~ Illinois ~

Power of Attorney for Health Care
Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make health care decisions for you. It revokes any prior power of attorney for health care that you may have made. If you wish to change your power of attorney for health care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, your health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse or your domestic partner, and your marriage is annulled or you are divorced or domestic partnership is terminated after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this record revokes any prior record of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document on file with your personal papers where it can be easily accessed by your health care agent, close family, or friends, if needed.

ILLINOIS POWER OF ATTORNEY FOR HEALTH CARE

Written in Accordance with Illinois Power of Attorney Act (755 ILCS 45/4-10)

Document made this _________ day of __________________________, ____________.
Month Year

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, ________________________________, ____,
Print full legal name Address

_______/______/______, being of sound mind, intend by this document to create a power of attorney for health care.
Date of birth

My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate

________________________________, ____,
Health care agent Address

(______) ___________________, to be my health care agent for the purpose of making health care decisions on my behalf.
Phone

If he or she is ever unable or unwilling to do so, I hereby designate ______________________________________,
Successor health care agent

____, (_____) ___________________,
Address Phone

to be my successor health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my successor health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

© Christian Life Resources, Inc.
Revised 2022; Reviewed 2023

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility, or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES

My health care agent may admit me to a nursing home for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

A nursing home **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 7-10)

If I have not checked either "Yes" or "No" immediately above, my health care agent may only admit me for short-term stays for recuperative care or respite care.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 7-10)

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withheld or withdrawn from me.

© Christian Life Resources, Inc.
Revised 2022; Reviewed 2023

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 7-10)

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if he or she knows I am pregnant.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items if needed):

1. I request that the attached Addendum (pages 7-10) be included as a valid part of this Power of Attorney for Health Care document.

2. I request, but not as a requirement, that my health care agent consult my clergy regarding health care decisions.

3. ____

____

____

____

[Attach additional pages, if needed]

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my health care agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

© Christian Life Resources, Inc.
Revised 2022; Reviewed 2023

The principal and the witness(es) must sign the document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Power of Attorney for Health Care)

Signature: ____ Date: ____________________

(The signing of this document by the principal revokes all previous power of attorney for health care documents.)

STATEMENT OF WITNESS(ES)

The state of Illinois requires the principal to sign this Power of Attorney for Health Care in front of one adult witness. CLR recommends two adult witnesses.

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, or an employee of an inpatient health care facility in which the principal is a patient. I am not the advance practice nurse, physician assistant, dentist, podiatric physician, optometrist, or mental health service provider (nor a relative of all such professionals). I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness #1 (Required)

Print name: ____ Date: ____________________

Address: ____

Signature: ____

Witness #2 (Recommended)

Print name: ____ Date: ____________________

Address: ____

Signature: ____

© Christian Life Resources, Inc.
Revised 2022; Reviewed 2023

STATEMENT OF HEALTH CARE AGENT AND SUCCESSOR HEALTH CARE AGENT

I understand that ____ has designated me to be his or her health care
Name of principal
agent or successor health care agent if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

____ has discussed his or her desires regarding health care decisions
Name of principal
with me.

Agent's signature: ____

Address: ____

Successor agent's signature: ____

Address: ____

ANATOMICAL GIFTS

Optional

Upon my death:

_______ I wish to donate only the following organs or parts:

____
(specify the organs or parts)
____

____

____

____

_______ I wish to donate any needed organ or part.

_______ I wish to donate my body for anatomical study if needed.

_______ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failing to check any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift.

Signature: ____ Date: ____________________

© Christian Life Resources, Inc.
Revised 2022; Reviewed 2023

ADDENDUM TO STATE OF ILLINOIS POWER OF ATTORNEY FOR HEALTH CARE

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my health care agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.
2. My health care agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

© Christian Life Resources, Inc.
Revised 2022; Reviewed 2023

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked “Yes” to the “Withhold or withdraw a feeding tube” option in the “PROVISION OF FEEDING TUBE” section below, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

© Christian Life Resources, Inc.
Revised 2022; Reviewed 2023

The principal and the witness(es) must sign this document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Power of Attorney for Health Care)

Signature: ______________________________ Date: ____________________

(The signing of this document by the principal revokes all previous power of attorney for health care documents.)

STATEMENT OF WITNESS(ES)

The state of Illinois requires the principal to sign this Power of Attorney for Health Care in front of one adult witness. CLR recommends two witnesses.

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this Addendum to the Power of Attorney for Health Care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, or an employee of an inpatient health care facility in which the principal is a patient. I am not the advance practice nurse, physician assistant, dentist, podiatric physician, optometrist, or mental health service provide (nor a relative of all such professionals). I am not the principal's health care or successor health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness #1 (Required)

Print Name ______________________________ Date: ____________________

Address ____

Signature: ______________________________

Witness #2 (Recommended)

Print name: ______________________________ Date: ____________________

Address: ____

Signature: ______________________________

© Christian Life Resources, Inc.
Revised 2022; Reviewed 2023

STATEMENT OF HEALTH CARE AGENT AND SUCCESSOR AGENTS

I understand that ______________________________ has designated me to be his or her health care agent
(Name of principal)
or successor if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions.

______________________________________ has discussed his or her desires regarding health care decisions
(Name of principal)
with me.

Agent's signature: ____

Address ____

First successor's signature: ______________________________________

Address ____

Second successor's signature: ____________________________________

Address ____

CLERGY

Optional

The principal has requested that the agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the agent to help meet the directives as described in this Power of Attorney for Health Care document and attached Addendum.

Clergy's signature: ______________________________ Phone: (_____) _______________

Church Address: ____

I have given copies of this Power of Attorney for Health Care – Christian Version to:

____

____

____

____

____

____

© Christian Life Resources, Inc.
Revised 2022; Reviewed 2023