

ILLINOIS

Advance Directive

Planning for Important Healthcare Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Using These Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

INTRODUCTION TO YOUR ILLINOIS ADVANCE DIRECTIVE

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Illinois Power of Attorney for Healthcare** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Power of Attorney for Healthcare is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.
2. The **Illinois Declaration** is your state's living will. It lets you state your wishes about medical care in the event that you develop a terminal condition and can no longer make your own medical decisions. The Declaration becomes effective if death would occur without the use of death-delaying procedures. (Your doctor must personally examine you and certify in writing that you are terminally ill.)

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

COMPLETING YOUR ILLINOIS POWER OF ATTORNEY FOR HEALTHCARE

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (An agent may also be called an “attorney-in-fact” or “proxy.”) Neither your doctor nor any other healthcare provider involved in your medical care can serve as your agent.

You can appoint a second and third person as your alternate agents. The alternate will step in if the first person you name as agent is unable, unwilling or unavailable to act for you.

How do I make my Illinois Power of Attorney for Healthcare legal?

The law requires that you sign your document in the presence of one adult witness. There are no specific legal requirements concerning who may act as your witness.

Note: You do not need to notarize your Power of Attorney for Healthcare.

Should I add personal instructions to my Illinois Power of Attorney for Healthcare?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your agent's power to act in your best interest.

Talk with your agent about your future medical care and describe what you consider to be an acceptable “quality of life.” If you want to record your wishes about specific treatments or conditions, you should use your Illinois Declaration (the living will).

COMPLETING YOUR ILLINOIS POWER OF ATTORNEY FOR HEALTHCARE (CONTINUED)

What if I change my mind?

You may revoke your Illinois Power of Attorney for Healthcare at any time, regardless of your mental or physical condition, by:

- obliterating, burning, tearing or otherwise destroying or defacing your document,
- signing and dating a written revocation, or directing another to do so for you, or
- orally or otherwise expressing your intent to revoke the document in the presence of a witness 18 years of age or older, who must sign and date a written confirmation that you orally or otherwise expressed your intent to revoke.

You also may amend your document at any time by a written amendment signed and dated by you or another person acting at your direction.

COMPLETING YOUR ILLINOIS DECLARATION

How do I make my Illinois Declaration legal?

State law requires that you sign your Declaration, or direct another person to sign, in the presence of two witnesses, 18 years of age or older, who must also sign to show that they personally know you and believe you to be of sound mind, that they witnessed your signature and did not sign on your behalf, that they signed the document in your presence, and that they are neither entitled to any part of your estate nor financially responsible for your medical care.

Note: You do not need to notarize your Illinois Declaration.

Can I add personal instructions to my Declaration?

Yes. You can add personal instructions in the part of the document called "Other directions." This is very important because the Illinois Declaration limits your right to refuse medical treatment in two major ways: the Declaration does not apply if you have an irreversible condition that would not be considered "terminal," and it does not allow you to refuse artificial nutrition and hydration (tube feeding) under any condition if death would result solely from dehydration or starvation rather than from the underlying condition.

COMPLETING YOUR ILLINOIS DECLARATION (CONTINUED)

If you have appointed an agent, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Declaration are to be decided by my agent."

What if I change my mind?

You may revoke your Declaration at any time, regardless of your mental or physical condition, by:

- obliterating, burning, tearing or otherwise destroying or defacing your document,
- signing and dating a written revocation, or directing another to do so for you, or
- orally or otherwise expressing your intent to revoke the document in the presence of a witness 18 years of age or older, who must sign and date a written confirmation that you orally or otherwise expressed your intent to revoke.

Your revocation becomes effective once you or a witness notify your doctor, who must then make it part of your medical record.

What other important facts should I know?

Due to restrictions in the state law, a pregnant patient's Illinois Declaration will not be honored if it is possible that the fetus could develop to the point of live birth with the continued application of death-delaying procedures.

**ILLINOIS STATUTORY SHORT FORM
POWER OF ATTORNEY FOR HEALTHCARE – PAGE 1 OF 6**

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR "AGENT") BROAD POWERS TO MAKE HEALTHCARE 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 YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME OR OTHER INSTITUTION. 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, AND NO HEALTHCARE PROVIDER MAY BE NAMED. 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 BECOME 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 HEALTHCARE LAW" OF WHICH THIS FORM IS A PART. THAT 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.

INSTRUCTIONS

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE — PAGE 2 OF 6

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE

POWER OF ATTORNEY made this _____ day of _____.
(day) (month, year)

PRINT THE DATE

I, _____
(name)

PRINT YOUR NAME AND ADDRESS

(address)

hereby appoint: _____
(name of agent)

PRINT THE NAME AND ADDRESS OF YOUR AGENT

(address)

as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains.

ANATOMICAL GIFT (OPTIONAL)

Effective upon my death, my agent has the full power to make an anatomical gift of the following:

____ Any organ, tissues, or eyes suitable for transplantation or used for research or education.

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES

____ Specific organs and/or tissues:

____ I do not wish to make an anatomical gift of any organs or tissues, and I do not authorize anyone else to make such a donation on my behalf.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF FOOD AND WATER AND OTHER LIFE-SUSTAINING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF

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**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 3 OF 6**

YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES OR LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.):

ADD LIMITATIONS
TO YOUR AGENT'S
POWER (IF ANY)

THIS PARAGRAPH
APPLIES TO THE
STATEMENTS ON
THE FOLLOWING
PAGE

THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT; BUT DO NOT INITIAL MORE THAN ONE.

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**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 4 OF 6**

INITIAL THE
STATEMENT THAT
BEST REFLECTS
YOUR WISHES

(DO NOT INITIAL
MORE THAN ONE)

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed _____

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

Initialed _____

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures.

Initialed _____

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU IN THE MANNER PROVIDED IN SECTION 4-6 OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW." ABSENT AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH, AND BEYOND IF ANATOMICAL GIFT, AUTOPSY OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

3. () This power of attorney shall become effective on _____

(insert a future date or event during your lifetime, such court determination of your disability, when you want this power to first take effect).

PRINT EFFECTIVE
DATE
(OPTIONAL)

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**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 5 OF 6**

PRINT EXPIRATION
DATE
(OPTIONAL)

4. () This power of attorney shall terminate on _____.
(insert a future date or event, such as court determination of your
disability, when you want this power to terminate prior to your death)

ALTERNATE
AGENTS

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND
ADDRESSES OF SUCH SUCCESSORES IN THE FOLLOWING PARAGRAPH.

5. If any agent named by me shall die, become incompetent, resign,
refuse to accept the office of agent or be unavailable, I name the
following (each to act alone and successively, in the order named) as
successors to such agent:

FIRST
ALTERNATE

1. Name _____

Address _____

Phone _____

2. Name _____

Address _____

Phone _____

SECOND
ALTERNATE

For purposes of this paragraph 5, a person shall be considered to be
incompetent if and while the person is a minor or an adjudicated
incompetent or disabled person or the person is unable to give prompt
and intelligent consideration to health care matters, as certified by a
licensed physician.

IF YOU WISH TO NAME YOUR AGENT AS GUARDIAN OF YOUR PERSON,
IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED,
YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY RETAINING THE
FOLLOWING PARAGRAPH. THE COURT WILL APPOINT YOUR AGENT IF
THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST
INTERESTS AND WELFARE. STRIKE OUT PARAGRAPH 6 IF YOU DO NOT
WANT YOUR AGENT TO ACT AS GUARDIAN.

PRINT NAME AND
ADDRESS OF
GUARDIAN
(YOUR AGENT) IF
DESIRED

6. 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.

(name of nominated guardian)

(address)

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**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 6 OF 6**

7. I am fully informed as to all the contents of this form and understand the full importance of this grant of powers to my agent.

Signed _____
(principal)

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

Witness _____

Residing at _____

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of agent
(and successors).

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

(agent)

(principal)

(successor agent)

(principal)

(successor agent)

(principal)

SIGN YOUR
DOCUMENT HERE

YOUR WITNESS
SIGNS HERE

SPECIMEN
SIGNATURES OF
YOUR AGENTS AND
ALTERNATES, IF
DESIRED.
YOU MUST SIGN TO
CERTIFY THEIR
SIGNATURES

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ILLINOIS DECLARATION – PAGE 1 OF 2

PRINT THE DATE

This declaration is made this _____ day of _____.
(day) (month, year)

PRINT YOUR NAME

I, _____,
(name)

being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed. If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

Other directions:

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ILLINOIS DECLARATION — PAGE 2 OF 2

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

SIGN THE DOCUMENT AND PRINT YOUR PLACE OF RESIDENCE

Signed _____

City, County and State of Residence _____

WITNESSING PROCEDURE

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of interstate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

WITNESSES SIGN HERE

Witness -----

Witness -----

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YOU HAVE FILLED OUT YOUR ADVANCE DIRECTIVE, NOW WHAT?

1. Your Illinois Power of Attorney for Healthcare and Illinois Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agents, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and alternates, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your Illinois documents.
6. Be aware that your Illinois documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**