

WYOMING

Advance Directive

Planning for Important Healthcare Decisions

Courtesy of CaringInfo

www.caringinfo.org

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR WYOMING ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, the **Wyoming Advance Health Care Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Part 1, the Wyoming Power of Attorney for Health Care, lets you name someone, called your “agent,” to make decisions about your health care—including decisions about life support—if you can no longer speak for yourself, or immediately if you specify this in your document. The Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you lack the capacity to make your own health care decisions, not only at the end of life.

Part 2, the Wyoming Instructions for Health Care, functions as your state’s living will. It lets you state your wishes about health care in the event that you lack the capacity to make your own health care decisions.

Part 3, Donation of Organs at Death, is an optional section that authorizes the donation of your organs at death.

Part 4, Primary Physician, is an optional section that allows you to designate your primary physician.

Part 5, Execution, contains the signature and witnessing provisions to make your advance health care directive valid.

You must complete Part 1, Part 2, or both, depending on your advance-planning needs in order to have a valid advance health care directive. Part 3 and Part 4 are optional. **You must complete Part 5.**

How do I make my Wyoming Advance Health Care Directive legal?

You must sign and date your advance directive or direct someone to do so for you if you are unable to sign it yourself. Your signature must be witnessed by a notary public or by two witnesses. If witnessed, your witnesses may not be:

- your treating health care provider or an employee of the provider;
- your agent, if you appoint one;
- the operator of a community care facility or employee of the operator or facility; or
- the operator of a residential care facility or employee of the operator or facility.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Your agent cannot be an owner, operator, or employee of a residential or community care facility at which you are receiving care, unless that person is related to you by blood, marriage, or adoption.

Should I add personal instructions to my advance health care directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Unless you make it effective immediately, Part 1, your **Power of Attorney for Health Care** becomes effective when your doctor certifies in writing that you lack the ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate your health care decisions.

Part 2, Your **Instructions for Health Care**, become effective when your doctor determines that you lack the capacity to make health care decisions.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent will be bound by the current laws of Wyoming as they regard pregnancy and termination of pregnancies.

What if I change my mind?

So long as you have capacity to make your own decisions, you may revoke all or part of your advance health care directive, other than the designation of an agent in Part I, at any time and in any manner that communicates an intention to revoke. Any oral revocation should, as soon

as possible after the revocation, be documented in a signed and dated writing. You may revoke the designation of your agent (in Part I) only by a signed and dated writing and only as long as you have capacity to make your own decisions.

A decree of annulment, divorce, dissolution of marriage, or legal separation revokes the designation of your spouse as agent, unless you otherwise specify in your advance health care directive.

An advance health care directive that conflicts with an earlier directive revokes the earlier directive to the extent of the conflict.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

WYOMING ADVANCE HEALTH CARE DIRECTIVE – PAGE 1 OF 8

PRINT YOUR NAME
AND THE DATE

PART 1

PRINT NAME,

ADDRESS AND
TELEPHONE
NUMBERS OF
YOUR PRIMARY
AGENT

PRINT NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF
YOUR FIRST
ALTERNATE AGENT

PRINT NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF
YOUR SECOND
ALTERNATE AGENT

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Revised.

I, _____(print name), make
this Advance Health Care Directive on _____(print date).

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as
my agent to make health care decisions for me:

(name of individual you choose as agent)

(address, city, state, zip code)

(home phone and work phone)

OPTIONAL: 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 first alternate agent:

(name of individual you choose as agent)

(address, city, state, zip code)

(home phone and work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate
agent or if neither is willing, able or reasonably available to make a
health care decision for me, I designate as my second alternate agent:

(name of individual you choose as agent)

(address, city, state, zip code)

(home phone and work phone)

INITIAL THE BOX
ONLY IF YOU WISH
YOUR AGENT'S
AUTHORITY TO
BECOME EFFECTIVE
IMMEDIATELY

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 3 OR 4 THAT DO NOT REFLECT YOUR WISHES.

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(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 to keep me alive, except as I state here:

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician or supervising health care provider determines that I lack the capacity to make my own health care decisions unless I initial the following box. If I initial this box [☐], my agent's authority to make health care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this Power of Attorney for Health Care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent 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.

INITIAL ONLY ONE

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, (please initial one of the following):

[☐] I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

[☐] I nominate the following to be guardian in the order designated:

(name, address and phone of individual designated as guardian)

(name, address and phone of second alternate designated as guardian)

[☐] I do not nominate anyone to be guardian.

PART 2

STRIKE THROUGH
AND INITIAL ANY
LANGUAGE THAT
DOES NOT REFLECT
YOUR WISHES

INITIAL ONLY ONE

INITIAL THE BOX
ONLY IF YOU WANT
ARTIFICIAL
NUTRITION AND
HYDRATION
REGARDLESS OF
YOUR MEDICAL
CONDITION

PART 2: INSTRUCTIONS FOR HEALTH CARE

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my health care provide, withhold or withdraw treatment in accordance with the choice I have initialed below:

[☐] (a) **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, or
- (iii) the likely risks and burdens of treatment would outweigh the expected benefits.

OR

[☐] (b) **Choice to Prolong Life** – I want my life to be prolonged as long as possible within the limits of generally accepted health care standards

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I initial the following box. If I initial this box [☐], artificial hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times:

ADD OTHER
INSTRUCTIONS, IF
ANY, REGARDING
YOUR ADVANCE
CARE PLANS

THESE

INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH
ADDITIONAL PAGES
IF NEEDED

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

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Revised.

(Add additional sheets if needed.)

PART 3

IF YOU DO NOT
WISH TO DONATE
ORGANS, DO NOT
COMPLETE PART 3

OTHERWISE INITIAL
THE STATEMENTS
THAT REFLECT
YOUR INTENT AND
CROSS OUT ANY
STATEMENTS THAT
DO NOT REFLECT
YOUR INTENT

PART 3: DONATION OF ORGANS AT DEATH (OPTIONAL)

(10) UPON MY DEATH (initial applicable box):

[☐] (a) I give my body; or

[☐] (b) I give any needed organs, tissues or parts; or

[☐] (c) I give the following organs, tissues or parts only:

(d) My gift is for the following purpose (strike and initial any of the following you do NOT want)

- (i) Any purpose authorized by law;
- (ii) Transplantation;
- (iii) Therapy;
- (iv) Research;
- (v) Medical education.

PART 4

IF YOU DO NOT
WANT TO NAME A
PRIMARY
PHYSICIAN, DO NOT
COMPLETE PART 4.

OTHERWISE, PRINT
THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF YOUR
PRIMARY
PHYSICIAN AND
ANY ALTERNATE
PRIMARY
PHYSICIAN.

PART 4: PRIMARY PHYSICIAN (OPTIONAL)

(11) PRIMARY PHYSICIAN: I designate the following physician as my primary physician:

(name, address and phone of primary physician)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following as my primary physician:

(name, address and phone of alternate primary physician)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

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PART 5

SIGN AND DATE
AND PRINT YOUR
NAME AND
ADDRESS

PART 5. EXECUTION

Sign: _____ Date: _____

Print Name: _____

Residence Address: _____

WITNESS STATEMENT

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this document in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a treating health care provider, an employee of a treating health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility or an employee of an operator of a residential care facility.

WITNESSES

Witness #1:

Sign: _____ Date: _____

Print Name: _____

Residence Address: _____

Witness #2:

Sign: _____ Date: _____

Print Name: _____

Residence Address: _____

HAVE YOUR
WITNESSES SIGN
AND DATE THE
DOCUMENT AND
PRINT THEIR NAME
AND ADDRESS HERE

—OR—

—OR—

HAVE A NOTARY
PUBLIC FILL OUT
THIS SECTION

SIGNATURE OF NOTARY PUBLIC IN LIEU OF WITNESSES

The State of Wyoming

County of _____

Subscribed, sworn to, and acknowledged before me by

_____, the principal, this

____ day of _____, 20____.

(SEAL) _____

Courtesy of CaringInfo
www.caringinfo.org