL WITH TRUST OF

.....
(Insert Your Name)

Article 1. Declaration

This is my will and I revoke any prior wills and codicils (additions to prior wills).

Article 2. Disposition of My Property

2.1. PERSONAL, RECREATIONAL AND HOUSEHOLD ITEMS. Except as provided in paragraph 2.2, I give all my furniture, furnishings, household items, recreational equipment, personal automobiles and personal effects to my spouse, if living; otherwise they shall be divided equally among my children who survive me.

2.2. GIFTS TO PERSONS OR CHARITIES. I make the following gifts to the persons or charities in the cash amount stated in words (.... Dollars) and figures (\$....) or of the property described. I SIGN IN EACH BOX USED. I WRITE THE WORDS “NOT USED” IN THE REMAINING BOXES. If I fail to sign opposite any gift, then no gift is made. If the person mentioned does not survive me or if the charity does not accept the gift, then no gift is made.

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
---	--	--

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
--	---	-------------------------------------

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
--	---	-------------------------------------

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
--	---	-------------------------------------

FULL NAME OF PERSON OR CHARITY TO RECEIVE GIFT. (Name only one. Please print.)	AMOUNT OF CASH GIFT OR DESCRIPTION OF PROPERTY.	SIGNATURE OF TESTATOR.
--	---	-------------------------------------

2.3. ALL OTHER ASSETS (MY “RESIDUARY ESTATE”). I adopt only one Property Disposition Clause in this paragraph by writing my signature on the line next to the title of the Property Disposition Clause I wish to adopt. I SIGN ON ONLY ONE LINE. I WRITE THE WORDS “NOT USED” ON THE REMAINING LINES. If I sign on more than one line or if I fail to sign on any line, the property will be distributed as if I did not make a will in accordance with Chapter 852 of the Wisconsin Statutes.

IF YOU HAVE A SUBSTANTIAL ESTATE, CHOOSING CLAUSE (a) OR (b) MIGHT NOT BE THE MOST ADVANTAGEOUS TAX OPTION AVAILABLE TO YOU. If you have questions concerning the tax implications of these clauses, you should consult a competent tax adviser.

PROPERTY DISPOSITION CLAUSES (Select one.)

(a) TO MY SPOUSE IF LIVING; IF NOT LIVING, THEN
IN ONE TRUST TO PROVIDE FOR THE SUPPORT
AND EDUCATION OF MY CHILDREN AND THE
DESCENDANTS OF ANY DECEASED CHILD BY
RIGHT OF REPRESENTATION UNTIL I HAVE NO
LIVING CHILD UNDER 21 YEARS OF AGE.

.....

(b) TO MY SPOUSE IF LIVING; IF NOT LIVING, THEN
IN ONE TRUST TO PROVIDE FOR THE SUPPORT
AND EDUCATION OF MY CHILDREN AND THE
DESCENDANTS OF ANY DECEASED CHILD BY
RIGHT OF REPRESENTATION UNTIL I HAVE NO
LIVING CHILD UNDER . . . YEARS OF AGE.

.....

(IF YOU DO NOT WANT 21 YEARS OF AGE TO
APPLY, PRINT A DIFFERENT AGE, 18 OR ABOVE,
IN CLAUSE (B) AND SIGN ON THE LINE BESIDE
THAT CLAUSE.)

Article 3. Nominations of Personal Representative, Trustee and Guardian**3.1. PERSONAL REPRESENTATIVE. (Name at least one.)**

I nominate the person or institution named in the first box of this paragraph to serve as my personal representative. If that person or institution does not serve, then I nominate the others to serve in the order I list them in the other boxes. I confer upon my personal representative the authority to do and perform any act which he or she determines is in the best interest of the estate, with no limitations. This provision shall be given the broadest possible construction. This authority includes, but is not limited to, the power to borrow money, pledge assets, vote stocks and participate in reorganizations, to sell or exchange real or personal property, and to invest funds and retain securities without any limitation by law for investments by fiduciaries.

FIRST PERSONAL REPRESENTATIVE

SECOND PERSONAL REPRESENTATIVE

THIRD PERSONAL REPRESENTATIVE

3.2. TRUSTEE. (Name at least one.)

Because it is possible that after I die my property may be put into a trust, I nominate the person or institution named in the first box of this paragraph to serve as trustee of that trust. If that person or institution does not serve, then I nominate the others to serve in the order I list them in the other boxes.

FIRST TRUSTEE

SECOND TRUSTEE

THIRD TRUSTEE

3.3. GUARDIAN. (If you have a child under 18 years of age, you should name at least one guardian of the child.)

If my spouse dies before me or for any other reason a guardian is needed for any child of mine, then I nominate the person named in the first box of this paragraph to serve as guardian of the person and estate of that child. If the person does not serve, then I nominate the person named in the second box of this paragraph to serve as guardian of that child.

FIRST GUARDIAN

SECOND GUARDIAN

3.4. BOND.

My signature in this box means I request that a bond, as set by law, be required for each individual personal representative, trustee or guardian named in this will. IF I DO NOT SIGN IN THIS BOX, I REQUEST THAT A BOND NOT BE REQUIRED FOR ANY OF THOSE PERSONS.

I sign my name to this Wisconsin Basic Will With Trust on(date), at.....(city),..... (state).

Signature of Testator.

STATEMENT OF WITNESSES (You must use two witnesses, who should be adults.)

I declare that the testator signed the will in front of me, acknowledged to me that this document was his or her will *or* acknowledged to me that the signature above is his or her signature. The testator appears to me to be of sound mind and not under undue influence.

Signature Residence Address:

Print Name Here: Date Signed:

I declare that the testator signed the will in front of me, acknowledged to me that this document was his or her will *or* acknowledged to me that the signature above is his or her signature. The testator appears to me to be of sound mind and not under undue influence.

Signature Residence Address:

Print Name Here: Date Signed:

History: 1983 a. 376; 1993 a. 304; 1997 a. 188.

853.57 Personal, recreational and household items.

The following is the full text of paragraph 2.1 of the Wisconsin basic will and the basic will with trust:

If my spouse survives me, I give my spouse all my books, jewelry, clothing, personal automobiles, recreational equipment, household furnishings and effects, and other tangible articles of a household, recreational or personal use, together with all policies of insurance insuring any such items. If my spouse does not survive me, the personal representative shall distribute those items among my children who survive me, and shall distribute those items in as nearly equal shares as feasible in the personal representative's discretion. If none of my children survive me, the items described in this paragraph shall become part of the residuary estate.

History: 1983 a. 376.

853.58 Residuary estate; basic will. The following is the full text of the property disposition clauses referred to in paragraph 2.3 of the Wisconsin basic will:

(a) TO MY SPOUSE IF LIVING; IF NOT LIVING, THEN TO MY CHILDREN AND THE DESCENDANTS OF ANY DECEASED CHILD BY RIGHT OF REPRESENTATION.

If my spouse survives me, then I give all my residuary estate to my spouse. If my spouse does not survive me, then I give all my residuary estate to my descendants by right of representation who survive me. If my spouse and descendants do not survive me, the personal representative shall distribute my residuary estate to my heirs at law, their identities and respective shares to be determined according to the laws of the State of Wisconsin in effect on the date of my death.

(b) TO BE DISTRIBUTED AS IF I DID NOT HAVE A WILL:

The personal representative shall distribute my residuary estate to my heirs at law, their identities and respective shares to be determined according to the laws of the State of Wisconsin in effect on the date of my death.

History: 1983 a. 376.

853.59 Residuary estate; basic will with trust. The following is the full text of the property disposition clause referred to in paragraph 2.3 of the Wisconsin basic will with trust, except that if a different age is specified by the testator in the Wisconsin basic will with trust, that specified age is substituted for 21 years in this section:

(a) TO MY SPOUSE IF LIVING; IF NOT LIVING, THEN IN ONE TRUST TO PROVIDE FOR THE SUPPORT AND EDUCATION OF MY CHILDREN AND THE DESCENDANTS OF ANY DECEASED CHILD UNTIL I HAVE NO LIVING CHILD UNDER 21 YEARS OF AGE.

(1) If my spouse survives me, then I give all my residuary estate to my spouse.

(2) If my spouse does not survive me and if any child of mine under 21 years of age survives me, then I give all my residuary estate to the trustee, in trust, on the following terms:

(A) As long as any child of mine under 21 years of age is living, the trustee shall distribute from time to time to or for the benefit of any one or more of my children and the descendants of any deceased child (the beneficiaries) of any age as much, or all, of the principal or net income of the trust or both, as the trustee deems necessary for their health, support, maintenance and education. Any undistributed income shall be accumulated and added to the principal. "Education" includes, but is not limited to, college, vocational and other studies after high school, and reasonably related living expenses. Consistent with the trustee's fiduciary duties, the trustee may distribute trust income or principal in equal or unequal shares and to any one or more of the beneficiaries to the exclusion of other beneficiaries. In deciding on distributions, the trustee may take into account the beneficiaries' other income, outside resources or sources of support, including the capacity for gainful employment of a beneficiary who has completed his or her education.

(B) The trust shall terminate when there is no living child of mine under 21 years of age. The trustee shall distribute any remaining principal and accumulated net income of the trust to my descendants by right of representation who are then living. If principal becomes distributable to a person under legal disability, the trustee may postpone the distribution until the disability is removed. In that case, the assets shall be administered as a separate trust under this Wisconsin basic will with trust and the net income and principal shall be applied for the benefit of the beneficiary at such times and in such amounts as the trustee considers appropriate. If the beneficiary dies before the removal of the disability, the remaining assets shall be distributed to his or her estate.

(3) If my spouse does not survive me and if no child of mine under 21 years of age survives me, then I give all my residuary estate to my descendants by right of representation who survive me. If my spouse and descendants do not survive me, the personal representative shall distribute my residuary estate to my heirs at



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Power of Attorney for Financial Affairs

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.



State of Wisconsin
Department of Health Services

This Power of Attorney for Finances form allows you to plan for future financial decision-making even if you are unable to make your own decisions. More information is available to assist you in filling out this form¹. This form is not the answer for everyone. Only select someone you trust to be your agent. You may wish to consult with an attorney to explore other financial planning tools such as a Power of Attorney for Finances drafted by an attorney, or special accounts or trusts.

This is an important legal document. Do not sign it until you, and your chosen agent, understand the powers being granted. By signing this document, you are not giving up any powers or rights to control your finances or property. Instead, you are giving your agent, in addition to yourself, the authority to handle your finances and property. While it is not required that you sign this document in the presence of a notary, acknowledged signatures create a lawful presumption of genuineness and will be more easily accepted by businesses and financial institutions.

This document is effective immediately when executed unless you state a future date or occurrence that will activate the powers expressed in this form.

This Power of Attorney for Finances is "durable" (does not terminate upon the principal's incapacity) unless you specifically state that it terminates if you become incapacitated.

If you name your spouse or domestic partner as your agent and the marriage or domestic partnership is terminated (annulment or divorce), this document becomes invalid unless the special instructions in this document state that such an action will not terminate the authority given to the agent.

If you used a former state Power of Attorney for Finances form, that form is still valid. Executing a new Power of Attorney for Finances does not, automatically, revoke a prior document.

If you wish to change this Power of Attorney for Finances in the future, you must complete a new document and revoke this one. You may revoke this document at any time; a suggested method is a written and dated statement expressing your intent to revoke this document. If you revoke this document, you should notify your agent and any other persons or entities that have a copy.

In general, an agent who is not the principal's spouse or domestic partner may not use the principal's property for the benefit of the agent or a person to whom the agent owes an obligation of support. Gifting to others is also generally not allowed².

Your agent is entitled to reasonable compensation unless you state otherwise in the special instructions. This document does not give your agent the power to make medical, long-term care or other health care decisions for you.

Once your Power of Attorney for Finances form is completed and signed, send a copy of this document to your financial contacts (e.g. your bank, stockbroker, mortgage company, insurance agent, etc.) Give a copy to your agent and alternate agents as well as to trustworthy family members and/or to your attorney. Finally place a copy in a safe place in your home along with a list of who has a copy of the document.

¹ Greater Wisconsin Agency on Aging Resources: Guardianship Support Center (www.gwaar.org)

² For more information on gifting, see Wis. Stats. §244.57

This Page is for information only and is not part of the Power of Attorney

Wisconsin.gov

**WISCONSIN STATUTORY
POWER OF ATTORNEY FOR
FINANCES AND PROPERTY
IMPORTANT INFORMATION**

This Power of Attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney for Finances and Property Act in Chapter 244 of the Wisconsin Statutes.

This Power of Attorney does not authorize the agent to make health-care decisions for you.

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.

Your agent is entitled to reasonable compensation unless you state otherwise in the special instructions.

This form provides for designation of one agent. If you wish to name more than one agent, you may name a co-agent in the special instructions. Co-agents are not required to act together unless you include that requirement in the special instructions.

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 2nd successor agent.

This Power of Attorney becomes effective immediately unless you state otherwise in the special instructions. This Power of Attorney does not revoke any Power of Attorney executed previously unless you so provide in the special instructions.

If you revoke this Power of Attorney, you should notify your agent 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 divorced or legally separated or the domestic partnership is terminated after signing this document, the document is invalid.

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.

Recording Area ↑

Name and Return Address

Parcel Identification Number (if any)

DESIGNATION OF AGENT

I, _____ (name of principal), name the following person as my agent:

Name of agent: _____

Agent's address: _____

Agent's telephone number: _____

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of successor agent: _____

Successor agent's address: _____

Successor agent's telephone number: _____

If my successor agent is unable or unwilling to act for me, I name as my 2nd successor agent:

Name of 2nd successor agent: _____

Second successor agent's address: _____

Second successor agent's telephone number: _____

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined (see Appendix) in the Uniform Power of Attorney for Finances and Property Act in chapter 244 of the Wisconsin statutes:

(INITIAL each subject you want to include in the agent's general authority.)

☐	Real property
☐	Tangible personal property
☐	Digital property
☐	Stocks and bonds
☐	Commodities and options
☐	Banks and other financial institutions
☐	Operation of entity or business
☐	Insurance and annuities
☐	Estates, trusts, and other beneficial interests
☐	Claims and litigation
☐	Personal and family maintenance
☐	Benefits from governmental programs or civil or military service
☐	Retirement plans
☐	Taxes

LIMITATION ON AGENT'S AUTHORITY

An agent who is not my spouse or domestic partner MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the special instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions in the following space

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the special instructions.

NOMINATION OF GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a guardian of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of nominee for guardian of my estate: _____

Nominee's address: _____

Nominee's telephone number: _____

Name of nominee for guardian of my person: _____

Nominee's address: _____

Nominee's telephone number: _____

RELIANCE ON THIS POWER OF ATTORNEY FOR FINANCES AND PROPERTY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows that the power of attorney has been terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

Your signature _____ Date _____

Your name printed _____

Your address: _____

Your telephone number: _____

State of: _____ County of: _____

This document was acknowledged before me on

Date _____ by name of principal _____

(Seal, if any)

Signature of notary _____

Name of notary (typed or printed) _____

My commission expires: _____

This document prepared by: _____

IMPORTANT INFORMATION FOR AGENT AGENT'S DUTIES

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the Power of Attorney is terminated or revoked. You must do all the following:

- (1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest.
- (2) Act in good faith.
- (3) Do nothing beyond the authority granted in this Power of Attorney.
- (4) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner: _____
(principal's name) by _____ (your signature) as agent

Unless the special instructions in the Power of Attorney state otherwise, you must also do all the following:

- (1) Act loyally for the principal's benefit.
- (2) Avoid conflicts that would impair your ability to act in the principal's best interest.
- (3) Act with care, competence, and diligence.
- (4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal.
- (5) Cooperate with any person that has authority to make health-care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest.
- (6) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

TERMINATION OF AGENT'S AUTHORITY

You must stop acting on behalf of the principal if you learn of any event that terminates this Power of Attorney or your authority under this Power of Attorney. Events that terminate a Power of Attorney or your authority to act under a Power of Attorney include all the following:

- (1) Death of the principal
- (2) The principal's revocation of the Power of Attorney or your authority.
- (3) The occurrence of a termination event stated in the Power of Attorney.
- (4) The purpose of the Power of Attorney is fully accomplished.
- (5) If you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the special instructions in this Power of Attorney state that such an action will not terminate your authority.
- (6) If you are the principal's domestic partner and your domestic partnership is terminated, unless the special instructions in this Power of Attorney state that such an action will not terminate your authority.

LIABILITY OF AGENT

The meaning of the authority granted to you is defined in the Uniform Power of Attorney for Finances and Property Act in Chapter 244 of the Wisconsin Statutes. If you violate the Uniform Power of Attorney for Finances and Property Act in Chapter 244 of the Wisconsin Statutes or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

OPTIONAL SIGNATURE OF AGENT

I have read and accept the duties and liabilities of the agent as specified in this Power of Attorney.

Agent's signature _____ Date _____

Attached:

- (1) Agent's certification as to the validity of Power of Attorney for Finances and Property and agent's authority (Optional).
- (2) Appendix: Power of Attorney for Finances and Property Statutory Authority Definitions (Optional).

The following optional form may be used by an agent to certify facts concerning a power of attorney for finances and property:

**AGENT'S CERTIFICATION AS TO THE VALIDITY OF
POWER OF ATTORNEY FOR FINANCES AND PROPERTY AND AGENT'S AUTHORITY**

State of: _____

County of: _____

I, _____ (name of agent), certify under penalty of perjury that
_____ (name of principal) granted me authority as an agent or
successor agent in a power of attorney dated _____ .

I further certify that to my knowledge:

- (1) The principal is alive and has not revoked the power of attorney or my authority to act under the power of attorney, and the power of attorney and my authority to act under the power of attorney have not terminated.
- (2) If the power of attorney was drafted to become effective upon the happening of an event or contingency, the event or contingency has occurred.
- (3) If I was named as a successor agent, the prior agent is no longer able or willing to serve.
- (4) _____
(insert other relevant statements)

SIGNATURE AND ACKNOWLEDGMENT

Agent's signature _____ Date _____

Agent's name printed _____

Agent's address: _____

Agent's telephone number: _____

State of: _____ County of: _____

This document was acknowledged before me on

Date _____ by (name of agent) _____

(Seal, if any)

Signature of notary _____

Name of notary (typed or printed) _____

My commission expires: _____

This document prepared by: _____

APPENDIX
Power of Attorney for Finances and Property
Statutory Authority Definitions

244.44 Real property. Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to real property authorizes the agent to do all of the following:

- (1) Demand, buy, lease, receive, accept as a gift or as security for an extension of credit, or otherwise acquire or reject an interest in real property or a right incident to real property.
- (2) Sell; exchange; convey with or without covenants, representations, or warranties; quit claim; release; surrender; retain title for security; encumber; partition; consent to partitioning; subject to an easement or covenant; subdivide; apply for zoning or other governmental permits; plat or consent to platting; develop; grant an option concerning; lease; sublease; contribute to an entity in exchange for an interest in that entity; or otherwise grant or dispose of an interest in real property or a right incident to real property.
- (3) Pledge or mortgage an interest in real property or right incident to real property as security to borrow money or pay, renew, or extend the time of payment of a debt of the principal or a debt guaranteed by the principal.
- (4) Release, assign, satisfy, or enforce by any lawful means a mortgage, deed of trust, conditional sale contract, encumbrance, lien, or other claim to real property which exists or is asserted.
- (5) Manage or conserve an interest in real property or a right incident to real property owned or claimed to be owned by the principal, including by doing any of the following:
 - (a) Insuring against liability or casualty or other loss.
 - (b) Obtaining or regaining possession of or protecting the interest or right by litigation or otherwise.
 - (c) Paying, assessing, compromising, or contesting taxes or assessments or applying for and receiving refunds in connection with taxes or assessments.
 - (d) Purchasing supplies, hiring assistance or labor, and making repairs or alterations to the real
- (6) Use, develop, alter, replace, remove, erect, or install structures or other improvements upon real property in or incident to which the principal has, or claims to have, an interest or right.
- (7) Participate in a reorganization with respect to real property or an entity that owns an interest in or right

incident to real property and receive, hold, and act with respect to stocks and bonds or other property received in a plan of reorganization, including by doing any of the following:

- (a) Selling or otherwise disposing of the stocks, bonds, or property.
- (b) Exercising or selling an option, right of conversion, or similar right with respect to the stocks, bonds, or property.
- (c) Exercising any voting rights in person or by proxy.
- (8) Change the form of title of an interest in or right incident to real property.
- (9) Dedicate to public use, with or without consideration, easements or other real property in which the principal has, or claims to have, an interest.

244.445 Digital property. Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to digital property authorizes the agent, subject to s. 711.06 (1), to do all of the following:

- (1) Find, access, manage, protect, distribute, dispose of, transfer, transfer ownership rights in, or otherwise control digital devices, and any digital property stored thereon, with digital devices to include desktop, laptops, tablets, peripherals, storage devices, mobile telephones, smartphones, and any similar digital device, either currently in existence or that may exist as technology develops.
- (2) Access, manage, distribute, delete, terminate, transfer, transfer ownership rights in, or otherwise control digital accounts, other than the content of electronic communications, as defined in s. 711.03 (6), with digital accounts to include bank or other financial institution accounts, electronic mail accounts, blogs, software licenses, social network accounts, social media accounts, file-sharing and storage accounts, financial management accounts, domain registration accounts, domain name service accounts, Web hosting accounts, tax preparation service accounts, online store accounts, and affiliated programs currently in existence or that may exist as technology develops.
- (3) Access, manage, distribute, delete, transfer, transfer ownership rights in, or otherwise control any digital property the principal may own or otherwise possess rights to, other than the content of electronic

communications, as defined in s. 711.03 (6), regardless of the ownership of the digital device on which the digital property is stored or the ownership of the digital account within which the digital property is stored.

244.45 Tangible personal property. Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to tangible personal property authorizes the agent to do all of the following:

- (1) Demand, buy, receive, accept as a gift or as security for an extension of credit, or otherwise acquire or reject ownership or possession of tangible personal property or an interest in tangible personal property.
- (2) Sell; exchange; convey with or without covenants, representations, or warranties; quit claim; release; surrender; create a security interest in; grant options concerning; lease; sublease; or otherwise dispose of tangible personal property or an interest in tangible personal property.
- (3) Grant a security interest in tangible personal property or an interest in tangible personal property as security to borrow money or pay, renew, or extend the time of payment of a debt of the principal or a debt guaranteed by the principal.
- (4) Release, assign, satisfy, or enforce by litigation or otherwise, a security interest, lien, or other claim on behalf of the principal, with respect to tangible personal property or an interest in tangible personal property.
- (5) Manage or conserve tangible personal property or an interest in tangible personal property on behalf of the principal, including by doing any of the following:
 - (a) Insuring against liability or casualty or other loss.
 - (b) Obtaining or regaining possession of or protecting the property or interest, by litigation or otherwise.
 - (c) Paying, assessing, compromising, or contesting taxes or assessments or applying for and receiving refunds in connection with taxes or assessments.
 - (d) Moving the property from place to place.
 - (e) Storing the property for hire or under a gratuitous bailment.
 - (f) Using and making repairs, alterations, or improvements to the property.
- (6) Change the form of title of an interest in tangible personal property.

244.46 Stocks and bonds. Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to stocks and bonds authorizes the agent to do all of the following:

- (1) Buy, sell, and exchange stocks and bonds.
- (2) Establish, continue, modify, or terminate an account with respect to stocks and bonds.
- (3) Pledge stocks and bonds as security to borrow, pay, renew, or extend the time of payment of a debt of the principal.
- (4) Receive certificates and other evidences of ownership with respect to stocks and bonds.
- (5) Exercise voting rights with respect to stocks and bonds in person or by proxy, enter into voting trusts, and consent to limitations on the right to vote.
- (6) Exercise in person or by proxy, or enforce by litigation or otherwise, a right, power, privilege, or option the principal has or claims to have as the holder of stocks and bonds.
- (7) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation to which the principal is a party concerning stocks and bonds.

244.47 Commodities and options. Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to commodities and options authorizes the agent to do all of the following:

- (1) Buy, sell, exchange, assign, settle, and exercise commodity futures contracts and call or put options on stocks or stock indexes traded on a regulated option exchange.
- (2) Establish, continue, modify, and terminate option accounts.

244.48 Banks and other financial institutions. Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to banks and other financial institutions authorizes the agent to do all of the following:

- (1) Continue, modify, and terminate an account or other banking arrangement made by or on behalf of the principal.

(2) Establish, modify, and terminate an account or other banking arrangement with a bank, trust company, savings and loan association, credit union, thrift company, brokerage firm, or other financial institution selected by the agent.

(3) Contract for services available from a financial institution, including renting a safe deposit box or space in a vault.

(4) Withdraw, by check, order, electronic funds transfer, or otherwise, money or property of the principal deposited with or left in the custody of a financial institution.

(5) Receive statements of account, vouchers, notices, and similar documents from a financial institution and act with respect to them.

(6) Enter a safe deposit box or vault and withdraw or add to the contents.

(7) Borrow money and pledge as security personal property of the principal necessary to borrow money or pay, renew, or extend the time of payment of a debt of the principal or a debt guaranteed by the principal.

(8) Make, assign, draw, endorse, discount, guarantee, and negotiate promissory notes, checks, drafts, and other negotiable or nonnegotiable paper of the principal or payable to the principal or the principal's order; transfer money, receive the cash or other proceeds of those transactions; and accept a draft drawn by a person upon the principal and pay it when due.

(9) Receive for the principal and act upon a sight draft, warehouse receipt, or other document of title whether tangible or electronic, or other negotiable or nonnegotiable instrument.

(10) Apply for, receive, and use letters of credit, credit and debit cards, electronic transaction authorizations, and traveler's checks from a financial institution and give an indemnity or other agreement in connection with letters of credit.

(11) Consent to an extension of the time of payment with respect to commercial paper or a financial transaction with a financial institution.

244.49 Operation of entity or business. Subject to the terms of a document or an agreement governing an entity or business or an entity or business ownership interest, and unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to operation of an entity or business authorizes the agent to do all of the following:

(1) Operate, buy, sell, enlarge, reduce, or terminate an ownership interest.

(2) Perform a duty or discharge a liability and exercise in person or by proxy a right, power, privilege, or option that the principal has, may have, or claims to have.

(3) Enforce the terms of an ownership agreement.

(4) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation to which the principal is a party because of an ownership interest.

(5) Exercise in person or by proxy, or enforce by litigation or otherwise, a right, power, privilege, or option the principal has or claims to have as the holder of stocks and bonds.

(6) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation to which the principal is a party concerning stocks and bonds.

(7) With respect to an entity or business owned solely by the principal, do all of the following:

(a) Continue, modify, renegotiate, extend, and terminate a contract made by or on behalf of the principal with respect to the entity or business before execution of the power of attorney.

(b) Determine all of the following:

1. The location of its operation.

2. The nature and extent of its business.

3. The methods of manufacturing, selling, merchandising, financing, accounting, and advertising employed in its operation.

4. The amount and types of insurance carried.

5. The mode of engaging, compensating, and dealing with its employees and accountants, attorneys, or other advisors.

(c) Change the name or form of organization under which the entity or business is operated and enter into an ownership agreement with other persons to take over all or part of the operation of the entity or business.

(d) Demand and receive money due or claimed by the principal or on the principal's behalf in the operation of the entity or business and control and disburse the money in the operation of the entity or business.

(8) Put additional capital into an entity or business in which the principal has an interest.

(9) Join in a plan of reorganization, consolidation,

conversion, interest exchange, domestication, or merger of the entity or business.

(10) Sell or liquidate all or part of an entity or business.

(11) Establish the value of an entity or business under a buy-out agreement to which the principal is a party.

(12) Prepare, sign, file, and deliver reports, compilations of information, returns, or other papers with respect to an entity or business and make related payments.

(13) Pay, compromise, or contest taxes, assessments, fines, or penalties and perform any other act to protect the principal from illegal or unnecessary taxation, assessments, fines, or penalties, with respect to an entity or business, including attempts to recover, in any manner permitted by law, money paid before or after the execution of the power of attorney.

244.50 Insurance and annuities. Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to insurance and annuities authorizes the agent to do all of the following:

(1) Continue, pay the premium or make a contribution on, modify, exchange, rescind, release, or terminate a contract procured by or on behalf of the principal which insures or provides an annuity to either the principal or another person, whether or not the principal is a beneficiary under the contract.

(2) Procure new, different, and additional contracts of insurance and annuities for the principal and the principal's spouse or domestic partner, children, and other dependents, and select the amount, type of insurance or annuity, and mode of payment.

(3) Pay the premium or make a contribution on, modify, exchange, rescind, release, or terminate a contract of insurance or annuity procured by the agent.

(4) Apply for and receive a loan secured by a contract of insurance or annuity.

(5) Surrender and receive the cash surrender value on a contract of insurance or annuity.

(6) Exercise an election.

(7) Exercise investment powers available under a contract of insurance or annuity.

(8) Change the manner of paying premiums on a contract of insurance or annuity.

(9) Change or convert the type of insurance or annuity with respect to which the principal has or claims to

have authority described in this section.

(10) Apply for and procure a benefit or assistance under a statute, rule, or regulation to guarantee or pay premiums of a contract of insurance on the life of the principal.

(11) Collect, sell, assign, hypothecate, borrow against, or pledge the interest of the principal in a contract of insurance or annuity.

(12) Select the form and timing of the payment of proceeds from a contract of insurance or annuity.

(13) Pay, from proceeds or otherwise, compromise or contest, and apply for refunds in connection with, a tax or assessment levied by a taxing authority with respect to a contract of insurance or annuity or its proceeds or liability accruing by reason of the tax or assessment.

244.51 Estates, trusts, and other beneficial

interests. (1) In this section, "estates, trusts, and other beneficial interests" means a trust, probate estate, guardianship, conservatorship, escrow, or custodianship or a fund from which the principal is, may become, or claims to be, entitled to a share or payment.

(2) Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to estates, trusts, and other beneficial interests authorizes the agent to do all of the following:

(a) Accept, receive, receipt for, sell, assign, pledge, or exchange a share in or payment from an estate, trust, or beneficial interest.

(b) Demand or obtain money or another thing of value to which the principal is, may become, or claims to be, entitled by reason of an estate, trust, or beneficial interest, by litigation or otherwise.

(c) Exercise for the benefit of the principal a presently exercisable general power of appointment held by the principal.

(d) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation to ascertain the meaning, validity, or effect of a deed, will, declaration of trust, or other instrument or transaction affecting the interest of the principal.

(e) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation to remove, substitute, or surcharge a fiduciary.

(f) Conserve, invest, disburse, or use anything received for an authorized purpose.

(g) Transfer an interest of the principal in real property, stocks and bonds, accounts with financial institutions or securities intermediaries, insurance, annuities, and other property to the trustee of a revocable trust created by the principal as settlor.

(h) Sign a waiver or consent in a probate matter. (i)

Reject, renounce, disclaim, release, or consent to a reduction in or modification of a share in or payment from an estate, trust, or beneficial interest.

244.52 Claims and litigation. Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to claims and litigation authorizes the agent to do all of the following:

(1) Assert and maintain before a court or administrative agency a claim, claim for relief, cause of action, counterclaim, offset, recoupment, or defense, including an action to recover property or other thing of value, recover damages sustained by the principal, eliminate or modify tax liability, or seek an injunction, specific performance, or other relief.

(2) Bring an action to determine adverse claims or intervene or otherwise participate in litigation.

(3) Seek an attachment, garnishment, order of arrest, or other preliminary, provisional, or intermediate relief and use any available procedure to effect or satisfy a judgment, order, or decree.

(4) Make or accept a tender, offer of judgment, or admission of facts, submit a controversy on an agreed statement of facts, consent to examination, and bind the principal in litigation.

(5) Submit to alternative dispute resolution, settle, and propose or accept a compromise.

(6) Waive the issuance and service of process upon the principal, accept service of process, appear for the principal, designate persons upon which process directed to the principal may be served, execute and file or deliver stipulations on the principal's behalf, verify pleadings, seek appellate review, procure and give surety and indemnity bonds, contract and pay for the preparation and printing of records and briefs, receive, execute, and file or deliver a consent, waiver, release, confession of judgment, satisfaction of judgment, notice, agreement, or other instrument in connection with the prosecution, settlement, or defense of a claim or litigation.

(7) Act for the principal with respect to bankruptcy or insolvency, whether voluntary or involuntary, concerning the principal or some other person, or with respect to a reorganization, receivership, or application for the appointment of a receiver or trustee which affects an interest of the principal in property or other thing of value.

(8) Pay a judgment, award, or order against the principal or a settlement made in connection with a claim or litigation.

(9) Receive money or other thing of value paid in settlement of or as proceeds of a claim or litigation.

244.53 Personal and family maintenance. (1) Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to personal and family maintenance authorizes the agent to do all of the following:

(a) Perform the acts necessary to maintain the customary standard of living of the principal, the principal's spouse or the principal's domestic partner, and the following individuals, whether living when the power of attorney is executed or later born:

1. The principal's children.

2. Other individuals legally entitled to be supported by the principal.

3. The individuals whom the principal has customarily supported or indicated the intent to support.

(b) Make periodic payments of child support and other family maintenance required by a court or governmental agency or an agreement to which the principal is a party.

(c) Provide living quarters for the individuals described in par. (a) by doing any of the following:

1. Purchasing, leasing, or entering into a contract.

2. Paying the operating costs, including interest, amortization payments, repairs, improvements, and taxes, for premises owned by the principal or occupied by those individuals.

(d) Provide normal domestic help, usual vacations and travel expenses, and funds for shelter, clothing, food, appropriate education, including postsecondary and vocational education, and other current living costs for the individuals described in par. (a).

(e) Pay expenses for necessary health care and custodial care on behalf of the individuals described in par. (a).

(f) Act as the principal's personal representative under 42 USC 1320d, the Health Insurance Portability and Accountability Act, and applicable regulations, in making decisions related to the past, present, or future payment for the provision of health care consented to by the principal or anyone authorized under the law of this state to consent to health care on behalf of the principal.

(g) Continue any provision made by the principal for motor vehicles or other means of transportation, including registering, licensing, insuring, and replacing the vehicles, for the individuals described in par. (a).

(h) Maintain credit and debit accounts for the convenience of the individuals described in par. (a) and open new accounts.

(i) Continue payments incidental to the membership or affiliation of the principal in a religious institution, club, society, order, or other organization or to continue contributions to those organizations.

(2) Authority with respect to personal and family maintenance is neither dependent upon, nor limited by, authority that an agent may or may not have with respect to gifts under this chapter.

244.54 Benefits from governmental programs or civil or military service. (1) In this section, "benefits from governmental programs or civil or military service" means any benefit, program or assistance provided under a statute, rule, or regulation, including social security, Medicare, and Medicaid.

(2) Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to benefits from governmental programs or civil or military service authorizes the agent to do all of the following:

(a) Execute vouchers in the name of the principal for allowances and reimbursements payable by the United States or a foreign government or by a state or subdivision of a state to the principal, including allowances and reimbursements for transportation of the individuals described in s. 244.53 (1) (a), and for shipment of their household effects.

(b) Take possession and order the removal and shipment of property of the principal from a post, warehouse, depot, dock, or other place of storage or safekeeping, either governmental or private, and execute and deliver a release, voucher, receipt, bill of lading, shipping ticket, certificate, or other instrument for that purpose.

(c) Enroll in, apply for, select, reject, change, amend, or discontinue, on the principal's behalf, a benefit or program.

(d) Prepare, file, and maintain a claim of the principal for a benefit or assistance, financial or otherwise, to which the principal may be entitled under a statute, rule, or regulation.

(e) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation concerning any benefit or assistance the principal may be entitled to receive under a statute, rule, or regulation.

(f) Receive the financial proceeds of a claim described in par. (d) and conserve, invest, disburse, or use for a lawful purpose anything so received.

244.55 Retirement plans. (1) In this section, "retirement plan" means a plan or account created by an employer, the principal, or another individual to provide retirement benefits or deferred compensation of which the principal is a participant, beneficiary, or owner, including the following plans or accounts:

(a) An individual retirement account under section 408 of the Internal Revenue Code.

(b) A Roth individual retirement account under section 408A of the Internal Revenue Code.

(c) A deemed individual retirement account under section 408 (q) of the Internal Revenue Code.

(d) An annuity or mutual fund custodial account under section 403 (b) of the Internal Revenue Code.

(e) A pension, profit-sharing, stock bonus, or other retirement plan qualified under section 401 (a) of the Internal Revenue Code.

(f) A plan under section 457 (b) of the Internal Revenue Code.

(g) A nonqualified deferred compensation plan under section 409A of the Internal Revenue Code.

(2) Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to retirement plans authorizes the agent to do all of the following:

(a) Select the form and timing of payments under a retirement plan and withdraw benefits from a plan.

- (b) Make a rollover, including a direct trustee-to-trustee rollover, of benefits from one retirement plan to another.
- (c) Establish a retirement plan in the principal's name.
- (d) Make contributions to a retirement plan.
- (e) Exercise investment powers available under a retirement plan.
- (f) Borrow from, sell assets to, or purchase assets from a retirement plan.

244.56 Taxes. Unless the power of attorney otherwise provides, language in a power of attorney granting general authority with respect to taxes authorizes the agent to do all of the following:

- (1)** Prepare, sign, and file federal, state, local, and foreign income, gift, payroll, property, Federal Insurance Contributions Act, and other tax returns, claims for refunds, requests for extension of time, petitions regarding tax matters, and any other tax-related documents, including receipts, offers, waivers, consents, including consents and agreements under 2032A of the Internal Revenue Code, closing agreements, and any power of attorney required by the Internal Revenue Service or other taxing authority with respect to a tax year upon which the statute of limitations has not run and the following 25 tax years.
- (2)** Pay taxes due, collect refunds, post bonds, receive confidential information, and contest deficiencies determined by the Internal Revenue Service or other taxing authority.
- (3)** Exercise any election available to the principal under federal, state, local, or foreign tax law.
- (4)** Act for the principal in all tax matters for all periods before the Internal Revenue Service, or other taxing authority.



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Advance Health Care Directive

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.



State of Wisconsin

Department of Health Services

Instructions to Complete the Power of Attorney for Health Care Form

To Whom It May Concern:

Enclosed is the Power of Attorney for Health Care form 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 upon the death of the donor).

Be sure to read all six (6) pages of the form carefully and understand it before you complete and sign it. Talk with those 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, domestic partnership, 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 cannot 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 nor 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 or other primary care provider. 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 filing with the Register in Probate 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.

One copy of the Power of Attorney for Health Care form is available free to anyone who sends a stamped, self-addressed, business-size envelope to: Power of Attorney, Division of Public Health, P.O. Box 2659, Madison, Wisconsin 53701-2659. You may make additional blank copies of the form you receive from the Division of Public Health. The form is also available on the Department of Health Services Web page, <https://www.dhs.wisconsin.gov/forms/advdirectives/index.htm>.

Definitions 'Department' means the Department of Health 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 State Statute 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 State Statutes 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 §§ 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 State Statute Chapter 441, a chiropractor licensed under Chapter 446, a dentist licensed under Chapter 447, a physician, podiatrist or physical therapist licensed or an occupational therapist or occupational therapy assistant certified under Chapter 448, a person practicing Christian Science treatment, an optometrist licensed under Chapter 449, a psychologist licensed under

Chapter 455, a partnership thereof, a corporation thereof that provides health care services, an operational cooperative sickness care plan organized under State Statute 185.981 to 185.985 that directly provides services through salaried employees in its own facility, or a home health agency, as defined in State Statute 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 54 is presumed not to be of sound mind.

Procedure 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, or a physician and a psychologist, as defined in State Statute 448.01 (5), or nurse practitioner, or physician assistant 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 nor 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 State Statute 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 Chapter 155; complying with the decision of a health care agent that is made under a Power of Attorney for Health Care that is in compliance with Chapter 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 Chapter 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.

Important:

You must keep pages 1-6 of the form together as your executed document. Copies distributed to health care providers, etc. must include pages 1 - 6.

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, health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse or your domestic partner, and your marriage is annulled or you are divorced or your 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.

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, nurse practitioner, or physician assistant 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 persons with intellectual disability, 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, physician assistant, or nurse practitioner 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, domestic partnership, 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 _____



State of Wisconsin
Department of Health Services

The Declaration to Health Care Professionals (Living Will) 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 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, physician assistant, or advanced practice registered nurse 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 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.

When you have completed and signed the form:

- The original signed form should be kept in a safe, easily accessible place until needed.
- You should make relatives and friends aware that you have signed the document and the location where it is kept.
- A copy of the signed form may be kept on file with your physician, physician assistant, or advanced practice registered nurse. You are responsible for notifying your attending physician, physician assistant, or advanced practice registered nurse of the existence of the Declaration. An attending physician, physician assistant or advanced practice registered nurse who is notified shall make the Declaration part of your medical records.
- 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 filing with the Register in Probate has been set by State at \$8.

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 Health Care Professionals 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 Health Care Professionals.

Up to four copies of the Declaration to Health Care Professionals are available free to anyone who sends a stamped, self-addressed, business-size envelope to Living Will, Division of Public Health, PO Box 2659, Madison, Wisconsin 53701-2659. You may make additional copies of the enclosed blank form. The form is also available on the Department of Health Services Web page <https://www.dhs.wisconsin.gov/forms/advdirectives/index.htm>.

INSTRUCTIONS FOR DECLARATION TO HEALTH CARE PROFESSIONALS FORM

Definitions

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

“Department” means the Department of Health 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 judgment 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 judgment 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 two health care professionals and one of whom is a physician, who have personally examined the declarant.

“Attending health care professional” means a health care professional who has primary responsibility for the treatment and care of the patient.

“Advanced practice registered nurse” means a nurse licensed under ch. 154 who is currently certified by a national certifying body approved by the board of nursing as a nurse practitioner, certified midwife, certified registered nurse anesthetist, or clinical nurse specialist.

“Health care professional” means any of the following: a physician licensed under ch. 154, a physician assistant licensed under ch. 154, or an advanced practice registered nurse.

“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 judgment of the attending health care professional, 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 a medical procedure; or (b) the provision of nutrition or hydration.

Procedures for Signing Declarations

A Declaration must be signed by the declarant in the presence of two 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 two witnesses.

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.

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, signed and dated by the declarant expressing the intent to revoke.
- 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, physician assistant, or advanced practice registered nurse of the revocation.
- 4) By executing a subsequent Declaration.

The attending physician, physician assistant, or advanced practice registered nurse 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.

Liabilities

No physician, physician assistant, or advanced practice registered nurse, inpatient health care facility or health care professional acting under direction of a physician, physician assistant, or advanced practice registered nurse may be held criminally 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, physician assistant, or advanced practice registered nurse to comply with a Declaration of a qualified patient constitutes unprofessional conduct if the physician, physician assistant, or advanced practice registered nurse refuses or fails to make a good faith attempt to transfer the patient to another physician, physician assistant, or advanced practice registered nurse who will comply with the Declaration.

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

DECLARATION TO HEALTH CARE PROFESSIONALS (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, physician assistant or advanced practice registered nurse, 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 a physician, physician assistant, or advanced practice registered nurse, who have personally examined me, and if a physician who has also personally examined me agrees with that determination, 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 a physician, physician assistant, or advanced practice registered nurse who have personally examined me, and if a physician who has also personally examined me agrees with that determination, 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 a physician, physician assistant, or advanced practice registered nurse who has personally examined me, and if a physician who has also personally examined me agrees with that determination, 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, PHYSICIAN ASSISTANT,
OR ADVANCED PRACTICE REGISTERED NURSE**

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when a physician and another physician, physician assistant, or advanced practice registered nurse, one of whom is the attending health care professional, 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, physician assistant, or advanced practice registered nurse 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:



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Physician Orders for Life Sustaining Treatment (POLST)

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

PROVIDER ORDERS FOR SCOPE OF TREATMENT (POST)

FIRST follow these orders, **THEN** contact physician. This is a medical order form based on the person's medical condition and preferences. Any section not completed implies full treatment for that section. POST complements a Power of Attorney for Health Care (POAHC) and is not intended to replace that document. Recognize the dignity of all people and treat everyone with respect.

PATIENT LAST NAME:	PATIENT FIRST NAME:	M.I.:
DATE OF BIRTH: (mm/dd/yyyy) ____/____/____	GENDER: ☐ MALE ☐ FEMALE	
ADDRESS: (street/city/state/zip)		

A. CARDIOPULMONARY RESUSCITATION (CPR): *If Patient has no pulse and is not breathing.*

- CHECK ONE ☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B.)
☐ Do Not Attempt Resuscitation/DNR

When not in cardiopulmonary arrest, follow orders in B and C.

B. MEDICAL INTERVENTIONS: *If Patient has pulse and is breathing.*

- CHECK ONE ☐ FULL TREATMENT – primary goal of prolonging life by all medically effective means.
 In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ TRIAL PERIOD OF FULL TREATMENT
- ☐ SELECTIVE TREATMENT – primary goal of treating medical conditions while avoiding burdensome measures.
 In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Transfer to hospital when indicated, generally avoid intensive care.
- ☐ COMFORT-FOCUSED TREATMENT – primary goal of maximizing comfort.
 Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. *Request transfer to hospital only if comfort needs cannot be met in current location.*

ADDITIONAL ORDERS: _____

C. ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food and fluids by mouth if feasible.*

In principle medically assisted nutrition and hydration are provided unless these measures cannot reasonably be expected to prolong life or when they would be excessively burdensome for the patient or would cause significant physical discomfort.

- CHECK ONE ☐ Determine the use of artificial nutrition when needed. ADDITIONAL ORDERS: _____
☐ Long-term artificial nutrition by tube. _____
☐ Defined trial period of artificial nutrition by tube. _____
☐ No artificial nutrition by tube. _____

D. DISCUSSION PARTICIPANTS:

- CHECK ONE ☐ Patient (Patient has capacity) ☐ Health Care Agent – Name/phone: _____
☐ Parent of minor ☐ Court-Appointed Guardian – Name/phone: _____
☐ Other: _____

E. SIGNATURE OF PATIENT/AGENT/GUARDIAN: (either patient/agent/guardian must sign or physician or nurse practitioner must initial)

SIGNATURE: (recommended) _____ NAME: (print) _____ RELATIONSHIP: (write "self" if patient) _____

- ☐ The signing physician or NP has initialed this box to verify that the patient/agent/guardian consent to these orders but was unwilling or unable to sign in the space above.

F. SIGNATURE OF PHYSICIAN/NP:

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

PHYSICIAN/NP SIGNATURE: (required) _____ PRINT SIGNING PHYSICIAN/NP NAME: (required) _____ TIME AND DATE: (required) _____

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

PATIENT NAME:

Decisions on the POST form are voluntary, informed decisions. This POST form records your wishes for medical treatment in your current state of health if there is a medical emergency outside of the hospital.

During the course of your medical treatment risks and benefits of your chosen therapy may change. Your decisions and this form can be changed by you (or your agent or guardian) to reflect your new wishes at any time (contact your health care professional to make any changes to this form). No form can address all the medical treatment decisions that may need to be made. A Power of Attorney for Health Care (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC is recommended for all capable adults and allows you to document in detail your general health care instructions and name a health care agent to speak for you if you are unable to speak for yourself. Consider reviewing your POAHC and giving a copy of it to your health care professional.

CONTACT INFORMATION

PREPARER NAME:	PREPARER TITLE:	PHONE NUMBER:
PRIMARY CARE PROFESSIONAL:		DATE PREPARED: (mm/dd/yyyy)

DIRECTIONS FOR HEALTH CARE PROFESSIONALS**COMPLETING POST**

- Decisions on a POST are voluntary, informed decisions.
- Should reflect current preferences of persons with serious advanced illness or frailty. Encourage completion of a Power of Attorney for Health Care.
- Verbal/phone orders are acceptable with follow-up signature by physician/NP in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies on canary yellow paper or faxes are acceptable in a skilled nursing facility, assisted living/community based residential facility (CBRF) or in home hospice.
- Health care professionals should always include patients, including those with developmental disabilities or significant mental health conditions, in the conversation to the extent possible before completing the POST form.
- The POST is available to providers in all La Crosse area health care facilities. To obtain the document in La Crosse, or for use by providers in other Wisconsin health care facilities, please use the following link:
<http://www.gundersenhealth.org/advance-care/resources>.

USING POST

- Any incomplete section of POST implies full treatment for that section.

SECTION A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

SECTION B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture.)
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- EMS protocols are written based on this form; "additional orders" written in Section B may not be implemented by EMS if they go beyond the scope of their protocols.

REVIEWING POST

This POST should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

VOIDING POST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw a line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



Funeral Designation Form

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Wisconsin Authorization for Final Disposition

I, (print name and address): _____,

being of sound mind, willfully and voluntarily make known by this document my desire that, upon my death, the final disposition of my remains be under the control of my representative under the requirements of section 154.30, Wisconsin statutes, and, with respect to that final disposition only, I hereby appoint the representative and any successor representative named in this document. All decisions made by my representative or any successor representative with respect to the final disposition of my remains are binding.

Name of representative: _____

Address: _____

Telephone number: _____

If my representative dies, becomes incapacitated, resigns, refuses to act, ceases to be qualified, or cannot be located within the time necessary to control the final disposition of my remains, I hereby appoint the following individuals, each to act alone and successively, in the order specified, to serve as my successor representative:

1. Name of first successor representative _____

Address _____

Telephone number _____

2. Name of second successor representative _____

Address _____

Telephone number _____

Suggested special directions:

Suggested instructions concerning religious observances:

Suggested source of funds for implementing final disposition directions and instructions:

This authorization becomes effective upon my death. _____ (initials)

I hereby revoke any prior authorization for final disposition that I may have signed before the date that this document is signed. _____ (initials)

I hereby agree that any funeral director, crematory authority, or cemetery authority that receives a copy of this document may act under it. Any modification or revocation of this document is not effective as to a funeral director, crematory authority, or cemetery authority until the funeral director, crematory authority, or cemetery authority receives actual notice of the modification or revocation. No funeral director, crematory authority, or cemetery authority may be liable because of reliance on a copy of this document. _____ (initials)

The representative and any successor representative, by accepting appointment under this document, assume the powers and duties specified for a representative under section 154.30, Wisconsin statutes.

Signed this day of _____

Signature of declarant _____

I hereby accept appointment as representative for the control of final disposition of the declarant's remains.

Signed this day of _____

Signature of representative _____

I hereby accept appointment as successor representative for the control of final disposition of the declarant's remains.

Signed this day of _____

Signature of 1st successor representative _____

Signed this day of _____

Signature of 2nd successor representative _____

I attest that the declarant signed or acknowledged this authorization for final disposition in my presence and that the declarant appears to be of sound mind and not subject to duress, fraud, or undue influence. I further attest that I am not the representative or the successor representative appointed under this document, that I am aged at least 18, and that I am not related to the declarant by blood, marriage, or adoption.

Witness (print name) _____

Signature _____

Address _____

Date _____

Witness (print name) _____

Signature _____

Address _____

Date _____

State of Wisconsin County of _____

On (date) _____, before me personally appeared (name of declarant) _____, known to me or satisfactorily proven to be the individual whose name is specified in this document as the declarant and who has acknowledged that he or she executed

the document for the purposes expressed in it. I attest that the declarant appears to be of sound mind and not subject to duress, fraud, or undue influence.

Notary public _____

My commission expires _____



Triage Cancer Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



HIPAA Authorization Form

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:

Relationship:

Contact information: _____

Health Information to be disclosed upon the request of the person named above --
(Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
 - ☐ Mental health records
 - ☐ Communicable diseases (including HIV and AIDS)
 - ☐ Alcohol/drug abuse treatment
 - ☐ Other (please specify):

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of the Individual Giving this Authorization

Date of birth

Signature of the Individual Giving this Authorization

Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524