

WYOMING

Advance Directive

Planning for Important Health Care Decisions

CaringInfo
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CARINGINFO

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- Learn** about options for end-of-life services and care
- Implement** plans to ensure wishes are honored
- Voice** decisions to family, friends and health care providers
- Engage** in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
2. These materials include:
 - 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.

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 the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care 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 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. 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.

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.

Unless you make it effective immediately, 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, 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.

Your Instructions for Health Care become effective when your doctor determines that you lack the capacity to make 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.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old) or an emancipated minor.

Instructions for your Wyoming Advance Health Care Directive

How do I make my 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 health care 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 health care 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 directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

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.

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PRINT YOUR NAME
AND THE DATE

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

PART 1

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:

PRINT NAME,

ADDRESS AND
TELEPHONE
NUMBERS OF
YOUR PRIMARY
AGENT

(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:

PRINT NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF
YOUR 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:

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

(name of individual you choose as agent)

(address, city, state, zip code)

(home phone and work phone)

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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 alternate 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).

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—

HAVE A NOTARY
PUBLIC FILL OUT
THIS SECTION

—OR—

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) _____

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Palliative Care
Organization.
2019 Revised.

Courtesy of CaringInfo
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www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your Wyoming Advance Health Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in 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.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Wyoming document.
7. Be aware that your Wyoming document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of \$35, \$50 or \$100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation.** Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.



YES! I want to support the important work of the National Hospice Foundation.

\$35 helps us provide webinars to hospice professionals

\$50 helps us provide free advance directives

\$100 helps us maintain our free InfoLine

\$_____ to support the mission of the National Hospice Foundation.

Return to:
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Philadelphia, PA 19182-4401



OR donate online today: www.NationalHospiceFoundation.org/donate