

NOTICE TO THE INDIVIDUAL SIGNING THE POWER OF ATTORNEY FOR HEALTH CARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your “health care agent.” Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an “advance directive.” You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision making authority once this document goes into effect, in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

- (i) What is most important to you in your life?**
- (ii) How important is it to you to avoid pain and suffering?**
- (iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?**
- (iv) Would you rather be at home or in a hospital for the last days or weeks of your life?**
- (v) Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?**
- (vi) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?**
- (vii) Do you have an existing advanced directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.**

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

- (i) talk with physicians and other health care providers about your condition.
- (ii) see medical records and approve who else can see them.
- (iii) give permission for medical tests, medicines, surgery, or other treatments.
- (iv) choose where you receive care and which physicians and others provide it.
- (v) decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.
- (vi) agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.
- (vii) decide what to do with your remains after you have died, if you have not already made plans.
- (viii) talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your health care expenses.

WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

- (i) is at least 18 years old;
- (ii) knows you well;
- (iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;
- (iv) would be comfortable talking with and questioning your physicians and other health care providers;
- (v) would not be too upset to carry out your wishes if you became very sick; and
- (vi) can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a “surrogate.” There are reasons why you may want to name an agent rather than rely on a surrogate:

- (i) The person or people listed by this law may not be who you would want to make decisions for you.
- (ii) Some family members or friends might not be able or willing to make decisions as you would want them to.
- (iii) Family members and friends may disagree with one another about the best decisions.
- (iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes.

You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or on-line resources to guide you through this process.

WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

- (i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.
- (ii) Ask the witness to sign it, too.
- (iii) There is no need to have the form notarized.
- (iv) Give a copy to your agent and to each of your successor agents.

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- (v) Give another copy to your physician.
- (vi) Take a copy with you when you go to the hospital.
- (vii) Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you, designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory health care power. If you have questions about the use of any form, you may want to consult your physician, other health care provider, and/or an attorney.

MY POWER OF ATTORNEY FOR HEALTH CARE

**THIS POWER OF ATTORNEY REVOKES ALL
PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE.**

My name: [PRINCIPAL]
My address: [CLIENTADDRESS]

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT
(an agent is your personal representative under state and federal law):

(Agent name): [PRINCIPALAGENT]
(Agent address): [PRIMARYAGENTADDRESS]
Phone: _____

SUCCESSOR HEALTH CARE AGENT(S) (optional)

If the agent selected by me is unable or does not want to make health care decisions for me, I name below to be my successor health care agent(s). Only one person at a time can serve as my agent:

[AGENT2] of _____.

[AGENT3] of _____.

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

- (i) Deciding to accept, withdraw, or decline treatment for any physical ~~or mental~~ condition of mine, including life-and-death decisions.
- (ii) Agreeing to admit me to or discharge me from any hospital, ~~home, or other institution, including a mental health facility.~~

_____ I specifically authorize my agent to make a temporary residential placement decision on my behalf for up to 90 days to allow my medical, mental health and cognitive condition to be appropriately evaluated after my condition has been stabilized as to medical problems, nutrition, medications, hygiene, mobility, deficient home environment, mental health, and other appropriate factors. During this 90 day period I will not be able to revoke my Power of Attorney.

- (iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die, **within appropriate parameters as set forth below.**

(iv) *If I have executed a Mental Health Treatment Preference Declaration that document shall be used for determination of mental health treatment decisions to the fullest extent possible. If I have not executed a Mental Health Treatment Preference Declaration, my agent, to the fullest extent possible under the Illinois Mental Health Code, may authorize the administration of psychotropic medications or electroconvulsive therapy (ECT) under 405 ILCS 5/2-102(a-5).*

(v) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole body donation, autopsy, cremation, and burial. See below for specific instructions on organ donation.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

I AUTHORIZE MY AGENT TO (please check any one box):

Make decisions for me only when I cannot make them for myself. The physician taking care of me will determine when I lack this ability. **This will include but is not limited to whether: I lack a) the capacity to give informed consent to appropriate health care matters or, b) the ability to understand and appreciate the nature and consequences of a decision regarding forgoing life-sustaining treatment and the ability to reach and communicate an informed decision in the matter.**

I ___ do ___ do not want my agent to have access to my medical records prior to when my agent is authorized to make decisions on my behalf. Any records authorization shall only be effective as to my primary agent, unless the primary agent is permanently unable to attend to his or her duties under this power of attorney.

~~Starting now,~~ *If I allow my agent to have access to my medical records commencing at time of execution of this instrument, for the purpose of assisting me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, subject to restrictions set forth below, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself.*

(If no box is checked, then the box above shall be implemented.) OR

Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

If I have chosen the first option, the authorization under this power of attorney shall no longer be in effect at such time as my primary treating physician or another licensed physician certifies that I have regained the ability to make informed decisions concerning my health care and medical treatments.

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf. **A Supplement is attached to this Healthcare Power of Attorney on this important subject.**

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Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

**SELECT ONLY ONE STATEMENT BELOW
THAT BEST EXPRESSES YOUR WISHES (optional):**

The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

I limit the authorization of my agent to share records as set forth below:

RECORDS:

During my lifetime:

My agent is authorized to share all standard medical information with healthcare providers and residential institutions. In addition, the agent may, in his/her discretion, share standard medical information with immediate family members.

My agent is authorized to share genetic information with my relatives and healthcare providers.

My agent is authorized to share mental health information and records with healthcare providers, residential institutions, and appropriate providers under the Mental Health and Developmental Disabilities Confidentiality Act. Therapist/Psychotherapist notes shall only be shared as absolutely necessary.

HIV/AIDS related health information and/or records and drug/alcohol diagnosis and treatment information shall only be shared, as necessary, with healthcare providers and residential institutions.

After my death:

My agent shall share standard medical information and genetic information with my immediate family. Disclosure of all other records shall terminate and will be subject to the authority and discretion of my executor or administrator.

Other Exclusions:

If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security. If an agent is advised of a guardianship petition and does not contest the appointment of a guardian of the person then the guardian of the person shall assume all of the duties of the agent under this power of attorney.

My signature: _____

Today's date: _____, 20__.

**HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW,
AND THEN COMPLETE THE SIGNATURE PORTION:**

I am at least 18 years old. (Check one of the options below):

I saw the principal sign this document, or

The principal told me that the signature or mark on the principal signature line is his or hers. I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, advanced practice nurse, dentist, podiatric physician, optometrist, psychologist, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness's printed name and address:

Daniel G. Deneen

207 W. Jefferson St., Ste. 603

P.O. Box 3575

Bloomington, IL 61702-3575

Witness signature: _____

Today's date: _____, 20__.

This form has been prepared by the Law Office of Daniel G. Deneen. The principal has had an opportunity to review the above form and has signed the form or acknowledged his or her signature or mark on the form in the presence of Daniel G. Deneen or his staff. Sections in bold or *italics* are additions or modifications to the statutory form.

OTHER INSTRUCTIONS

My agent shall make anatomical gift as follows:

- Any organs, tissues or eyes suitable for transplantation or used for research or education.
- Any organs, tissues or eyes suitable for transplantation.
- Specific organs: _____.
- My entire body
- No organs.

I have made funeral and/or burial arrangements already with (funeral) _____ (burial) _____.

I have not made funeral arrangements.

- I want my remains embalmed and buried at _____.
- I want my remains cremated and my ashes buried at _____ or given to _____.

CERTIFICATION OF SIGNATURES:

Specimen signatures of agent (and successors)

I certify that the signatures of my agent (and successors) are correct.

[PRINCIPALAGENT]

[PRINCIPAL]

[AGENT2]

[PRINCIPAL]

[AGENT3]

[PRINCIPAL]

The certification of the signatures of my agents is not required to allow this Health Care Power of Attorney to be effective.

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HEALTH CARE POWER OF ATTORNEY SUPPLEMENT

I hereby instruct my agent and physicians that life-sustaining/“death delaying” procedures **not be used to delay my death but only to help me to recover from illness, injury or surgery, including anesthesia.** If I have a terminal condition, and do not have decisional capacity, as defined in the Illinois Healthcare Surrogate Act, then I provide the following directions to my agent, to be followed by my physician(s) or other healthcare providers:

- I DO DO NOT want my agent to execute a Do Not Resuscitate Order.
- I DO DO NOT want my agent to withhold or withdraw Artificial Nutrition.
- I DO DO NOT want my agent to withhold or withdraw Artificial Hydration.
- I DO DO NOT want my agent to authorize appropriate terminal pain management and palliative care, preferably in conjunction with a hospice program.

If I have a terminal condition, and do not have decisional capacity, as defined in the Illinois Healthcare Surrogate Act, then I provide the following directions to my agent, to be followed by my physician(s) or other healthcare providers, as to whether the medical procedures or treatments shall or shall not be approved.

- My agent SHALL SHALL NOT authorize the use of Assisted Ventilation.
- My agent SHALL SHALL NOT authorize the use of Blood Transfusions.
- My agent SHALL SHALL NOT authorize the initiation or continuance of chemotherapy or radiation for cancer.
- My agent SHALL SHALL NOT authorize the use of Assisted Kidney Treatments.
- My agent SHALL SHALL NOT authorize the use of antibiotics if I have gross mental incapacity, including but not limited to the inability to recognize or effectively communicate with family or friends, for 3 weeks.

This list is not meant to be exclusive, but only to list the most common life-sustaining/death delaying procedures, including those listed in the Illinois Living Will Act. For ethical conflicts my agent shall follow the guidelines of the following established religious organization: _____

If I have a terminal illness with a life expectancy of under six months my agent should enroll me in the OSF (St. Joseph Hospital) Hospice Program, the Carle BroMenn Hospital Hospice program, or another Hospice Care Program, if I meet the other criteria of the Hospice Care Program. I understand that hospice programs offer “comfort care” and the alleviation of pain, and that this might lead to a shortening of my life, especially if combined with a cessation of medical treatments for the underlying terminal condition.

At such point in time the **quality of my life, rather than quantity**, should be the prime consideration. I wish to avail myself of the less invasive nature of a hospice care program, as well as alternative pain management and support of my caregivers.

I understand that by initialing the shaded areas I have instructed my agent(s) and physicians to minimize medical procedures if I have a terminal condition.

Dated: _____

Print Name

Witness: _____

X _____