

**JEANNE M. CASSEL**

**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, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON 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.

## POWER OF ATTORNEY FOR HEALTH CARE

Document made this 13th day of October, 2017.

### CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, **Jeanne M. Cassel**, 5307 Robin Drive, Greendale, WI 53129, (414) 507-6927 (cell), Date of Birth: December 16, 1942, 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 my spouse, **Edward R. Cassel**, 5307 Robin Drive, Greendale, WI 53129, (414) 507-6923 (cell), to be my health care agent for the purpose of making health care decisions on my behalf. If he is ever unable or unwilling to do so, I hereby designate my son, **Edward J. Cassel**, 1333 Madison Avenue, South Milwaukee, WI 53172, (414) 232-6273, to be my alternate health care agent for the purpose of making health care decisions on my behalf. If he is ever unable or unwilling to do so, I hereby designate my sister-in-law, **Barbara Gruenwald**, 3363 N. 45<sup>th</sup> Street, Milwaukee, WI 53216, (414) 442-4043, to be my alternate health care agent for the purpose of making health care decisions on my behalf. If she is ever unable or unwilling to do so, I hereby designate my brother, **Robert J. Bahr**, 16001 N. 99<sup>th</sup> Drive, Sun City, AZ 85351, (602) 908-2247, 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 agents whom I have designated are 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 healthcare 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  N/A

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): See Attached

**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:

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

**SIGNATURE OF PRINCIPAL**

(Person creating the Power of Attorney for Health Care)

Signature  Date: October 13, 2017  
Jeanne M. Cassel

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

**STATEMENT OF WITNESSES**

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

I know the principal personally and I believe the principal to be of sound mind and at least 18 years of age. I believe that the principal's 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 employee of the health care provider, other than a chaplain or a social worker, or an employee, 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 No. 1 (Print) Name: **Sumeeta A. Krishnaney**  
250 E. Wisconsin Avenue, Suite 1000  
Milwaukee, WI 53202

Signature  Date: October 13, 2017

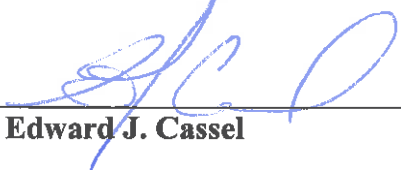
Witness No. 2 (Print) Name: **Silvia D. Robey**  
250 E. Wisconsin Avenue, Suite 1000  
Milwaukee, WI 53202

Signature  Date: October 13, 2017

**STATEMENT OF HEALTH CARE AGENT AND ALTERNATE  
HEALTH CARE AGENT**

I understand that **Jeanne M. Cassel** has designated me to be her health care agent or alternate health care agent if she is ever found to have incapacity and unable to make health care decisions herself. **Jeanne M. Cassel** has discussed her desires regarding health care decisions with me.

Agent's Signature   
**Edward R. Cassel**

Alternate's Signature   
**Edward J. Cassel**

Alternate's Signature Barbara Gruenwald  
Barbara Gruenwald

Alternate's Signature Robert J. Bahr  
Robert J. Bahr

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           *Jeanne Cassel*            
          Jeanne M. Cassel

Date: October 13, 2017

**Attachment to Power of Attorney for Health Care for Jeanne M. Cassel**

**STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS**

- A. Although I desire to live and enjoy life as long as possible, I also believe that there are many alternatives far more difficult and less acceptable to me than my death. Therefore, it is my desire that my life not be prolonged and I do not want to receive life-sustaining treatment if two physicians, who have personally examined me, one of whom is my attending physician, determine that either of the following conditions exist:
- (1) I have an incurable or irreversible injury or illness which the physicians have determined to be a terminal condition and that my death will occur within a relatively short time so that the application of life-sustaining procedures would serve only to prolong artificially the dying process.
  - (2) I am in a coma or persistent vegetative state which is reasonably concluded to be irreversible and the physicians believe, within their reasonable medical judgment, that I will not regain cognitive brain function or otherwise be able to interact with others.
- B. If the physicians determine that either of the conditions described in Paragraph A, above, exist, then my health care agent is directed to act as follows:
- (1) To direct that treatment or procedures that will only postpone the moment of my death or prolong an irreversible coma or persistent vegetative state not be started, or, if previously started, direct that they be discontinued.
  - (2) To sign on my behalf any documents necessary to carry out the powers granted in this Section (including waivers and releases of liability required by any health care provider or any documents titled or purporting to be a "consent to permit

treatment," "refusal to permit treatment," or "leaving hospital against medical advice.")

- (3) To direct and consent to the writing of a No Code or Do Not Resuscitate order by any health care provider.
- (4) To direct or order whatever is appropriate to keep me as comfortable and free of pain as is reasonably possible, including the administration of pain-relieving drugs of any kind or other surgical or medical procedures calculated to relieve my pain, including unconventional pain relief therapies that my agent believes may be helpful, even though such drugs or procedures or therapies may lead to permanent physical damage or addiction, or hasten the moment of my death.