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 healthcare 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 healthcare agent. Your agent is the person you trust to make healthcare decisions for you if you're unable or don't want to make them yourself. These decisions should be based on your personal values and wishes.

It's 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 online 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 HEALTHCARE 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're 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 healthcare interventions or withdraw treatment. Your agent will need to think about conversations you've had, your personality and how you handled important healthcare issues in the past. Therefore, it's 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 advance directive, such as a living will, that contains your specific wishes about healthcare 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.

520-0322

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there's ever a period of time when your physician determines that you can't make your own healthcare decisions, or if you don't want to make your own decisions, some of the decisions your agent could make are to:

(i) Talk with physicians and other healthcare 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're 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 haven't already made this decision yourself. This could include donation for transplant, research and/or education. You should let your agent know whether you're 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've died, if you haven't 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 healthcare expenses.

WHOM SHOULD I CHOOSE TO BE MY HEALTHCARE AGENT?

You can pick a family member, but you don't 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're 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 healthcare providers.

(v) Wouldn't be too upset to carry out your wishes if you became very sick.

(vi) Can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT ISN'T 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 isn't 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 backup 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 DON'T CHOOSE A HEALTHCARE AGENT?

If you become unable to make your own healthcare decisions and have not named an agent in writing, your physician and other healthcare 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'S NO ONE AVAILABLE WHOM I TRUST TO BE MY AGENT?

In this situation, it's especially important to talk to your physician and other healthcare providers and create written guidance about what you want or don't want, in case you're ever critically ill and can't 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 healthcare provider and ask him or her to write it down in your chart. You might also want to use written or online resources to guide you through this process.

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

Follow these instructions after you've completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and can't 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.

(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 DON'T WANT TO USE THIS FORM?

In the event you don't 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 healthcare power.

If you have questions about the use of any form, you may want to consult your physician, other healthcare provider and/or an attorney.

Name:______________________________

MRN:_______________________________

Date of Birth:______________________

MY POWER OF ATTORNEY FOR HEALTH CARE

POA

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

My name (print):____ Date of Birth:____________________

Address:____ Phone:____________________

I WANT THE FOLLOWING PERSON TO BE MY HEALTHCARE AGENT:

(An agent is your personal representative under state and federal law.)

Agent name:____

Agent phone number: Cell ____________________ Work ____________________ Home ____________________

Agent address:____

SUCCESSOR HEALTHCARE AGENT(S):

If the agent I selected is unable or does not want to make healthcare decisions for me, then I request the person(s) I name below to be my successor healthcare agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

Successor agent #1 name:____ Phone:____________________

Address:____

Successor agent #2 name:____ Phone:____________________

Address:____

MY AGENT CAN MAKE HEALTHCARE 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.

iii. Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

iv. 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.

I AUTHORIZE MY AGENT TO:

(Select only one statement. If multiple or none are selected, then option 1 will be used.)

☐ 1. Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

OR

☐ 2. Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. But starting now, for the purpose of assisting me with my healthcare plans and decisions, my agent shall have (1) complete access to my medical and mental health records, (2) the authority to share them with others as needed, and (3) the complete ability to communicate with my personal physician(s) and other healthcare providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself.

OR

☐ 3. 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. This authority includes having complete access to my medical records, authority to share my records, and communicate with my physician(s) as stated in option #2.

Check box if applicable (optional):

☐ If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

Name:____________________________

MRN:_____________________________

Date of Birth:______________________

MY POWER OF ATTORNEY FOR HEALTH CARE

LIFE-SUSTAINING 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.

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 healthcare 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.

OR

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of procedures, or how unlikely my chances are for recovery. 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 healthcare decisions on your behalf. If you wish to limit the scope of your agent's power, prescribe special rules, or limit the power to authorize an autopsy or dispose of remains, you may do so on the lines below or add another page if needed.

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YOU AND A WITNESS MUST SIGN THIS FORM BEFORE IT IS VALID.

My signature:____Today's date:__________________

WITNESS MUST AGREE TO THE FOLLOWING AND SIGN BELOW (REQUIRED):

- I am at least 18 years of age AND either I saw the principal sign this document OR the principal told me that the signature or mark on the principal signature line is his/hers. The principal is known to me and I believe him/her to be of sound mind.
- 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 registered nurse, physician assistant, dentist, podiatrist, 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 healthcare facility where the principal is a patient or resident.

Witness printed name:____ Phone:______________________

Witness address:____

Witness signature:____ Today's date:__________________