WYOMING ADVANCE DIRECTIVE

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Advanced Health Care Directive

Including living Wills, Durable Power of Attorney and Organ Donation

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A traditional will addresses what you want to happen to your property and minor children if you die. A living will expresses what you want to happen to you regarding medical treatment while you are alive. In Wyoming, the law also provides for a "health care power of attorney" which gives someone you trust authority to make decisions about your medical treatment in the event you cannot. (See Appendix for document)

WYOMING HEALTH CARE DECISIONS ACT OF WYOMING

The document in the Appendix of this manual, "Make Your Wishes Known", expresses the Wyoming law and includes forms that are meant to be utilized by individuals to convey their health care wishes.

Your desires may have changed since you previously generated a living will, a durable power of attorney and/or an organ donation designation. Although these documents are still valid under Wyoming law, you may wish to fill out the "Wyoming Advanced Health Care Directive" to ensure that your current wishes are adequately recorded and will be honored. If you do complete the Directive, please destroy old documents.

What is the Wyoming Health Care Decision Act?

It is a law that provides a way to make your decisions known about prolonging life when you are in a hospital and are unable to communicate or breathe on your own. Decisions on whether to prolong life can involve great turmoil and debate, and individual members of your family may not agree.

The Wyoming law provides a simple and comprehensive form for you to record your personal wishes in the event your attorney has not already drawn up a health care directive document for your benefit.

Should I have a Health Care Directive?

Yes, each of us should have a Health Care Directive as well publicized end-of-life cases have shown. Every adult, regardless of age or status of health, should have an advanced health care directive in place—just in case. It can serve as a gift to those you love. It saves them the anguish of worrying whether they are making the decision that you would have wanted.

What Does The Wyoming Advance Health Care Directive Do?

It allows you to:

1. Name an agent to make health care decisions for you if you become incapable of communicating or making your own decisions.
2. Name an alternate agent in case your first choice is not able, willing or reasonably available to make decisions on your behalf.
3. Designate the level of decision-making power of your agent (s).
4. Nominate a person to act as your guardian if a court determines that you need one.
5. Give specific instructions on whether to continue or withhold or withdraw treatment, including nutrition or hydration, as well as pain relief.
6. Express whether you wish for your organs, tissues, or entire body to be donated upon your death.
7. Designate a supervising primary health care provider to have primary responsibility for your care.

What does the Advanced Health Care Directive Replace?
It has the potential to take the place of a living will, a durable power of attorney and an organ donation designation. If you do complete the Wyoming Advanced Health Care Directive, please destroy any old documents to avoid confusion. Also, notify your designated agent, family, friends, your primary physician and your local hospital of your new advance directive.

Do I need a witness and must the document be notarized?
Yes, to both questions, and the Wyoming law also states that no matter what form you use for an advance directive, a witness may not be any of the following:
1. A health care provider
2. The agent or agents designated in your advance directive
3. An employee of a health care provider or a health care facility of which you are a patient at the time of the signing

What else should I do?
-Keep the original, signed document in a safe place. It is an important legal document.
-Let others know of the document and where it is kept.
-If you are hospitalized, take a copy of the document with you so it can be placed in your medical records.

Can I make changes to my Advanced Health Care Directive?
Yes. Remember that a new document must be witnessed or notarized for the changes to take place. To revoke your advanced directive, you must express that in writing, and it is wise to notify anyone who may have a copy of your advance directive.

Wyoming Resources include:
-AARP Wyoming – 1-866-663-3290

-Wyoming Bar Association – WyomingBar.org

-Wyoming Department of Health, Aging Division – 1-800-442-2766

-Wyoming Legal Services – 1-800-442-6170

-Wyoming Senior Citizens, Inc. 1-800-856-4398

Disclaimer
This manual is not intended to be a substitute for legal advice. It is designed to help you become familiar with some of the tools available in planning an estate, and the need to do such planning. Laws change when the Wyoming State Legislature meets and votes to change a section of the law. This publication is based on laws as they exist at the time of this document's printing.

Wyoming Advance Health Care Directive Form for:

_____

(print your full name)

Please place the completed document on the front of your refrigerator or another location where an emergency responder might easily see it.

These materials have been prepared as a public service by AARP Wyoming and are for informational purposes only and should not be construed as legal advice or as official State of Wyoming documents.

Print your full name: _____

Today's date: _____ **Initial that you have completed the page:** _____

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

PLEASE NOTE: *Answering any of the following questions is optional, but the more information you provide on this form, the better your designated agent may act on your behalf. This form is not to be used to designate a financial power of attorney. It is for health care matters only. This form is in compliance with Wyoming State Statute 35-22-401 through 416.*

(1) Designation of agent: I designate the following person as my agent to make health care decisions for me:

_____
(name of person you choose as your agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone) (cell phone)

If I revoke my agent's authority, or if my agent is not willing, able or reasonably available to make a health-care decision for me, **I designate as my alternate agent:**

_____
(name of person you choose as your alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone) (cell phone)

(2) Agent's authority: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care, except as I state here:

_____

_____

_____
(Add additional sheets if needed.)

(3) When agent's authority becomes effective: My agent's authority to make health care decisions for me takes effect at the following time (**check and initial only one (1) option**):

Check Initial

☐ _____ If I check the box and initial**,** my agent's authority to make health care decisions for me becomes effective only when my primary physician or, in his/her absence, my treating primary health care provider determines that I lack the capacity to make my own health care decisions; **OR**

☐ _____ If I check the box and initial**,** my agent's authority to make health care decisions for me becomes effective only when my primary physician (and **not** when any then treating health care provider of mine) determines that I lack the capacity to make my own health care decisions; **OR**

☐ _____ If I check the box and initial**,** my agent's authority to make health care decisions for me becomes effective as necessary immediately upon my execution of this Advance Health Care Directive Form.

(4) Agent's obligation: My agent shall make health care decisions for me in accordance with this power of attorney for health care using any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent that my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

Print your full name: _____

Today's date: _____ **Initial that you have completed the page:** _____

PART 2: INSTRUCTIONS FOR HEALTH CARE

(5) End-of-Life decisions: I direct that those involved in my care provide, withhold or withdraw treatment in accordance with the choice I have checked and initialed below (check and initial only one option):

Check Initial

☐ _____ (a) **Choice to Prolong Life:** I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

OR

☐ _____ (b) **Choice Not to Prolong Life:** I do not want my life to be prolonged if:

(i) I have an incurable and irreversible condition that will result in my death within a relatively short time;

(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness;

(iii) The likely risks and burdens of treatment would outweigh the expected benefits.

(6) Artificial nutrition and hydration: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (5) unless I have checked and initialed **one** of the boxes below:

Check Initial

☐ _____ I **want** artificial nutrition regardless of my condition.

☐ _____ I **do NOT** want artificial nutrition regardless of my condition.

☐ _____ I **want** artificial hydration regardless of my condition.

☐ _____ I **do NOT** want artificial hydration regardless of my condition.

Print your full name: _____
Today's date: _____ **Initial that you have completed the page:** _____

(7) Relief from pain:

Check **Initial**

☐ _____ I **want** treatment for the alleviation of pain or discomfort at all times;

OR

☐ _____ I **do NOT** want treatment for the alleviation of pain or discomfort.

(8) Other wishes: (If you do not agree with the choices above, you may write your own or add to the instructions above. Examples may include: blood or blood products; chemotherapy; simple diagnostic tests; invasive diagnostic tests; minor surgery; major surgery; antibiotics; oxygen; wish to die at home if possible; etc.) I direct that:

_____

_____

_____

_____

PART 3: DONATION OF ORGANS AND TISSUES UPON DEATH

(9) Upon my death (check and initial applicable boxes):

Check **Initial**

☐ _____ (a) I have arranged to give my body to science.

☐ _____ (b) I have arranged through the Wyoming Donor Registry to give any needed organs and/or tissues (For enrollment information, call 1-888-868-4747 or visit WyomingDonorRegistry.org).

☐ _____ (c) **I do NOT** wish to donate my body, organs and/or tissues.

Print your full name: _____
Today's date: _____ **Initial that you have completed the page:** _____

PART 4: INFORMATION ABOUT MY HEALTH CARE PROVIDER

(10) The following physician is my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

More information about my health care can be obtained through:

_____
(name of health care institution/hospice)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

(11) Effect of copy: A copy of this form has the same effect as the original.

SIGNATURE (Sign and date the form here):

_____
(print your name)

_____
(sign your name) (date)

_____
(address)

_____
(city) (state) (zip code)

SIGNATURES OF WITNESSES or NOTARY PUBLIC:

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is known to me to be the principal, and that the principal signed or acknowledged this document in my presence.

Please Note: *Under Wyoming State Statute 35-22-403 (b), a witness may not be a treating health care provider, operator of a treating health care facility or an employee of a treating health care facility.*

First witness

_____ _____
(print witness' name) (address)

_____ _____
(signature of witness) (date)

Second witness

_____ _____
(print witness' name) (address)

_____ _____
(signature of witness) (date)

OR

Notary (in lieu of witnesses)

State of Wyoming

County of_____ } SS.

Subscribed and sworn to and acknowledged before me by_____,
the Principal, this _____ day of _____, _____.

My commission expires: _____.

_____
Notary Public's signature

Wyoming Advance Health Care Directive Form

Guidance and Glossary

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs.

Unless you state otherwise, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. Unless you limit the authority of your agent, your agent will have the right to:

a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

b) Select or dismiss health-care providers and institutions;

c) Approve or deny diagnostic tests, surgical procedures, medication and orders not to resuscitate; and

d) Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

If you use this form, you may choose whether to complete all or any part of it or you may modify any part of it. You also are free to use a different form.

Once you have completed the form:

Give a copy of the signed and completed form to your primary physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named.

Post a copy of the form on the front of your refrigerator or another location where an emergency responder will easily see it.

You should talk to the person you have named as agent to make sure that he or she fully understands your wishes and is willing to take the necessary responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

Glossary of Advance Health Care Directive Terms

Advance Health Care Directive: A general term describing two kinds of legal documents, an individual's instruction and a power of attorney for health care. These documents allow a person to give instructions about future medical care in case they are unable to participate in medical decisions due to serious illness or incapacity.

Agent is a person designated in a power of attorney for health care to make health-care decisions for the person granting the power.

Artificial nutrition and hydration: Supplying food and water through a conduit, such as a tube or an intravenous line where the recipient is not required to chew or swallow voluntarily, including, but not limited to, nasogastric tubes, gastrostomies, jejunostomies and intravenous infusions. Artificial nutrition and hydration does not include assisted feeding, such as spoon or bottle feeding.

Capacity: An individual's ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health-care decision.

Health care: Any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

Health care decisions: A decision made by an individual or the individual's agent, guardian, or surrogate, regarding the individual's health care, which may include: a) Selection and discharge of health care providers and institutions; b) Approval or denial of diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and c) Directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care.

Health care institution: An institution, facility or agency licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business.

Hospice: An institution or service that provides palliative care when medical treatment is no longer expected to cure the disease or prolong life.

Individual Instruction: An individual's wishes concerning a health-care decision for the individual.

Glossary of Advance Health Care Directive Terms - Continued

Notary Public: A person who administers oaths, certifies documents, takes affidavits, and attests to the authenticity of signatures.

Physician: An individual authorized to practice medicine under the Wyoming Medical Practice Act.

Principal: The person who gives authority to an agent to make health-care decisions in the event that he or she becomes incapacitated. Also, the person for whom the advance health care directive has been created.

Power of Attorney for Health Care: The designation of an agent to make health-care decisions for the individual granting the power. This type of advance directive might also be called a health care proxy, or durable power of attorney for health care.

Health care provider: Any person licensed under the Wyoming statutes practicing within the scope of that license as a licensed physician, licensed physician's assistant or licensed advanced practice registered nurse.

Primary physician: A physician designated by an individual or the individual's agent, guardian or surrogate to have primary responsibility for the individual's health care or, in the absence of a designation, or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

CRITICAL STEP:
SHARE YOUR COMPLETED DOCUMENT!

Your document is only helpful if people know where to find it when it is needed. It's important to discuss the decisions outlined in your document with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your document once it has been completed and satisfies the legal requirements for your state (if applicable).

WHO NEEDS A COPY OF YOUR DOCUMENT?

- Anyone assigned a decision-making role in the document
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

HOW TO SHARE YOUR DOCUMENT

1) **Use Cake!** Upload your document to a free Cake account for safekeeping. Share 24/7 secure document access with anyone that has an email address*

   Create your free Cake account: www.joincake.com/share-free

2) **Or, print** and provide copies to everyone who needs one

WHY PLAN & SHARE WITH CAKE?

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print all your end-of-life documents
- Share 24/7 document access with anyone that has an email address*

Create your free Cake account: www.joincake.com/share-free

** Some healthcare providers may require a paper copy of your document to be able to enter it into their records.*