ILLINOIS
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. 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.

4. Once the form is completed and signed, photocopy, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR ILLINOIS ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **Illinois Advance Health Care Directive,** that protects 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.

Your Illinois Advance Directive has two documents. The **Illinois Statutory Short Form Power of Attorney for Health Care** lets you name someone—your agent—to make decisions about your medical care if you can no longer speak for yourself. The form lets you set down your wishes regarding organ donation, life-sustaining treatment, burial arrangements, and other issues. The second document is an **Illinois Living Will.** This document allows you to direct that, if you are suffering from a terminal condition, death-delaying procedures will not be utilized to prolong your life. The **Illinois Living Will** is limited to this instruction and is **not effective if you have an effective Power of Attorney for Health Care.** The Illinois Living Will is useful if you do not want to name an agent and want to avoid prolonging your life in the event you have a terminal condition.

How do I make my Illinois Advance Health Care Directive legal?

The Illinois Statutory Short Form, on which the following power of attorney for health care form is based, requires that your signature be witnessed by one adult, 18 years of age or older. Your witness cannot be:

- Your attending physician, advanced practice nurse, physician assistant, dentist, podiatric physician, optometrist, or mental health service provider or a relative thereof;
- An owner, operator, or relative of an owner or operator of a health care facility in which you are a patient or resident;
- Your parent, sibling, descendant, or any of their spouses;
- Your agent's parent, sibling, or descendant, or any of their spouses; or
- Your agent or successor agent.

The Illinois Living Will, requires that your signature be witnessed by two adults, 18 years of age or older. The witnesses cannot be a person signing on your behalf, directly financially responsible for your medical care, or entitled to any portion of your estate. As noted above, an Illinois Living Will is not effective if you have a valid Illinois Power of Attorney for Health Care in place.

Note: You may sign your document by hand or electronically. You do not need to notarize your power of attorney for health care or your living will.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may 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 healthcare decisions for you.

Your agent cannot be your attending physician or any other healthcare provider who is administering healthcare to you at the time you execute this document.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your **Power of Attorney for Health Care** goes into effect when your doctor determines that you are no longer able to make or communicate your healthcare decisions. You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent will be bound by the current laws of Illinois as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Illinois Power of Attorney for Health Care or your Illinois Living Will at any time 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, regardless of whether the written revocation is in electronic or hard copy format,
- expressing your intent, orally or otherwise, 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 expressed your intent to revoke, or
- for an electronic declaration, by deleting in a manner indicating the intention to revoke, using a generic, technology-neutral system in which each user is assigned a unique identifier that is securely maintained and in a manner that meets the regulatory requirements for a digital or electronic signature.

Revocation of your Living Will is not effective until it is communicated to your attending physician.

You also may amend your Power of Attorney for Health Care at any time by a written amendment signed and dated by you or another person acting at your direction.

You may also choose a delayed revocation by initialing the appropriate box in the power of attorney form – this will create a 30-day waiting period such that your revocation of your power of attorney will not take effect until 30 days after you voice the intent to revoke.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

STATUTORY NOTICE

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE – PAGE 1 OF 12

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 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 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 the legal requirements of Illinois. 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.

STATUTORY NOTICE CONTINUED

WHAT ARE THE THINGS I WANT MY HEALTH CARE 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 are 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 health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is 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 health care 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.

STATUTORY NOTICE CONTINUED

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

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

(i) talk with physicians and other health care 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 are 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 have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are 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 have died, if you have not 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 health care expenses.

STATUTORY NOTICE CONTINUED

WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

You can pick a family member, but you do not 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 are 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 health care providers;

(v) would not be too upset to carry out your wishes if you became very sick; and

(vi) 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, then the second agent you chose will make the decisions; if your second agent is not 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 back-up 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 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 physician 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:

(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 IS NO ONE AVAILABLE
WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot 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 health care provider and ask him or her to write it down in your chart. You might also want to use written or on-line resources to guide you through this process.

STATUTORY NOTICE CONTINUED

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

Follow these instructions after you have completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and cannot 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. If you are concerned you may revoke your power of attorney at a time when you may need it the most, you may initial the box at the end of the form to indicate that you would like a 30-day waiting period after you voice your intent to revoke your power of attorney. This means if your agent is making decisions for you during that time, your agent can continue to make decisions on your behalf. This election is purely optional, and you do not have to choose it. If you do not choose this option, you can change your mind and revoke the power of attorney at any time.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not 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 health care power.

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.

MY POWER OF ATTORNEY FOR HEALTH CARE

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)

PRINT YOUR NAME AND ADDRESS

My name (Print your full name): _____

My address: _____

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT

(an agent is your personal representative under state and federal law):

PRINT THE NAME, ADDRESS, AND PHONE NUMBER OF YOUR AGENT

(Agent name) _____

(Agent address) _____

(Agent phone number) _____

(Please check box if applicable)

CHECK THIS BOX IF YOU WOULD ALSO LIKE TO NOMINATE YOUR AGENT AS THE GUARDIAN OF YOUR PERSON, IN THE EVENT ONE IS TO BE APPOINTED FOR YOU

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

NAME YOUR SUCCESSOR AGENTS HERE, IF YOU CHOOSE TO APPOINT ANY

SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care 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, address and phone number)

_____

(Successor agent #2 name, address and phone number)

THIS PARAGRAPH LISTS THE POWERS THAT ARE AUTOMATICALLY GRANTED TO YOUR AGENT

MY AGENT CAN MAKE HEALTH CARE 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.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

CHECK ONE OF THE THREE BOXES TO INDICATE THE SITUATION THAT BEST DESCRIBES WHEN YOU WANT YOUR AGENT'S POWERS TO TAKE EFFECT

I AUTHORIZE MY AGENT TO (please check any one box):

☐ 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. (If no box is checked, then the box above shall be implemented.) OR

☐ 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. Starting now, for the purpose of assisting me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself. OR

☐ 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.

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.

Additional 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 health care provider if you have any questions about these statements.

YOU MAY CHECK ONE OF THE TWO BOXES, OR YOU MAY DECLINE TO CHECK EITHER

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.

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

IF THERE ARE ANY POWERS THAT YOU DO NOT WANT YOUR AGENT TO HAVE, YOU SHOULD LIST THEM HERE

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 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 may do so specifically in this form.

LIST ANY LIMITS TO AGENT'S POWERS

_____

_____

SIGN AND DATE HERE

My signature: _____

Today's date: _____

DELAYED REVOCATION

CHECK ONE OF THESE BOXES TO DETERMINE WHEN YOUR REVOCATION OF THIS POWER OF ATTORNEY WILL TAKE EFFECT

☐ I elect to delay revocation of this power of attorney for 30 days after I communicate my intent to revoke it.

☐ I elect for the revocation of this power of attorney to take effect immediately if I communicate my intent to revoke it.

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN COMPLETE THE SIGNATURE PORTION:

I am at least 18 years old. (check one of the options below):

☐ I saw the principal sign this document, or

YOUR WITNESS MUST CHECK ONE OF THE TWO BOXES AND AGREE TO THE STATEMENT ABOUT RESTRICTIONS ON WITNESSES

☐ the principal told me that the signature or mark on the principal signature line is his or hers.

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, dentist, podiatric physician, optometrist, psychologist, or a relative of one of those individuals. I am not the principal's physician, mental health service provider, 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 health care facility where the principal is a patient or resident.

HAVE YOUR WITNESS PRINT THEIR NAME AND ADDRESS AND SIGN HERE

Witness printed name: _____

Witness address: _____

Witness signature: _____

Today's date: _____

DATE YOUR DOCUMENT HERE

PRINT YOUR NAME HERE

SIGN HERE BY HAND OR ELECTRONICALLY

PRINT YOUR ADDRESS HERE

TWO WITNESSES MUST SIGN BY HAND OR ELECTRONICALLY

DECLARATION

This declaration is made this_____day of _____

(month, year). I,_____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. 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.

Signed_____

City, County and State of Residence _____

_____

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 intestate 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.

Witness_____

Witness _____

Courtesy of CaringInfo

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