

Notice to the Individual Signing the Power of Attorney for Health Care

This form meets the requirements of the Illinois Power of Attorney for Health Care Act (as of 7/1/11 rev.)

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 Power of Attorney 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 Illinois' legal requirements. 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?

Your agent will need to think about conversations you have had, your personality and how you handled important issues in the past. It is important to talk with your agent and your family about such things as:

- What is most important to you in your life?
- How important is it to you to avoid pain and suffering?
- If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?
- Would you rather be at home or in a hospital for the last days or weeks of your life?
- Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?

What kind of decisions can my agent make?

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

- Talk with doctors and other health care providers about your condition.
- See medical records and approve who else can see them.
- Give permission for medical tests, medicines, surgery or other treatments.
- Choose where you receive care and which doctors and others provide it.
- Decide about 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.
- Agree or decline to donate your organs if you have not already made this decision yourself. This could include donation for transplant, research and/or education.
- Decide what to do with your remains after you have died, if you haven't already made plans.
- Talk with your other loved ones to help come to a decision (but the agent has the final say).

Your agent is not automatically responsible for your healthcare expenses.

Whom should I choose to be my health care agent?

You can pick a family member, but you don't have to. Your agent will have the responsibility to make medical treatment decisions together with your doctor and other professionals, even if other people close to you might urge a different decision. Choose a family member or friend who:

- Is at least 18 years old.
- Knows you well.
- You trust to do what is best for you and is willing to carry out your wishes, even if your agent may not agree with your wishes.
- Would be comfortable talking with and questioning your doctors and other health care providers.
- Would not be too upset to carry out your wishes if you became very sick.
- 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 when the time comes, you can choose one or more "back-up" agents. Your back-up agents can 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 doctor 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:

- The person/people listed by this law may not be who you would want to make decisions for you.
- Some family members or friends might not be able or willing to make decisions as you would want them to.
- Family members and friends may disagree with one another about the best decisions.
- 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 doctor and other health care providers and create written guidance about what you want or don't want in case you are 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 doctor or other healthcare provider and ask them 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 if there are items on the form which I do not want to complete?

You must complete the front page of the document in its entirety. You are encouraged to complete the entire form. If there are parts of the back page of the form that you prefer not to complete, it is recommended that a line or "X" be drawn through those parts.

What do I do with this form once I complete it?

- Sign the form in front of a witness. See the form for a list of who can and can't witness it.
- Ask the witness to sign it too.
- There is no need to have the form notarized.
- Give a copy to your agent and to each of your back-up agents.
- Give another copy to your doctor.
- Take a copy with you when you go to the hospital.
- 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 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.

*For more on-line resources, go to nhdd.org

You are not required to use this form. There are other forms that can be used in Illinois, including a form written by the Illinois legislature. If you have questions about the use of any form, you may want to consult your doctor, other health care provider, and/or an attorney. You do not need a lawyer to complete this document.

My Power of Attorney for Health Care

This form meets the requirements of the Illinois Power of Attorney for Health Care Act (as of 7/1/11 rev.)

This Power of Attorney revokes all previous Powers of Attorney for Health Care

You must sign this form and a witness must also sign it before it is valid.

My name (printed): _____

My address: _____

I want the following person to be my health care agent:

(I understand that I cannot choose my doctor or health care provider as my agent.)

(Agent's printed name)

(Agent's address and phone number)

My agent can:

- Make decisions for me, including:
 - Request, consent to, or stop treatment for any physical or mental condition, including life-and-death decisions.
 - Agree to admit me to or discharge me from any hospital, home or other institution.
 - Have the same access to my medical records as I have, and share them with others as needed, including after I die.
 - Carry out the plans I have already made, or, if I have not done so, make decisions about my body/remains, including organ, tissue or body donation, autopsy, cremation, burial.

I want my agent to make health care decisions for me:

(Initial One:)

_____ Only when I cannot make them for myself. The doctors caring for me will decide when I lack this ability.

_____ 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 do so if I wish.

Date: _____ Time: _____ My signature or mark: _____

Have your witness agree to what is written below, then complete the lines below:

- I am at least 18 years old. I saw this document being signed or the signer told me this is his/her signature or mark.
- I am not the agent or back-up agent(s) named in this document. I am not related to the signer, the agent, or the back-up agent(s) by blood, marriage or adoption. I am not the signer's doctor or mental health service provider or one of their relatives. I am not an owner or operator (or the relative of an owner/operator) of the health care facility where the signer is a patient or resident.
- Signature below applies to page 1 and, if completed, to page 2.

_____ Date:

_____ Time:

_____ (Witness signature)

_____ (Witness printed name)

_____ (Witness address)



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Back-Up Health Care Agent(s) (Optional):

If my selected agent is unable or does not want to make decisions, then I request the person(s) named below to be my health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more back-up agent names):

(Back-up agent #1 name, address and phone number)

(Back-up agent #2 name, address and phone number)

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, CPR and antibiotics. Some general statements concerning the withholding or removal of life-sustaining treatment are described below. This can serve as a guide for your agent when making decisions for you. Ask your doctor/healthcare provider if you have any questions about these options.

You may, but don't have to, put your initials by whichever statement(s) below express your wishes.

1. If my agent thinks the burdens of the treatments will probably be greater than any benefits, I do not want treatments to prolong my life.
2. In the event that *I am unconscious and it is believed 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.
3. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards, no matter how sick I am, how much I am suffering, how unlikely my chances for recovery are, or the cost to myself or my loved ones.
4. I prefer not to select any of the above statements.

Specific limitations to my agent's decision-making authority and/or specific guidance for my agent in my own words follow (optional) (Here you can write any specific limitations or instructions if you wish, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue nutrition and fluids or other life-sustaining treatments in all events; instructions to refuse any specific types of treatment that are not acceptable to you for religious or other reasons, etc.):

Date: _____ Time: _____ My signature or mark: _____



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