Power of Attorney For Health Care

This form meets the requirements under the Illinois Power of Attorney For Health Care Act

Notice to the Individual Signing this Health Care Power of Attorney (HPOA) form

No one can predict when a serious illness or accident might occur. If something happened to you and you were not able to communicate your wishes, 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.

You can choose someone you trust to make health care decisions for you if you are unable or do not want to make them yourself. The person you choose is called your "Health Care Agent." It is important that you identify your Health Care Agent and record your health care preferences in writing based on your personal values and wishes by completing this form or another power of attorney form that complies with the Illinois legal requirements.

What are the things I want my Health Care Agent to know?

It is important to talk to the person you want to be your Health Care Agent about such things that are most important to you in your life:

- How important is it for you to avoid pain and suffering?
- If you had to choose, is it more important to you to live a quality life as long as possible, and avoid prolonged suffering, additional procedures, or disability, or live as long as possible even if it means losing quality of life?
- Would you rather be at home or in the hospital for the last days or weeks of your life?
- Do you have religious, spiritual or cultural beliefs you want your Health Care Agent to consider when fulfilling your care and end-of-life wishes?

Whom should I choose to be my Health Care Agent?

Choose a family member or friend who:

- Is at least 18 years old
- Knows you well
- Can be there for you when you need them
- You trust to do what is best for you and is willing to carry out your wishes even if they personally may not agree with your wishes
- Will tell your healthcare providers about the decisions you made on this form
- If your first choice is unable to serve this role, you may list a second or third alternate agent

The Health Care Agent you choose cannot be your physician, nurse, or other health care provider who works at your hospital or clinic unless that person is a family member who is not providing you treatment.

What will happen if I do not choose a Health Care Agent?

If you are too sick to make your own decisions, your physicians will ask your relatives or close friends to make decisions for you. In Illinois, the law directs the order in which these individuals will be asked. In that law, the individual is called a "surrogate." (In Illinois, partners are not considered close family unless you are legally married or have a civil union).

There are reasons why relying on a surrogate may pose a problem. For example, a person who agrees to be your surrogate may not be who you want to make health care decisions for you. Also, family members and friends may disagree with one another about the best health care decisions for you or what you would have wanted. Further, the person who agrees to be your surrogate may not be able to make all needed decisions. If this occurs, a court may appoint someone, possibly someone whom you do not know, to make health care decisions for you. **If you do not want someone whom you have not chosen to make health care decisions for you, then you must write the name of your Health Care Agent on this form.**

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 cannot witness it)
- Ask the witness to sign it, too
- You do not need to have the form notarized
- Give a copy of the signed form to your Health Care Agent and each of your Alternate Health Care Agents
- Share the form with those who care for you including: physicians, nurses, social workers, family and friends

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 Power of Attorney for Health Care and any copies. If you wish, fill out a new form and date and sign it with a witness. Then, make sure people destroy the old form and replace it with the revised version.

Note that you are not required to use this form. Other HPOA forms may be used in Illinois. 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.

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Completing this Power of Attorney Form revokes all previous Powers of Attorney for Health Care.
Both <u>you and a witness must sign this form before it is valid</u>.

1. My Information

My Name: _____ Date of Birth: _____
Print First and Last Name MM/DD/YYYY

My Address: _____
Street Address, City, State , Zip Code

2. Health Care Agent Information

I want the following person to be my health care agent or primary power of attorney for healthcare:
(I understand that I may not choose my doctor or health care provider or health care professional administering healthcare to me to be my agent.)

Agent name: _____ **Agent's phone #** _____

Agent's address: _____

3. Powers of My Health Care Agent

My agent may make decisions for me, include:

- Deciding whether to accept, withdraw or decline treatment for any physical or mental condition of mind, including life-and-death decisions.
- Agreeing to admit me to or discharge me from any hospital, home, or other institution.
- Having the same access to my medical and mental health records as I have, and sharing my records with my agent as needed, including accessing my records after I die.
- Carrying out the plans I have already made, or, if I have not done so, making decisions about my body/remains, including organ, tissue or body donation, autopsy, cremation, or burial.

4. Start of Agency

I want my agent to make health care decisions for me (initial one option below):

_____ Only when I cannot make them for myself. The physicians caring for me will decide when I lack this ability. (If neither option is selected, *this option will be implemented*.)

_____ 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 so elect.

5. Alternate Health Care Agent(s)

If the Health Care Agent I named above is unable or does not wish to make decisions, then I name the person(s) below, in the order listed, to be my Health Care Agent. Only one person at a time can serve as my Health Care Agent.

Alternate Agent #1: _____ _____ _____
Print First and Last Name | Street Address, City, State, Zip Code | Area Code and Number

Alternate Agent #2: _____ _____ _____
Print First and Last Name | Street Address, City, State, Zip Code | Area Code and Number

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6. Life Sustaining Treatment

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include CPR (chest compressions), breathing machines, tube feedings or fluids through a tube, blood transfusions or dialysis. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf. 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. Making a selection of one of the statements in the next section 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 the statements.

INITIAL 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. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

7. Specific Limitations on My Agent's Decision-Making Authority:

OPTIONAL: 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 specifically may include any limitations on the following lines. (You may add another page if more space is needed).

_____

_____

_____

8. Your Signature

My Signature or Mark: _____ Today's Date: _____
MM/DD/YYYY

9. Witness Signature

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

- I am at least 18 years old.
- I saw this document being signed by the principal or the principal told me that it is his/her signature or mark.
- I am not the principal, agent, one of the successor agent(s) named in this document, or a relative of one of those individuals by blood, marriage or adoption. I am not the principal's doctor, mental health service provider, advanced practice nurse, physician assistant, dentist, podiatric physician, optometrist, or a relative of one of those individuals by blood, marriage or adoption.
- 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. This prohibition does not apply to employees of the facility including social workers, chaplains, nurses, and other employees who are not owners of the facility.

_____ _____
Witness name (print) Witness signature

_____ _____
Witness address Today's date