TIMOTHY P. CRAWFORD, S.C.

Your Asset Protection Law Firm

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TIMOTHY P. CRAWFORD, CELA*, CPA, CAP**
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****Certified Elder Law Attorney***
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FREE

HEALTH CARE

POWER OF ATTORNEY

Without this Health Care Power of Attorney, no one can make a decision for you regarding your health care if you become incompetent as a result of a stroke, car crash, or for any other reason.

In Wisconsin, your spouse cannot make a decision for you.

PLEASE TAKE THIS FORM HOME WITH YOU, COMPLETE IT, AND SIGN IT UP IN FRONT OF TWO NEIGHBORS, TWO FRIENDS, OR TWO CHURCH MEMBERS.

Once you have signed it, please make sure the person you have selected knows what your wishes are. Do not put these wishes inside your Health Care Power of Attorney form.

kmw/POA/HCPOA COVER SHEET-2 SIDES/042011

NAELA™ National Academy of Elder Law Attorneys, Inc. MEMBER

* Attorney Timothy P. Crawford has been Nationally Board **C**ertified as an **E**lder **L**aw **A**ttorney by The National Elder Law Foundation which has been Approved as the Sole Certifying Organization for Elder Law Attorneys by The American Bar Association.

WHO NEEDS A HEALTH CARE POWER OF ATTORNEY?

Answer: Everyone 18 and older

IF YOU HAD AN ACCIDENT OR A STROKE, WHO COULD MAKE A HEALTH CARE DECISION FOR YOU?

Spouse?	**No**
Parent?	**No**
Child?	**No**
Health Care Agent?	**Yes**

In Wisconsin, if you are unable to communicate with your doctor, no one can make a health care decision for you unless you have signed a Health Care Power of Attorney authorizing someone to make a health care decision for you.

ATTORNEY TIMOTHY P. CRAWFORD
840 Lake Avenue - Suite 200 - Racine, WI 53403
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OUT OF OFFICE SIGNING PROCEDURE
FOR ORIGINAL HEALTH CARE POWER OF ATTORNEY

STEP

1. Review paragraph 1 of page 3, Designation of Health Care Agent, to see if there is any missing information. Please insert the missing information into all copies, if known. If not known at this time, as soon as you have obtained the missing information, insert the information into all copies of the Health Care Power of Attorney **BEFORE SIGNING**.

2. Sign the original on the last page of the document (before Attorney Certificate form) in the presence of two qualified witnesses. A qualified witness may not be a relative. A witness must be over 18 and able to attest to the fact that you are completing this document willingly.

3. People who **may not** be a witness:

    1. Anyone who works for your healthcare organization or hospital. The only exception to this, in Wisconsin, is the chaplains or social workers at these institutions.
    2. Your Doctor or anyone who works for your doctor.
    3. Your relatives by birth, marriage or adoption.
    4. Anyone who would benefit from your estate.

4. Have witness #1 sign and fill in the relevant information.

5. Have witness #2 sign and fill in the relevant information.

6. If the Agent is present, then have the Agent sign, date, and fill in the relevant information.

7. If the Alternate Agent is present, then have the Alternate Agent sign, date, and fill in the relevant information.

8. Insert the date of signing on pages 2 and 8. This is the date the document is signed by the Principal (yourself).

9. The document is valid and legal whether or not the Agent and Alternate Agent sign the form. If either the Agent or Alternate Agent are not immediately available to sign, then obtain their signatures in the future as soon as you can and before proceeding to Step 10.

10. After all information has been completed and all signatures have been obtained, the Health Care Power of Attorney needs to be photocopied and distributed to the following:

    1. <u>You</u> should keep the original signed document.
    2. <u>Your Agent</u> should get a photocopy.
    3. <u>Your Alternate Agent</u> should get a photocopy.
    4. <u>Your doctor</u> should get a photocopy.

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-00085 (Rev. 06/11)

STATE OF WISCONSIN
Chapter 155.30(1),(3)
Effective Date: August 3, 2009
608 266-1251

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, 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.

Attorney Timothy P. Crawford has furnished this document. Attorney Timothy P. Crawford was not involved in its preparation. If you would like to hire Attorney Timothy P. Crawford, I would be glad to assist you. Our office is located at:
840 Lake Avenue, Suite 200, Racine, WI 53403
Phone (262) 634-6659

POWER OF ATTORNEY FOR HEALTH CARE

Document made this_____day of _____(month),_____(year).

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I,_____

_____

_____

(print name, address, and date of birth), being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate_____

_____

print name, address and telephone number) to be my health care agent for the purpose of making health care decisions on my behalf. If he or she is ever unable or unwilling to do so, I hereby designate_____

_____

(print name, address and telephone number) to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions.

A copy of that statement must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the persons with mental retardation, a state treatment facility, or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

1. A nursing home - - ☐ Yes ☐ No

2. A community-based residential facility - - ☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may admit me only for short-term stays for recuperative care or respite care.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube - -☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withdrawn from me.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant - -☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions or limitations that I wish to state (add more items if needed):

1. _____

2. _____

3. _____

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

(a) Request, review and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records.
(b) Execute on my behalf any documents that may be required in order to obtain this information.
(c) Consent to the disclosure of this information.

(The principal and the witnesses all must sign the document at the same time.)

SIGNATURE OF PRINCIPAL

(Person creating the Power of Attorney for Health Care)

Signature_____ Date_____

(The signing of this document by the principal revokes all previous powers of attorney for health care documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, domestic partnership under Wisconsin Statutes chapter 770, or adoption, and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employe of the health care provider, other than a chaplain or a social worker, or an employe, other than a chaplain or a social worker, of an inpatient health care facility in which the declarant is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness Number 1

(Print) Name _____ Date _____

Address_____

Signature _____

Witness Number 2

(Print) Name_____ Date _____

Address_____

Signature _____

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

I understand that_____(name of principal) has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself._____ (name of principal) has discussed his or her desires regarding health care decisions with me.

Agent's Signature_____

Address_____

Alternate's Signature _____

Address_____

Attorney Timothy P. Crawford has furnished this document. Attorney Timothy P. Crawford was not involved in its preparation. If you would like to hire Attorney Timothy P. Crawford, I would be glad to assist you. Our office is located at:

840 Lake Avenue, Suite 200, Racine, WI 53403

Phone (262) 634-6659

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 _____

CHOOSING YOUR AGENTS

You can not name two people to serve at the same time as your Health Care Agent. The form is set up for you to name people in succession, your first choice, then a back up choice.

State law bars two people from serving as Agent at the same time under your Health Care Power of Attorney. They can serve in succession. That is to say if the first one dies, then the second one automatically steps up to serve. If you fill out the form with two serving at the same time, the form is void and can not be used.

ATTORNEY TIMOTHY P. CRAWFORD HAS PROVIDED THIS KIT TO YOU FREE OF CHARGE

By completing this Health Care Power of Attorney Kit, you can have peace of mind that the loved one that you picked will be able to make medical decisions for you when the doctor will not let you make these medical decisions for yourself.

When the doctor makes his decision that he wants to talk to your Health Care Agent instead of you, it is only because he believes he is unable to communicate with you. He is not necessarily stating that you are incompetent. Incompetency can only be determined by a Judge. It is determined only in a Guardianship proceeding. Therefore, just because your doctor has activated your Health Care Power of Attorney, it does not mean that you are incompetent and thus, are unable to make decisions and sign documents outside of the medical area.

However, if a doctor activates the Health Care Power of Attorney he will not give you the form activating it unless you ask him for it. Make sure your loved one realizes that when the doctor is talking to your loved one, and seeking a decision from your loved one, at that time your loved one needs to ask the doctor for the one page form that he has signed to activate your Health Care Power of Attorney. **PLEASE FURNISH THAT FORM TO ATTORNEY TIMOTHY P. CRAWFORD.**

If a doctor has activated your Health Care Power of Attorney form, you need to take immediate action. Contact Attorney Timothy P. Crawford immediately for what you need to do. Do not delay.

OVER

ADDITIONAL HELP IN COMPLETEING YOUR HEALTH CARE POWER OF ATTORNEY FORM

You may have noticed that in the form there are places to check a box *Yes* or *No*. I would encourage you to check all 4 boxes Yes. This is true even if you are a male.

In the area of *Statement of Desires* on page 4, my recommendation is that you put nothing in that area but instead instruct your Agent/loved one directly whom you have selected to make your medical decision. I encourage you to have a lengthy discussion with your loved one telling them what are your desires with respect to medical decisions. How do you want to be treated? When would you want to have a feeding tube removed? When would you want to have a respirator removed? There are many other items that you should be discussing with your loved one. To assist you with this, I have included some materials in this kit.

I HAVE ALSO GIVEN TO YOU SUGGESTIONS WITH RESPECT TO OTHER LEGAL DOCUMENTS WHICH YOU NEED AND SHOULD HAVE ATTORNEY TIMOTHY P. CRAWFORD PREPARE FOR YOU. PLEASE CONTACT OUR OFFICE AT:

Attorney Timothy P. Crawford
840 Lake Avenue, Suite 200
Racine, WI 53403
Phone: (262) 634-6659

Appendix 15C
25 Topics for Client Discussion with POAHC Agent

25 Suggested Topics to Discuss with Your Health Care Agent[302]

Before having your health care agent sign any forms, you should discuss your beliefs and wishes with him or her. When instructing your health care agent about your wishes in the event you become incapacitated and the agent needs to make health care decisions, we suggest you consider the following questions. We suggest no particular answers. Each person should answer these questions based on his or her own beliefs and convey those beliefs and wishes to his or her health care agent. Any other wishes or desires that you feel your health care agent should know should also be given to the agent so that he or she can carry out his or her responsibilities as you would wish.

1. Do you think it is a good idea to sign a legal document that says what medical treatments you want and do not want when you are dying? (This is called a "living will.")
2. Do you think you would want to have any of the following medical treatments performed on you?
   a. Kidney dialysis (used if your kidneys stop working)
   b. Cardiopulmonary resuscitation, also called CPR (used if your heart stops beating)
   c. Respirator (used if you are unable to breathe on your own)
   d. Artificial nutrition (used if you are unable to eat foods)
   e. Artificial hydration (used if you are unable to drink fluids)
3. Do you want to donate parts of your body to someone else at the time of your death? (This is called "organ donation.")
4. How would you describe your current health status? If you currently have any medical problems, how would you describe them?
5. If you have current medical problems, in what ways, if any, do they affect your ability to function?
6. How do you feel about your current health status?
7. If you have a doctor, do you like him or her? Why?
8. Do you think your doctor should make the final decision about any medical treatments you might need?
9. How important is independence and self-sufficiency in your life?
10. If your physical and mental abilities were decreased, how would that affect your attitude toward independence and self-sufficiency?
11. Do you wish to make any general comments about the value of independence and control in your life?
12. Do you expect that your friends, family and/or others will support your decisions regarding medical treatment you may need now or in the future?

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[302] Reprinted with permission from Helen Marks Dicks, *Power of Attorney for Health Care: A Manual for Legal Practitioners & Health Care Providers* (Center for Public Representation Mar. 1991).

13. What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?

14. Where would you prefer to die?

15. What is your attitude toward death?

16. How do you feel about the use of life-sustaining measures in the face of terminal illness?

17 How do you feel about the use of life-sustaining measures in the face of permanent coma?

18. How do you feel about the use of life-sustaining measures in the face of irreversible chronic illness (e.g., Alzheimer's disease)?

19. Do you wish to make any general comments about your attitude toward illness, dying, and death?

20. What is your religious background?

21. How do your religious beliefs affect your attitude toward serious or terminal illness?

22. Does your attitude toward death find support in your religion?

23. How does your faith community, church or synagogue view the role of prayer or religious sacraments in an illness?

24. Do you wish to make any general comments about your religious background and beliefs?

25. What else do you feel is important for your agent to know?

If, over time, your beliefs or attitudes in any area change, you should inform your health care agent. It is also wise to inform your health care agent of the status of your health when there are changes such as new diagnoses. In the event you are informed of a terminal illness, this, as well as the ramifications of it, should be discussed with him or her. How well your health care agent performs depends on how well you have prepared him or her.

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Choose a Health Care Agent with ANGST

Selecting someone to be the agent named in your power of attorney for health care is one of the most important decisions you will ever make. This person could be making life or death choices for you one day. Just being your first born or your closest friend may not be enough. Your ideal agent should possess those qualities necessary to make sound medical decisions under great stress. Your agent should have ANGST.

A-N-G-S-T:

A - Availability – Choose an agent who lives near enough to you to be able to get to the hospital quickly in an emergency and to visit frequently. Observing you, talking with your doctors and nurses and reviewing your medical records will allow your agent to get the full picture of your situation and to be present to advocate for your best care.

N - Nerve – Your agent needs the emotional fortitude to handle emergency situations at a very upsetting time. Do not choose someone who faints at the sight of blood or falls to pieces in a crisis.

G - Gumption – You need a feisty agent, one who will stand up to busy medical personnel to demand information, explanations and good care for you. Your agent is your advocate and speaks for you at a time when you cannot speak for yourself. Your agent even has the power to change doctors if he believes you are not getting appropriate care.

S - Smarts – If your agent is not knowledgeable about medical terms, issues and procedures, he must be intelligent enough to ask questions and educate himself. Good decisions come from a clear understanding of the facts and the options available.

T - Thinking – Choose an agent who thinks in the same way that you do about health care. For example, you might not want your agent to choose radical surgery or radiation for you if you are a proponent of medicinal herbs and acupuncture. Having the same view point is especially important regarding decisions about life support, hospice and artificially administered nutrition and hydration.

Choosing an agent with **ANGST** will assure that your agent will be able to make the wise and informed medical decisions that you would make for yourself if you were able.

QUESTIONS YOU MAY HAVE REGARDING
A HEALTH CARE POWER OF ATTORNEY

Q WHO CAN I NAME AS THE PERSON TO MAKE THE DECISION?

A Any adult, even a relative. Exception may be certain hospital workers. If the hospital worker is a relative, such person is acceptable.

Q WHO CAN BE THE TWO WITNESSES TO MY HEALTH CARE POWER OF ATTORNEY?

A Someone who knows you and is not related to you by blood, marriage or adoption, and not directly financially responsible for your health care. You cannot owe money to such person [such person cannot have a claim on your probate estate].

Q TO WHOM DO I GIVE COPIES OF MY HEALTH CARE POWER OF ATTORNEY?

A It is recommended that you keep the original of your health care power of attorney in a safe place. This should not be in your safe deposit box. A photocopy should be given to your spouse, each of your children, your health care agent, your alternate health care agent, the medical records department of your doctor's office, your minister, your hospital (only when you go in for a hospital stay), and put one in your glove box.

Q WHEN DOES THIS DOCUMENT BECOME EFFECTIVE?

A This is an advance written directive. It does not become effective until 2 doctors have determined that you are incapacitated and cannot communicate with your doctor.

Q WHAT IF I DON'T HAVE ONE – CAN'T MY WIFE DECIDE?

A NO, in Wisconsin, if you are unable to communicate with your doctor, no one can make a health care decision for you unless you have signed a Health Care Power of attorney authorizing someone to make a health care decision for you.

Q WHY CAN'T MY SPOUSE DECIDE?

A State law stops her.

Q BUT I KNOW SHE CAN.

A You have been watching too much "E.R."

Q HOW DO I KNOW THE PERSON I SELECT WILL FOLLOW MY WISHES?

A Pick someone you trust. Pick somebody who shares your same beliefs about death and dying.

Q WHY DOES MY 18 YEAR OLD CHILD NEED ONE?

A Because he is an adult and you lose your right to make a decision for him when he becomes 18.

Q WHAT IF I DON'T DO A HEALTH CARE POWER OF ATTORNEY?

A If you do not have one, the probate court judge will select someone of his choosing to make medical decisions for you. This could be a total stranger. This person would not be allowed to take you off of a respirator or a feeding tube.

Q WHAT IF I NEED HELP TO PREPARE THIS DOCUMENT?

A You can get FREE assistance at Attorney Timothy P. Crawford's office – 840 Lake Avenue, Suite 200, Racine. His staff would be glad to assist you. Call for a FREE appointment – 634-6659.

Q IF I SIGN THIS, CAN MY CHILD PUT ME INTO A NURSING HOME?

A Whether or not you sign it, you can be forced to go into a nursing home. This will be based upon your doctor's recommendation. If you do not have one then the stranger appointed by the judge will force you to go to the nursing home. If you are competent the person you selected to make decisions has no authority to decide, nor does the judge get involved.

Q WHAT HAPPENS IF I MOVE OUT OF STATE?

A It is recommended that you sign that state's form as well as keeping your Wisconsin Health Care Power of Attorney form. If you spend a considerable amount of time in another state it is recommended that you sign that state's form.

Q SHOULD I TAKE THIS FORM WITH ME WHEN I GO ON VACATION?

A Keep a photocopy of this document in your glove box at all times. Also put one in your luggage. Keep a card in your wallet that you have signed a health care power of attorney.

Q I HAVE A LIVING WILL, DO I STILL NEED A HEALTH CARE POWER OF ATTORNEY?

A Yes, you should still have a health care power of attorney. The living will is very restrictive. It only allows your doctor to make decisions. He can only make decisions regarding the use of a feeding tube and a respirator. He can only do this when you are terminally ill or in a persistent vegetative state. It is best to have the health care power of attorney so that the person you select can make all medical decisions at any time that you are unable to make these decisions for yourself. If you have both, then you should revoke the living will.

Q HOW DO I REVOKE THE LIVING WILL?

A You can revoke the living will by a new document canceling the prior living will. You can revoke the living will by destroying all copies of the original living will.

Q HOW DO I REVOKE A HEALTH CARE POWER OF ATTORNEY?

A You can revoke it by signing a new health care power of attorney. You can also revoke it by destroying all copies of the original health care power of attorney.

Q CAN I CHANGE MY MIND ONCE I HAVE SIGNED IT?

A Yes. You would simply revoke your prior one and do a new health care power of attorney.

Q WHAT DOES IT COST?

A It is free. You can get FREE assistance at Attorney Timothy P. Crawford's office – 840 Lake Avenue, Suite 200, Racine. His staff would be glad to assist you. Call for a FREE appointment – 262-634-6659.

Statement of Change of Address of My Agents

My Agents addresses and phone numbers were correct at the time I signed my Health Care Power of Attorney. Without going through the formalities and expense of creating a new document because of my agent's change of address, I have attached this statement indicating their new address and the date of the change.

PRINCIPAL AND/OR AGENT INFORMATION

(If different than original document)

Principal's Name: _____

Principal's Street Address: _____

Principal's City, State and Zip: _____

Principal's Phone Number: _____

Date of Change: _____

Agent's Name: _____

Agent's Street Address: _____

Agent's City, State and Zip: _____

Agent's Phone Number: _____

Date of Change: _____

Alt. Agent's Name: _____

Alt. Agent's Street Address: _____

Alt. Agent's City, State and Zip: _____

Alt. Agent's Phone Number: _____

Date of Change: _____

TIMOTHY P. CRAWFORD, S.C.

Your Asset Protection Law Firm

Greater Milwaukee Area Offices:
Brookfield, WI
Glendale, WI
Milwaukee, WI
Oak Creek, WI
Racine, WI

840 Lake Avenue
Racine, WI 53403
(Please send mail to this office)

Telephone: (262) 634-6659
Toll Free: (888) 634-6675
Fax: (262) 634-1234

E-Mail: tpc@tpcelderlaw.com
Website: www.TpcLaw.com

TIMOTHY P. CRAWFORD, CELA*, CPA, CAP**
Board Member of the National Academy of Elder Law Attorneys
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****Member of the Council of Advanced Practitioners***

Vincent Heine - Attorney
Lynn M. Vassh – Senior Legal Secretary
Samantha A. Heft – Senior Legal Assistant
Nina M. Gonzales – Legal Assistant
Kay M. Tobias – Administrative Assistant
Sandi L. Weber – Administrative Assistant
Lisa C. Stindle – Administrative Assistant
Manny G. Munoz – Marketing Coordinator
Shronda T. Barry – Receptionist

Now that you have a Health Care Power of Attorney, you really should consider a Financial Power of Attorney.

- A Financial Power of Attorney can keep you out of Probate Court.
- A Financial Power of Attorney can keep a Probate Court Judge from appointing a total stranger to run your financial affairs if you become incompetent as a result of an auto accident, dementia or otherwise.
- Avoiding Probate Court can save you the cost of $2,000 per year to pay the fees and expenses of a Guardianship.
- Like a Health Care Power of Attorney, everyone 18 and over needs a Financial Power of Attorney.

You simply need to do a little planning ahead to avoid the need to go to Probate Court because you are incompetent resulting from an auto accident, etc.

Contact Attorney Timothy P. Crawford's office to have a Level III planning type Durable Financial Power of Attorney prepared for you at a cost of $250. This can be done in person or through the mail.

lmv/POA/NOW THAT YOU HAVE A HCPOA/042611

NAELA™ National Academy of Elder Law Attorneys, Inc. MEMBER

* Attorney Timothy P. Crawford has been Nationally Board **C**ertified as an **E**lder **L**aw **A**ttorney by The National Elder Law Foundation which has been Approved as the Sole Certifying Organization for Elder Law Attorneys by The American Bar Association.

TYPES OF PLANNING WITH WHICH ATTORNEY TIM CRAWFORD CAN ASSIST YOU

We can prepare for you:

- **Financial Powers Of Attorneys to avoid a Guardianship when you become incapacitated**
- **Documents to save 4% of your assets at death to give to your loved ones**
- **Documents to minimize death taxes**
- **Documents to hold money back from young children so they do not get it when they are 8 years old at the time of the death of their young parents**
- **Documents to make sure your parents don't have to spend $100,000 per year on nursing home care costs**

WE OFFER A FREE INITIAL CONFERENCE TO DETERMINE YOUR PLANNING NEEDS

IF YOU WOULD LIKE MORE INFORMATION, PLEASE CONTACT OUR OFFICE.

ATTORNEY TIMOTHY P. CRAWFORD

Your Asset Protection Law Firm

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