Healthcare Power of Attorney
of

_____

I, _____, Wisconsin, being of sound mind, intend by this document to create a Power of Attorney for Health Care, and hereby revoke all prior powers of attorney for health care. The person authorized to act on my behalf under this Power of Attorney for Health Care shall be referred to as my "Healthcare Agent" or simply as "Agent."

MY AGENT'S AUTHORITY IS EFFECTIVE IMMEDIATELY UPON MY SIGNING THIS DOCUMENT, AS PERMITTED IN WISCONSIN STATUTES SECTION 155.05(2). NO DETERMINATION OF INCAPACITY IS REQUIRED.

I want to leave my family, friends and those who care about me with assurances of my love, and without the burdens of guilt or conflict. My purposes in leaving these instructions are to alleviate uncertainty that otherwise may arise in connections with decisions about my medical care, to promote family harmony and to clarify instructions to my health care providers. I affirm my belief in the importance and value of my personal dignity, both in living and in dying. To this end, I have created and signed a supplemental document entitled Care & Consent to provide direction of my intentions regarding my medical care to my Agent in my Healthcare Power of Attorney. I ask my Agent to consult this document and strive to adhere to its content whenever possible within the discretion of my Agent. If I no longer have a Care & Consent document in place, my Agent shall use his or her best judgment and discretion as my advocate relying on his or her knowledge of my history, my strong beliefs, and my opinions with regard to my medical care.

Article One
Creation of Healthcare Power of Attorney

Section 1.01 Healthcare Power of Attorney

This document does not require activation. It is effective immediately upon signing by me. This Healthcare Power of Attorney shall remain in full force and effect until revoked in writing. Amendments shall be in writing by me personally (and not by my Agent) and shall be attached to the original of this document. This is a durable power, and my subsequent physical or mental disability, incapacity or incompetency shall not affect this power of attorney.

My Agent shall carry out my wishes despite any contrary feeling or opinions of my family, friends, conservator, trustee, or guardian and despite any contrary opinions or

recommendations of any medical facility or medical professional. This document is made with knowledge that I can rely on the love and affection of my family and friends and with thankfulness that they will understand my reasons.

I reserve the right to remove my Agent's authority in writing at any time.

Section 1.02 Determination of Legal Capacity

A DETERMINATION OF MY INCAPACITY IS NOT REQUIRED FOR MY AGENT TO EXERCISE THE AUTHORITY GRANTED BY ME UNDER THIS HEALTHCARE POWER OF ATTORNEY. NO ACTIVATION IS REQUIRED.

Section 1.03 Designation of Healthcare Agent

I designate _____, to serve as my Healthcare Agent giving to my Healthcare Agent the power to make decisions with regard to my health care.

If my Agent is unwilling or unable to serve, is removed by me or is not available as determined by my health care provider, I designate the following as alternate Healthcare Agents to serve in the order in which their names appear to exercise the authority set forth in this Healthcare Power of Attorney.

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Section 1.04 My Agents are My HIPAA Personal Representatives

I appoint my Healthcare Agent and Successor Healthcare Agents to serve concurrently as my Personal Representatives pursuant to the Health Insurance Portability and Accountability Act of 1996, (Pub. L. 104-191), and its regulations, 45 C.F.R. Sections 160 through 164 ("Health Insurance Portability and Accountability Act" or "HIPAA").

My Agents shall have the status, power, authority and rights to act immediately as my Personal Representative for all purposes provided in the Health Insurance Portability and Accountability Act. Therefore, I authorize any health care provider or entity covered by the Health Insurance Portability and Accountability Act, (including any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse) to give, disclose and release to my Agents, without restriction, any and all of my health information and medical records regarding any past, present, or future medical or mental health condition.

I intend that the authority given to my Agents pursuant to this Healthcare Power of Attorney shall supersede any prior agreement that I may have made with any health care provider to restrict access to or disclosure of my patient records and other protected health information that may be subject to and protected under the Health Insurance Portability

and Accountability Act, and I hereby authorize my Agents to execute any and all authorizations, releases or other documents necessary to obtain disclosure.

The authority given to my Agents pursuant to this Healthcare Power of Attorney has no expiration date and shall not expire until revoked in writing in either a written document signed by me, or a written document signed by my Agent, delivered to such individual or organization covered by the Health Insurance Portability and Accountability Act.

I authorize my Agent to appoint a Patient Advocate for me, who may be any person so designated by my Agent. My Patient Advocate shall have the same right to ask questions and receive information regarding my medical conditions, treatment, and any proposed treatment as I and my Personal Representative would have, and the right to be in attendance to me at all times.

I have separately signed, on the same date as this Healthcare Power of Attorney, an Authorization for the release of my health care information under the provisions of the Health Insurance Portability and Accountability Act of 1996 authorizing the immediate release of my health care information to my Agent, even if the Agent is not yet acting as an Agent, so my health care decisions may be made by my Agent expeditiously and without the need to first prove my incapacity.

In the event my Authorization cannot be located, is by its own terms no longer in force or is otherwise deemed invalid or is not accepted, I hereby grant to my Agent the power and authority as my legal representative to sign a new Authorization naming my Agent and Successor Agents, even if not acting, as my Personal Representative, under HIPAA.

UNLESS I EXPRESSLY INSTRUCT OTHERWISE, MY PATIENT ADVOCATE, CAREGIVERS, CARE FACILITIES AND RESIDENCE FACILITIES SHALL GIVE INFORMATION ABOUT MY CONDITION AND WHEREABOUTS TO ONLY THOSE SPECIFICALLY IDENTIFIED ON MY AUTHORIZATION FOR RELEASE OF MY PROTECTED HEALTH INFORMATION. I OR MY AGENT WILL PROVIDE THIS DOCUMENT TO THE HEALTH CARE PROVIDER. MY AGENT AND PERSONAL REPRESENTATIVE MAY, AT THEIR DISCRETION, GIVE INFORMATION ABOUT MY CONDITION AND WHEREABOUTS TO ALL WHO INQUIRE.

I authorize my Agents and Personal Representatives to take any and all legal steps necessary to ensure compliance with my instructions to provide access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of the courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorney fees against anyone who does not comply with this Healthcare Power of Attorney.

Article Two
My Healthcare Agent's Powers Regarding My Health Care

Section 2.01 Authority of My Healthcare Agent

My Agent is authorized to make all health care decisions for me, subject to my wishes and the limitations (if any) stated in this Healthcare Power of Attorney and after consulting any supplementary documents, such as a Care & Consent document, I may have created to provide clarity to my Agent. My Agent has the authority to demand and evaluate information concerning my medical diagnosis, prognosis, benefits or risks of the proposed health care, and alternatives to the proposed health care. My Agent shall consider the decision that I would have made if I had the ability to do so. If my Agent does not know my wishes regarding a specific health care decision, my Agent shall make a decision for me in accordance with what my Agent believes I would want under the circumstances. In determining what I would want done, my Agent shall consider my personal beliefs and core values.

If I am unable to make health care decisions, my Agent should try to discuss with me any specific proposed health care. If I am unable to communicate in any manner, my Agent shall base his or her decisions on any health care choices previously expressed by me.

I request, but do not require, my Agent consult with my family if it is reasonably possible to do so before making a health care decision authorized under this agreement.

I demand all health care facilities and health care providers who have treated, or may treat me, to release all records that my Agent may request. I waive all privileges that may be applicable to such records and to any communication pertaining to me made in the course of any confidential relationship recognized by law. My Agent may disclose my information as my Agent deems appropriate.

In order to carry out the directives of this document I authorize my Agent to:

act on my behalf concerning my medical care including, decisions concerning artificial life support, medical treatment, surgery and other medical procedures, artificial nutrition and hydration, resuscitation decisions (including directing or consenting to Do Not Resuscitate [DNR] orders and CPR directives), amputation of my limbs, blood transfusions, experimental drugs and medical procedures, the administration of pharmaceutical agents, and arrangements for my long-term care;

arrange for health care services, including the authority to select, employ, and discharge health care providers for my physical, mental and emotional well-being and to bind me to pay for such services and facilities;

arrange for home health care or make arrangements for me at any Health Care Facility and assure my needs are met;

revoke, withdraw, or modify consent to procedures, tests, and treatments, as well as home care or care in a Health Care Facility;

determine when medical procedures are no longer of benefit to me or that the benefits are outweighed by the burdens imposed;

give or withhold consent for any health care or medical treatment as long as health care for my comfort, dignity, and pain relief is provided;

call paramedics or other emergency medical personnel, or choose not to do so, as my Agent deems appropriate given my wishes and my medical status at the time;

make decisions regarding admission to or discharge from any Health Care Facility or service even against medical advice;

exercise my rights regarding health care or medical treatment even though the decision may be against conventional medical advice or hasten my death;

limit or restrict visits, although I desire that anyone who wants to visit me be allowed to do so, and

authorize or refuse an autopsy and direct the disposition of my remains.

Section 2.02 Instructions Concerning Medical Evaluations and Treatment

In exercising the authority granted to my Agent, my Agent is instructed to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner, however rudimentary, even by blinking my eyes. My Agent is further instructed that if I am unable to give an informed consent to medical treatment, my Agent shall exercise judgment and be guided by the following:

the provisions of this Healthcare Power of Attorney;

any preferences that I may previously have expressed on the subject;

any supplemental documents, such as a Care & Consent document, I may have created to provide additional information to my Agent as my advocate;

what my Agent believes I would want done in the circumstances if I were able to express myself; and

any information given to my Agent by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain, risks, and side effects of the treatment.

Section 2.03 Keep Me Comfortable and Free of Pain

I authorize my Agent to order whatever is appropriate to keep me as comfortable and free of physical pain and mental anguish as is reasonably possible including, the administration of pain-relieving drugs, unconventional pain-relief therapies, and drugs and procedures that may not have been approved by the Food and Drug Administration. I realize such drugs or procedures may have adverse side effects including addiction, lower blood pressure, lower levels of breathing, and hastening the moment of (but not intentionally causing) my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible, and I do not want to be neglected by medical or nursing staff.

Section 2.04 Artificial Nutrition/Hydration

I authorize my Agent to determine whether artificial nutrition or hydration should be withheld or withdrawn. I request nutrition and hydration be provided in the amount and kind determined by my physician to be appropriate to prevent dehydration.

Section 2.05 Consent by Electronic Communications and Telecommunications

All health care providers are authorized to rely upon consent given by my Agent using electronic communications, telephonic communications (including telephone, emails, texts, facsimiles or any other form of communication). These instructions shall be documented in my medical records and, if requested, my Agent shall furnish written confirmation as soon as practical.

Section 2.06 Mental Health Treatment

I authorize my Agent to admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility, and a public or private treatment facility.

My Agent may consent to experimental mental health research, psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures.

Section 2.07 Admission to Care Facilities

I wish to avoid the inconvenience and expense of formal guardianship proceedings. To accomplish this purpose, my Agent is authorized to:

arrange for admission and establish my residency in a secure unit at a Care Facility within or beyond the State of Wisconsin; and

admit me for both short-term and for long term care including "protective placement."; and

facilitate my transportation to a Care Facility.

Section 2.08 Intent to Return Home

I intend to return home if I am ever in a Care Facility. I empower my Agent to convey that intention.

Section 2.09 Anatomical Gifts for Transplant Purposes

I do not authorize my Healthcare Agent to make anatomical gifts on my behalf.

Article Three
My Agent's Power to Refuse Medical Treatment

Section 3.01 Terminal Condition, Permanent Coma or Severe Dementia

I wish to live and enjoy life as long as possible, but I also recognize that in some circumstances, medical treatment is futile. I direct that my Agent make a determination as to my treatment, such as providing Feeding Tubes and Life-sustaining Procedures, and whether or not such procedures be withheld or withdrawn in the following circumstances:

if I have a Terminal Condition where Feeding Tubes and Life-sustaining Procedures only serve to postpone the moment of my death; or

if I suffer from Severe Dementia, Permanent Loss of Consciousness, or a condition from which I cannot be restored to a quality of life acceptable to me where Feeding Tubes and, Life-sustaining Procedures only serve to prolong my life.

In these circumstances, I specifically demand that my Agent make a decision consistent with my Biblical beliefs, even if the decision is contrary to any medical opinion or medical professional's recommendation.

Section 3.02 Living Will

If I have executed a Living Will, to the extent that any provisions of this Healthcare Power of Attorney are deemed to conflict with my Living Will, the provisions of my Healthcare

Power of Attorney of Attorney shall prevail, and the decisions of my Healthcare Agent shall control.

If I become unconscious or incompetent in a state where my Living Will or this Healthcare Power of Attorney is not honored, I authorize my Healthcare Agent to transport me or arrange for my transportation to a jurisdiction or location where my medical directives will be enforceable.

Article Four
Hold Harmless and Enforcement

Section 4.01 Third Parties Held Harmless

Any person or entity attempting in good faith to carry out the provisions of this Healthcare Power of Attorney shall not be liable to me, my estate, or to my heirs for any damages or claims, and my estate shall defend and indemnify them, except for willful misconduct or gross negligence.

If this Healthcare Power of Attorney is revoked or amended, any party acting in good faith prior to receipt of written notice of termination or revocation shall be held harmless by me and my estate for any loss suffered or liability incurred.

Only my Agent can exercise these powers. Third Parties shall accept the direction of my Agent as being fully authorized by me, with the same force and effect as if I were personally present and acting on my own behalf.

No person acting in reliance upon any representation my Agent makes shall incur any liability to me or my estate for permitting him or her to exercise any such power, nor shall any person who deals with my Agent be responsible to determine or inquire into the scope of my Agent's authority.

Section 4.02 My Agent Held Harmless

My Agent and my Agent's estate are hereby released and forever discharged by me from liability and claims arising out of the acts or omissions of my Agent, except for willful misconduct or gross negligence.

Section 4.03 Enforcement

My Agent may take legal action to enforce this Healthcare Power of Attorney, and may demand damages, including punitive damages, for noncompliance.

Article Five
Miscellaneous Powers and Provisions

Section 5.01 Definitions

Artificial Nutrition or Hydration means food and fluids that are provided to me by artificial means such as a nasogastric tube or tube into the stomach, intestines or veins.

Care Facility means a Skilled Nursing Facility (SNF), Assisted Living Facility (ALF), Residential Care Apartment Complex (RCAC), Community Based Residential Care Facility (CBRF), Continuum of Care Residential Facility (CCRF), Senior Housing Unit, Memory Care Facility, Drug, Alcohol or any type of Addictive Rehabilitation Facility or similar facility.

Feeding Tubes 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.

Health Care Facility means a Care Facility and a Hospital, Hospice, Medical Clinic, Doctors Office, Chiropractor, Alternative Medicine Facility, Community Based Care Facility or any Similar Facility.

Health Care means all medical treatment, the provision, withholding or withdrawal of any health care or medical procedure, or service to maintain, diagnose, treat or provide for a patient's physical or mental health or personal care, unless such authority is otherwise limited by this document.

Health Care Decision means an informed decision to accept, maintain, discontinue or refuse any care, treatment, intervention, service or procedure to maintain, diagnose or treat my physical or mental condition, subject to any statement of my desires and any limitations included in this document.

Life-sustaining Procedure means any medical procedure or intervention that, in the judgement of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient. "Life-sustaining procedure" includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis or other similar procedures, but does not include:

the alleviation of pain by administering medication; or

by performing any medical procedure; or

the provision of nutrition or hydration.

Permanent Coma or **Permanent Loss of Consciousness** means that I am not conscious and am not aware of my environment, show no behavioral response, am not able to interact with others, and there is no reasonable expectation of recovery. Permanent Coma or

Permanent Loss of Consciousness include, but are not limited to, a persistent vegetative state.

Severe Dementia means I have been diagnosed with dementia from which I cannot be expected to improve, and my condition has progressed to the point where I am unable to recognize my loved ones, or I am delusional or unresponsive on most occasions.

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

Section 5.02 Photocopies

My Healthcare Agent is authorized to make photocopies and electronic and other facsimiles of this Healthcare Power of Attorney, which shall have the full force and effect of an original.

Section 5.03 Signing Documents, Waivers and Releases

My Agent is authorized to sign any necessary documents, waivers and releases.

Section 5.04 Reimbursement of Costs

My Agent shall be entitled to reimbursement for all reasonable expenses incurred while serving as my Healthcare Agent, however my Agent shall not be entitled to compensation for services.

Section 5.05 Resignation of My Agent

Any Agent may resign by written notice delivered to me or, to the trustee of my revocable living trust, or to my agent under any power of attorney.

If my spouse has been appointed my Agent and after signing this document an action is filed to dissolve our marriage, then the filing of such action shall automatically and immediately remove my spouse as my Agent.

Section 5.06 Severability

If any provision in this document is declared by a court of competent jurisdiction to be invalid for any reason, then insofar as reasonable and possible:

> the remainder of the Agreement and the application of such provision to other persons or circumstances shall not be affected, but shall be considered valid, operative, and enforceable to the maximum extent possible under law; and

effect shall be given to the intent manifested by the portion held invalid or inoperative.

Section 5.07 Valid in Any Jurisdiction

This Healthcare Power of Attorney is intended to be valid in any jurisdiction in which it is presented.

Section 5.08 Effective Date

This Healthcare Power of Attorney takes effect upon signing. No certificate of incapacity is required to activate this Healthcare Power of Attorney.

Signature of Principal

I have read and understand the contents of this Healthcare Power of Attorney. I am emotionally and mentally competent to make this declaration. It is my intention that this document be honored by my family and health care providers as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences from such refusal. I do not intend any direct taking of my life; but only that my dying not be unreasonably prolonged. It is not my intent to authorize affirmative or deliberate acts or omissions to shorten my life, rather, only to permit the natural process of dying, in God's timing. I have voluntarily signed this Healthcare Power of Attorney. I direct that photographic or facsimile copies of this document be made which shall have the same force and effect as the original. I authorize release of copies of this document to my health care providers.

I AM AWARE THAT BY SIGNING THIS DOCUMENT I HAVE AUTHORIZED MY AGENTS TO HAVE IMMEDIATE ACCESS TO MY HEALTH CARE INFORMATION UNLESS THIS HEALTHCARE POWER OF ATTORNEY IS REVOKED.

Dated: April 30, 2024 _____

Statement of Witnesses