



# Planning Ahead

How to Make Future Healthcare Decisions NOW

**Your Questions Answered About Illinois Living Wills  
and Powers of Attorney for Health Care**



# Making Future Healthcare Decisions **NOW**

# Table of Contents

**P 1 What You Need to Know About Advance Directives**

- Power of Attorney for Health Care Questions
- Living Will Questions
- Questions About Power of Attorney for Health Care and Living Wills
- Mental Health Treatment Preference Declaration
- Healthcare Surrogates

**P 5 Instructions for Execution of a Living Will Declaration**

- Living Will

**P 8 Instructions for Execution of a Power of Attorney for Health Care**

**P 9 Illinois Statutory Short Form**

- Power of Attorney for Health Care

**P 18 Excerpts from Illinois Powers of Attorney for Health Care**

- Section 4-5. Limitations on Healthcare Agencies
- Section 4-6. Revocation and Amendment of Healthcare Strategies
- Section 4-9. Penalties
- Section 4-10. Statutory Short Form Power of Attorney for Health Care
- Information Release





# What You Need to Know About Advance Directives

Illinois law gives you the right to accept or reject medical treatment. You also have the right to give directions—in advance—about the kind of health care you want if the time comes when you cannot make your own decisions.

You can control your future health care by completing a form naming a trusted relative

or friend to communicate for you. These forms, called advance directives, tell the kinds of life-sustaining treatments you want.

The next pages list commonly asked questions about advance directives, and this booklet provides examples of living will and power of attorney for health care forms that you can choose to complete.

## Power of Attorney for Health Care Questions

### **What is a power of attorney for health care?**

A power of attorney for health care is a document you sign that names another person, called your “agent,” to make healthcare decisions for you if you are unable to do so.

### **Who can create a power of attorney for health care?**

Any competent person who is at least 18 years old may create and sign a power of attorney for health care. Please consult a lawyer if you want legal advice.

### **Who can act as an agent?**

Any person who is at least 18 years old and is able to understand and decide about healthcare matters can be an agent. However, no physician, nurse or other healthcare provider who is giving you treatment may act as your agent. Most people choose a trusted relative or friend.

### **What happens if I name my spouse as an agent and we are later divorced?**

Your ex-spouse will no longer have authority to act under the power of attorney for health care. Even so, you should attempt to destroy all copies of the power of attorney, because doctors or hospitals may rely on it if they don’t know about the divorce.

### **Will my agent be held liable for my healthcare costs?**

No, your agent will not be held personally responsible for the cost of healthcare services and treatment that he or she arranges.

### **How do I create a power of attorney for health care?**

The surest way is to complete and sign the Illinois Statutory Short Form Power of Attorney for Health Care. One witness must also sign the form.

### **What powers do I give to my agent by completing the form?**

After the power of attorney for health care goes into effect, your agent may make any healthcare decision that you could make if you were able to do so. However, you can limit your agent's powers or give your agent special instructions by clearly stating them in your power of attorney.

### **How do I tell my agent what life-sustaining treatment I want?**

Talk personally with your agent and make sure he or she clearly understands your wishes about

life-sustaining treatment. Sections four and five of the Statutory Short Form Power of Attorney for Health Care is about life-sustaining treatment.

### **You may:**

1. Leave this section completely blank, giving your agent the broadest power to decide about life-sustaining treatment; OR
2. Write in your own instructions; OR
3. Choose one of the optional statements that are included in the section.

## **Living Will Questions**

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### **What is a living will?**

A living will (also called a "declaration") is a document you sign that states you do not want your physician to use death-delaying procedures if you develop a terminal condition.

### **Who may create a living will?**

Any competent person at least 18 years old.

### **How do I create a living will?**

The surest way is to fill out and sign the Living Will Declaration contained in the Illinois Living Will Act. It must be signed by you, or another person at your direction, in the presence of two witnesses.

### **Who can witness the signing of my living will?**

Anyone at least 18 years old who is not entitled to inherit from your estate or financially responsible for your medical care.

### **When does a living will take effect?**

When a physician certifies you have a terminal condition.

### **What is a death-delaying procedure?**

Death-delaying procedures serve only to postpone the moment of death. They may include assisted ventilation, artificial kidney treatments, medication, blood transfusions and tube feeding.

### **If I have a living will, can I still receive pain medication?**

Yes, your physician can provide you with pain medication or other care to make you comfortable.

### **What happens if I have a living will and a terminal illness and I am pregnant?**

A living will does not take effect so long as the attending physician believes the fetus could develop to the point of live birth if death-delaying procedures are used for the mother.

## **Questions About Power of Attorney for Health Care and Living Wills**

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### **How is a power of attorney for health care different from a living will?**

A living will takes effect only if you have a terminal illness and cannot speak for yourself. Also, it only addresses decisions concerning life-sustaining treatment. A power of attorney for health care is broader and more flexible and, in that way, is preferable to a living will. Under a power of attorney for health care, your agent can make healthcare decisions for you in any situation when you are unable to do so.

continued →





**Should I have both a power of attorney for health care and a living will?**

Your living will does not take effect so long as your agent under a power of attorney for health care is available and willing to make life-sustaining treatment decisions. If you do not wish to be kept alive by life-sustaining treatment, you should consider signing both documents because:

- The living will reinforces the intent of the power of attorney for health care.
- Your agent under the power of attorney for health care may die or be unable or unwilling to act when it comes time to make healthcare decisions.

**Will hospitals and physicians honor my living will and power of attorney for health care?**

Providers must comply with healthcare decisions of an agent or the directions stated in a living will unless they are morally opposed to them. If the provider is unwilling to comply, the provider must inform your agent, who is then responsible for arranging your transfer to another provider.

**For how long are my living will and power of attorney for health care effective?**

They remain valid until you revoke them.

**What should I do with my signed power of attorney for health care and living will?**

Copies should be given to the people you have named as the agent and successor agents under the power of attorney for health care. Give copies to your physician, family and friends, and discuss your wishes with them all as well. Inform your agent where the original documents are kept.

**In case of an emergency, how will a hospital know that I have a living will or who my agent is?**

A hospital can locate your agent or living will if you complete a Health Care Agent/Living Will wallet identification card included in this booklet and carry it with you in your wallet or purse.

**Can I revoke or change my power of attorney for health care or living will?**

They can be revoked at any time, regardless of your physical or mental condition, by doing one of the following:

- Tear up or otherwise destroy the document; OR
- Revoke the document in writing, sign and date it or direct someone else to do it for you; OR
- Express (orally or otherwise) in the presence of a witness at least 18 years old, your intent to revoke the document. Have the witness sign and date a statement confirming that such an expression of intent was made.

To change your power of attorney for health care, write in the changes and sign and date the document. To change your living will, revoke the current form and sign a new one. Also, a court may revoke or change your documents if it believes clarification is needed or your agent is not acting in your best interests.

**Should I have my living will and power of attorney for health care notarized?**

It is recommended that you have your documents notarized because some other states require notarization.

# Living Will and Power of Attorney for Health Care Forms





## Instructions for Execution of a Living Will Declaration

1. An individual of sound mind and having reached the age of majority (18 in Illinois) or having attained the status of an emancipated person pursuant to the Emancipation of Mature Minors Act may execute a living will declaration.
2. The declaration must be signed by the individual, or by another person at the direction of the individual, and witnessed by two people 18 years or older who are not entitled to any portion of the estate of the individual if the individual dies without a will; who are not, to the best of the witness' knowledge, a beneficiary under the individual's will and who are not financially responsible for the individual's medical care.
3. If the individual is an emancipated minor or if the living will is to be signed by another person at the direction of the individual, you should consider consulting your attorney. In addition, if you have any questions about the living will declaration or what it means, you should consult your attorney.

Please remember that healthcare employees involved in your care may not witness the above-named documents. We also encourage you to discuss your plans with a friend or family member, your physician and your attorney.



# Living Will

I, \_\_\_\_\_  
being of sound mind, willfully and voluntarily make known my desires that my moment of death should 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 interstate succession or, to the best of my knowledge and belief, under any will or declarant or other instrument taking effect at the declarant's death, or directly financially responsible for the declarant's medical care.

Witness \_\_\_\_\_

Witness \_\_\_\_\_

# Instructions for Execution of a Power of Attorney for Health Care

Note: The form refers to a “principal,” which is you or the person you’re helping fill out the form.

**Section 1.** Insert your name and address and the name, address and phone number of the agent. 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 do so by checking the box at the end of Section 1. The court will then appoint your agent if the court finds that such appointment will serve your best interests and welfare. If you do not want your agent to act as your guardian, leave the box unchecked.

**Section 2.** You can name a successor agent to act if the agent appointed under Section 1 is unable to act.

**Section 3.** You can choose when this document goes into effect in this section. There are three general statements regarding when the power of attorney should take effect and when your agent should have access to your medical and mental health records. If you agree with one of the statements, you may check the box next to it, but you must not check more than one statement. You do not need to check any of the statements. If no box is checked, the first scenario listed will be implemented.

**Section 4.** You can limit the powers granted to the agent by adding restrictions in this section. There are two general statements regarding the withholding or removal of life-sustaining treatment. Check the box next to the statement that best expresses your wishes. You do not need to check either of the statements.

**Section 5.** You can limit the scope of your agent’s powers, prescribe special rules or limit the power to authorize autopsy or dispose of remains in this section. Complete this section with any specific limitations or instructions. Add your signature and date at the end of this section.

**Section 6.** You must sign the form. An independent witness must witness the execution of the form by signing on the “witness” line and adding his or her address.

If you are competent but too weak to sign your name, you can sign with a mark. To do that, a witness can print your name as follows:

John ( X ) Doe  
his mark

You would then place an “X” in the parentheses. The execution by using a mark must be witnessed by two independent witnesses. The witnesses should sign their names, wherever space is available, adjacent to the mark.

If you have both a living will and a power of attorney for health care, the living will will not be used as long as there is an agent available to act under the power of attorney for health care. If no agent is available to act, the living will will be used if the patient has a terminal condition. If you have any questions about the power of attorney for health care or what it means, you should consult your attorney.



# Illinois Statutory Short Form

## Power of Attorney for Health Care

### **Notice:**

The purpose of this power of attorney is to give the person you designate (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 you to or discharge you from any hospital, home or 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 your 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 you cannot name any co-agent or healthcare provider. 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 if 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 Health Care 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.



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.

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 advanced 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.

#### 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.

#### 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.

## 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.

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)

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):

(Agent name) .....

(Agent address) .....

(Agent phone number) .....

(Please check box if applicable)  If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

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)

.....

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.



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.

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.

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.

.....  
.....

My signature .....

Today’s date: .....

Form effective 1/1/2016

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

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 nurse, dentist, podiatric physician, optometrist, psychologist, 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.

Witness printed name: .....

Witness address: .....

Witness signature: .....

Today's date: .....



# Excerpts from Illinois Powers of Attorney for Health Care

Law (755 ILCS 45/4)

## Section 4-5. Limitations on Healthcare Agencies

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Neither the attending physician nor any other healthcare provider may act as agent under a healthcare agency; however, a person who is not administering health care to the patient may act as healthcare agent for the patient even though the

person is a physician or otherwise licensed, certified, authorized or permitted by law to administer health care in the ordinary course of business or the practice of a profession, including any person employed by or acting for any such authorized person.

## Section 4-6. Revocation and Amendment of Healthcare Strategies

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(a) Every healthcare agency may be revoked by the principal at any time, without regard to the principal's mental or physical condition, by any of the following methods:

1. By being obliterated, burnt, torn or otherwise destroyed or defaced in a manner indicating intention to revoke;
2. By a written revocation of the agency, signed and dated by the principal or person acting at the direction of the principal; OR
3. By an oral or any other expression of the intent to revoke the agency in the presence of a witness 18 years of age or older who signs and dates a written confirmation that such an expression of intent was made.

(b) Every healthcare agency may be amended at any time by a written amendment signed and dated by the principal or person acting at the direction of the principal.

(c) Any person, other than the agent, to whom a revocation or amendment is communicated or delivered shall make all reasonable efforts to inform the agent of that fact as promptly as possible.



## Section 4-9. Penalties

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All persons shall be subject to the following sanctions in relation to healthcare agencies, in addition to all other sanctions applicable under any other law or rule of professional conduct:

- (a) Any person shall be civilly liable who, without the principal's consent, willfully conceals, cancels or alters a healthcare agency or any amendment of revocation of the agency, or who falsifies or forges a healthcare agency, amendment or revocation.
- (b) A person who falsifies or forges a healthcare agency or willfully conceals or withholds personal knowledge of an amendment or revocation of a healthcare agency with the

intent to cause a withholding or withdrawal of life-sustaining or death-delaying procedures contrary to the intent of the principal and thereby, because of such act, directly causes life-sustaining or death-delaying procedures to be withheld or withdrawn and death to the patient to be hastened shall be subject to prosecution of involuntary manslaughter.

- (c) Any person who requires or prevents execution of a healthcare agency as a condition of insuring or providing any type of healthcare services to the patient shall be civilly liable and guilty of a Class A misdemeanor.

## Section 4-10. Statutory Short Form Power of Attorney for Health Care

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Paragraph (a) sets out the form of statutory healthcare power that is reproduced on the face of this form.

- (b) The statutory short form power of attorney for health care (the "statutory healthcarepower") authorizes the agent to make any and all healthcare decisions on behalf of the principal which the principal could make if present and under no disability, subject to any limitations on the granted powers that appear on the face of this form, to be exercised in such a manner as the agent deems consistent with the intent and desires of the principal. The agent will be under no duty to exercise powers or to assume control of or responsibility for the principal's health care; but when granted powers are exercised, the agent will be required to use due care to act for the benefit of the principal in accordance with the terms of the statutory healthcare power and will be liable for negligent exercise. The agent may act in person or

through others reasonably employed by the agent for that purpose but may not delegate authority to make healthcare decisions. The agent may sign and deliver all instruments, negotiate and enter into all agreements, and do all other acts reasonably necessary to implement and exercise the powers granted to the agent. Without limiting the generality of the foregoing, the statutory healthcare power shall include the following powers, subject to any limitations appearing on the face of the form:

- (1) The agent is authorized to give consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment or procedures relating to the physical or mental health of the principal, including any medication program, surgical procedure, life-sustaining treatment or provision of food and fluids for the principal.

- (2) The agent is authorized to admit the principal to or discharge the principal from any and all types of hospitals, institutions, homes, residential or nursing facilities, treatment centers and other healthcare institutions providing personal care or treatment for any type of physical or mental condition. The agent shall have the same right to visit the principal in the hospital or other institution as is granted to a spouse or adult child of the principal, any rule of the institution to the contrary notwithstanding.
- (3) The agent is authorized to contract for any and all types of healthcare services and facilities in the name of and on behalf of the principal and to bind the principal to pay for all such services and facilities, and to have and exercise those powers over the principal's property as authorized under the statutory property power, to the extent the other agent deems necessary to pay healthcare costs; and the agent shall not be personally liable for any services or care contracted for on behalf of the principal.
- (4) At the principal's expense and subject to reasonable rules of the healthcare provider to prevent disruption of the principal's health care, the agent shall have the same right the principal has to examine, copy and consent to disclosure of all the principal's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home or other healthcare provider.
- (5) The agent is authorized: to direct an autopsy made pursuant to Section 2 of "An Act in Relation to Autopsy of Dead Bodies," approved August 13, 1965, including all amendments; to make a disposition of any part or all of the principal's body pursuant to the Uniform Anatomical Gift Act, as now or hereafter amended and to direct the disposition of the principal's remains.



# Advance Medical Directives Release

# Information Release

I am submitting the following advance medical directive(s) for deposit with my healthcare facility (check one or both):

Living Will     Power of Attorney for Health Care

I do/do not (circle one) authorize the release of the above document(s) to hospitals providing treatment to me upon request.

I understand that I may modify/delete my advance medical directive(s) from the depository by submitting a letter to that effect. I understand that I may withdraw my authorization for release of documents by submitting a letter to Health Alliance.

I understand that I should notify Health Alliance of any change of address.

Signature \_\_\_\_\_

(Please Print)

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Social Security Number \_\_\_\_\_

Mother's Maiden Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date \_\_\_\_\_





# Making Future Healthcare Decisions

## **DISCRIMINATION IS AGAINST THE LAW**

Health Alliance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance Medical Plans, Customer Service, 301 S. Vine Street, Urbana, IL 61801, telephone: 1-800-851-3379, TTY: 711, fax: 217-365-7494, [CustomerService@healthalliance.org](mailto:CustomerService@healthalliance.org). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TTY: 1-800-537-7697.

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame 1-800-851-3379 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。呼叫1-800-851-3379 (TTY: 711)。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. Zadzwoń 1-800-851-3379 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 1-800-851-3379 (TTY: 711).

주의: 당신이 한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-851-3379 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. Вызов 1-800-851-3379 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tumawag 1-800-851-3379 (TTY: 711).

سندعاء 1-800-851-3379 (TTY: 711) إذا كنت تتحدث اللغة العربية، خدمات المساعدة اللغوية، مجاناً، تتوفر لك.

Wenn Sie Deutsch sprechen, Sprachassistentendienste sind kostenlos, zur Verfügung. Anruf 1-800-851-3379 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez 1-800-851-3379 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. કોલ 1-800-851-3379 (TTY: 711).

注意：あなたは、日本語、無料で言語支援サービスを、話す場合は、あなたに利用可能です。1-800-851-3379コール (TTY: 711)。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. Bel 1-800-851-3379 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. Виклик 1-800-851-3379 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. Chiamare 1-800-851-3379 (TTY: 711).



