How to Complete This Illinois Power of Attorney for Health Care

Overview

The attached power of attorney for health care form is a legal document, developed to meet the legal requirements for Illinois. This document provides a way for a person to create a power of attorney for health care that will meet the basic requirements for this state.

This power of attorney for health care form allows you to appoint another person or persons to make your health care decisions if you become unable to make these decisions for yourself. The person (or persons) you appoint is your health care agent. This document gives your health care agent authority to make your decisions only when you have been determined incapable by your physician(s) to make your health care decisions. **It does not give your health care agent any authority to make your financial or other business decisions.**

Before completing this power of attorney for health care form, take time to read it carefully. It is also very important that you discuss your views, values, and this document with your health care agent! If you do not closely involve your health care agent and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

If you want to document your views about future health care, but do not want to or cannot use this power of attorney for health care form, ask your health organization or attorney for advice about alternatives.

How to Complete This Document

This power of attorney for health care form is divided into four parts.

Part I – Appointing a Health Care Agent
Part II – Authority of the Health Care Agent
Part III – Statement of Desires, Special Provisions, or Limitations
Part IV – Making the Document Legal.

Steps to Follow:

In each of the four parts of the attached document you will find instructions. Read and follow these instructions carefully. The basic things you must do are:

1) Provide the information on page 3;
2) Appoint at least one health care agent on page 5;
3) Indicate choices for Part II on page 6
4) Indicate any written instruction you want in Part III; pages 7 and 8
5) Sign and date the document on page 9; and
6) Have the document witnessed OR notarized.

After completing This Document

After you complete the document, keep the original document yourself, make copies to be given out as follows:

- one copy for yourself
- one copy for each health care agent appointed in the document
- one copy to share and discuss with your physician;
- one copy for your record at the hospital where you would go in an emergency;
- extra copies to share with others if you wish (loved ones, your minister/clergy/rabbi, and your attorney)

A photo or fax copy is as legally valid as an original. Be sure to keep one copy in an easily accessible location.

Need Assistance?

If you need assistance in completing this document you may contact the following places;

Generations Area Agency on Aging

935 E 53rd St
Davenport Iowa 52807
563-324-9085

Genesis

GMC – Dewitt
1118 11th St.
Dewitt IA 52742
563-653-4200

GMC – East
1227 E Rushholms St.
Davenport IA 52803
563-421-1000

GMC – West
1401 W Central Park
Davenport IA 52804
563-421-1000

GMC – Illini Campus
801 Hospital Rd
Silvis IL 61282
309-792-9363

Trinity

Trinity West Campus
2701 17th Street
Rock Island IL 61201
309-779-5000

Trinity 7th Street
500 John Deere Rd.
Moline IL 61265
309-779-5000

Trinity at Terrace Park
4500 Utica Ridge Rd
Bettendorf IA 52722
563-742-5000

Power of Attorney for Health Care

For

Name_____**Gender**_____

Other Names Used_____

Date of Birth:_____ **SSN(Optional)**_____

Address:_____

Telephone:_____

Copies of this document have been given to:

1._____

2._____

3._____

4._____

5._____

Power of Attorney for Health Care Document

Notice to Person Making this Document:

This power of attorney for health care gives the person you designate as your agent broad powers to make health care decisions for you, including power to require, consent to or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit or discharge you from any hospital, home or other institution. (Please note: the law states that no health care professional can be name as your agent.)

This form does not impose a duty on your agent to exercise granted powers; but when powers are exercised, your agent will have to use due care to act for your benefit and in accordance with this form and keep a record of receipts, disbursements and significant actions taken as agent.

A court can take away the powers of your agent if it finds the agent is not acting properly. You may name successor agents under this form but not co-agents. Unless you expressly limit the duration of this power in the manner provided below until you revoke this power or a court acting on your behalf terminates it, your agent may exercise the powers given here throughout your lifetime, even after you became disabled. The powers you give your agent, your right to revoke those powers and the penalties for violating the law are explained more fully in sections 4-5, 4-6, 4-9 and 4-10(b) of the Illinois “Powers of Attorney for Health Care Law” of which this form is a part. The law expressly permits the use of any different form of power of attorney you may desire. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

Part I – Appointing a person to make my health care decisions when I can't make my own health care decisions.

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my Health Care Agent. This person will make my health care decisions when I am determined to be incapable by my physician to make health care decisions as provided under state law.

Instructions for completing this part:

When selecting someone to be your health care agent, pick someone who knows you well; whom you trust; who is willing to represent your views and values; and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Make sure that you pick someone who will closely follow what you want and will be a good advocate for you. Whatever you do, take time to discuss this document and your views with the person(s) you pick to be your agent.

Your Health Care Agent should be at least 18 years old or older and should not be your health care provider or employee of your health care provider unless they are a close relative. Space has been provided for a second and third alternative health care agent.

The person I choose as my Health Care Agent is:

Name:_____

Day Phone:_____ Home/evening phone:_____

Cell Phone:_____ E-Mail Address:_____

Address:_____

City:_____ State:_____ Zip:_____

If this health care agent is unable or unwilling to make these choices for me, or if my spouse is designated as my Health Care Agent and our marriage is annulled or we are divorced, **then my next choice for a Health Care agent is:**

Second Choice

Name:_____

Day Phone:_____ Home/evening phone:_____

Cell Phone:_____ E-Mail Address:_____

Address:_____

City:_____ State:_____ Zip:_____

If this health care agent is unable or unwilling to make these choices for me, or if my spouse is designated as my Health Care Agent and our marriage is annulled or we are divorced, **then my next choice for a Health Care agent is:**

Third choice

Name:_____

Day Phone:_____ Home/evening phone:_____

Cell Phone:_____ E-Mail Address:_____

Address:_____

City:_____ State:_____ Zip:_____

Part II – General Authority of the Health Care Agent

I want my Health Care Agent to be able to do the following (Please cross out anything you do not want your Health Care Agent to do that is listed below):

- To make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment has already been started, my Health Care Agent can keep it going or have it stopped depending upon my stated instruction or my best interests.
- To interpret any instructions I have given in this form or given in other discussion according to my Health Care Agent's understanding of my wishes and values.
- To move me to another state if needed.
- To determine which health professionals and organizations provide my medical treatment.

Instructions for these Sections:

Place your initials in front of **ONE** of the following.

Agent authority to order the start, withholding, or withdrawal of feeding tube and I.V. hydration.

_____ Yes, my Health Care Agent has authority to have a feeding tube or I.V. hydration, started, withheld or withdrawn from me subject to any limitations I have set forth in this document.

_____ No, my Health Care Agent does not have authority to have a feeding tube or I.V. hydration started, withheld, or withdrawn from me.

Part III – Statement of Desires, Special Provisions, or Limitations

My Health Care Agent shall make decisions consistent with my stated desires, and is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my Health Care Agent and/or physician providing my medical care. If my Health Care Agent cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own health care.

Instructions for completing this part:

You are **not required** to provide any written instructions or make any selections in Part III. If you choose **not** to provide any instructions, your health care agent will make decisions based on your oral instruction or what is considered in your best interest. If you choose **not** to provide any instructions, draw a line and write "no instructions" across the page.

Stopping Attempts of Life Prolonging Treatment:

(Indicate your wishes by placing **YES** or **NO** on the provided line.)

_____ If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with myself, my family, friends, and environment, I want to stop or withhold a respirator/ventilator which might be used to only prolong my existence.

Pain and Symptom Control:

(Indicate your wishes by placing **YES** or **NO** on the provided line.)

_____ If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable, even if it risks my dying sooner.

Cardiopulmonary Resuscitation (CPR):

My CPR choice listed below may be reconsidered by my Health Care Agent in light of my other instructions or new medical information. If I do not want CPR attempted, my physician should be made aware of this choice. Other documents may be needed to control the actions of emergency personnel.

(Initial **ONE** and draw a line through the statements that you do not want.)

_____ I want Cardiopulmonary Resuscitation (CPR) attempted if my heart stops.

_____ I do not want CPR attempted if my heart stops.

_____ I want Cardiopulmonary Resuscitation attempted unless my physician determines one of the following

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if my heart stops; OR
- I have little chance of long term survival if my heart stops and the process of resuscitation would cause significant suffering.

If I indicate that I do not want CPR attempted, this choice, in itself , will not stop emergency personnel from attempting CPR in an emergency. Emergency personnel will provide CPR unless they are aware you have an out of hospital DNR order.

Religion: (optional)

I am of the _____ faith, and am a member of the _____ congregation, synagogue, or worship group. Phone number of congregation, synagogue, or worship group (if known):_____

Persons I Want My Agent to Include in the Decision Process:

I ask that my Health Care Agent include the following persons in my health care decisions if there is time: _____

Other Instructions or Limitations I Want My Health Care Agent to Follow:

If I am nearing my death, I want the following: (List things that would make dying more meaningful for you).

If I am nearing my death and cannot speak, I want my friends and family to know:

Part IV – Making the document legal

Instructions for completing this part:

This document signed and dated in the presence of one witness or a notary public.

I am thinking clearly, I agree with everything that is written in this document and I have made this document willingly.

_____ _____
My Signature Date

_____
Printed Name

Statement of Witness

I believe the above to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

Witness:

_____ _____
Signature Date

_____
Printed Name

_____
Address

Instructions for Notarizaton:

This document may be signed by a notary public authorized in their state instead of having a witness.

Notary Public

In my presence on _____(date), _____(Name) Acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a Health Care Agent or alternate Health Care Agent in this document.

(Notary Stamp)

_____
Signature of Notary