Center for Disability
& Elder Law

SCREENING FORM

Name		**Date:**	
Street Address			
City/State/Zip			
Phone Number(s)			
Gender			
Date of Birth (Disability, if any)			
Monthly Income	**Is your income more than $2,000 per month?** | Yes / No		
Race/Ethnicity			
Veteran Status	Yes / No		
Agent Name / Relationship	| |Phone		
Agent Address			
Successor Agent (if any)/Relation	| |Phone		
Successor Agent Address (if any)			
Person completing Screening			

SECONDARY SCREENING
(TO OCCUR AFTER COMPLETING FORMS)

Did Client Sign:	**(Please place a check in each box)**
Client Agreement	□
POA-Property	□
POA-Health Care	□
Living Will	□
Did Client Have Any	**Yes □ No □**
Other Legal Matter?	If "Yes" please describe:
(i.e., Client Wants Simple Will,	
Collection Matter,	
Real Estate, etc.)	
	Wills: has a "Simple Will Questionnaire" (SWQ) been provided? **Yes □ No □**
	If "Yes," Please attach or Indicate Deadline Date for Return of SWQ:

REVIEW INFORMATION

Name of Reviewer:	
Photo ID (for notarization)	**Yes □ No □**
Client Agreement?	**Yes □ No □**
POA-Property?	**Yes □ No □**
POA-Health Care?	**Yes □ No □**
Living Will?	**Yes □ No □**

Center for Disability & Elder Law

LIMITED CLIENT AGREEMENT

This Agreement confirms the scope and terms of representation provided by the Center for Disability & Elder Law (CDEL) regarding the Senior Center Power of Attorney Initiative (SCI).

I. I, _____ (Client Name), give my permission for CDEL and its volunteer attorneys to assist me in at the SCI workshop under the terms of this Agreement.

II. I understand and agree that CDEL's assistance is concerned solely with the SCI. CDEL and its volunteer attorneys will advise me concerning and assist me in completing the forms I request. That is the extent of the representation and no further representation is expected or desired.

III. I understand that all information I give to CDEL and its volunteer attorneys in relation to the SCI will be kept with CDEL and CDEL shall not disclose this information to third parties without my permission or unless a court orders CDEL to reveal such information.

IV. I understand that my participation is entirely voluntary. I understand that I am free to discharge CDEL and the volunteer attorney at any time during the SCI Workshop and not continue.

V. I understand that CDEL and its volunteer attorneys can stop handling my file if they believe that one or more of the following is/are true:

a. that, in the judgment of CDEL or its volunteer attorney, I lack the necessary ability (commonly called "capacity") to execute a Power of Attorney or Living Will Declaration,
b. that executing such documents are not in my best interest, or
c. if I do not cooperate or there is any other good reason within the Illinois Rules of Professional Conduct for CDEL and its volunteer attorneys to stop handling my file.

VI. I understand that after the Workshop, if I have any questions or concerns about the documents, I may contact CDEL to seek further review of my file.

VII. **I understand that CDEL provides this service free of charge and that I do not have to pay CDEL or CDEL volunteer attorneys for their legal services.**

VIII. I understand and agree to the terms set forth above.

Client
Signature _____

Printed Name _____

Date _____

Volunteer
Attorney Signature_____

Volunteer
Attorney
Printed Name _____

Non-Attorney Volunteer
Printed Name _____

Date_____

Center for Disability & Elder Law

LIMITED CLIENT AGREEMENT

This Agreement confirms the scope and terms of representation provided by the Center for Disability & Elder Law (CDEL) regarding the Senior Center Power of Attorney Initiative (SCI).

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VIII. I understand and agree to the terms set forth above.

Client
Signature _____

Printed Name _____

Date _____

Volunteer
Attorney Signature_____

Volunteer
Attorney
Printed Name _____

Non-Attorney Volunteer
Printed Name _____

Date_____

NOTICE TO THE INDIVIDUAL SIGNING THE ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR PROPERTY

PLEASE READ THIS NOTICE CAREFULLY. The form that you will be signing is a legal document. It is governed by the Illinois Power of Attorney Act. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

The purpose of this Power of Attorney is to give your designated "agent" broad powers to handle your financial affairs, which may include the power to pledge, sell, or dispose of any of your real or personal property, even without your consent or any advance notice to you. When using the Statutory Short Form, you may name successor agents, but you may not name co-agents.

This form does not impose a duty upon your agent to handle your financial affairs, so it is important that you select an agent who will agree to do this for you. It is also important to select an agent whom you trust, since you are giving that agent control over your financial assets and property. Any agent who does act for you has a duty to act in good faith for your benefit and to use due care, competence, and diligence. He or she must also act in accordance with the law and with the directions in this form. Your agent must keep a record of all receipts, disbursements, and significant actions taken as your agent.

Unless you specifically limit the period of time that this Power of Attorney will be in effect, your agent may exercise the powers given to him or her throughout your lifetime, both before and after you become incapacitated. A court, however, can take away the powers of your agent if it finds that the agent is not acting properly. You may also revoke this Power of Attorney if you wish.

This Power of Attorney does not authorize your agent to appear in court for you as an attorney-at-law or otherwise to engage in the practice of law unless he or she is a licensed attorney who is authorized to practice law in Illinois.

The powers you give your agent are explained more fully in Section 3-4 of the Illinois Power of Attorney Act. This form is a part of that law. The "NOTE" paragraphs throughout this form are instructions.

You are not required to sign this Power of Attorney, but it will not take effect without your signature. You should not sign this Power of Attorney if you do not understand everything in it, and what your agent will be able to do if you do sign it.

Please place your initials on the following line indicating that you have read this Notice:

_____Initial

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR PROPERTY

1. I,_____ (name),
_____(address),
hereby revoke all prior powers of attorney for property executed by me and appoint:
(NOTE: You may not name co-agents using this form.)
_____ (agent's name), my _____(relationship),
_____(address),
as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) with respect to the following powers, as defined in Section 3-4 of the "Statutory Short Form Power of Attorney for Property Law" (including all amendments), but subject to any limitations on or additions to the specified powers inserted in paragraph 2 or 3 below:

(NOTE: You must strike out any one or more of the following categories of powers you do not want your agent to have. Failure to strike the title of any category will cause the powers described in that category to be granted to the agent. To strike out a category you must draw a line through the title of that category. You should initial next to the line drawn through the title of any category stricken out.)

(a) Real estate transactions, including leasing transactions.
(b) Financial institution transactions.
(c) Stock and bond transactions.
(d) Tangible personal property transactions.
(e) Safe deposit box transactions.
(f) Insurance and annuity transactions.
(g) Retirement plan transactions.
(h) Social Security, unemployment and military service benefits.
(i) Tax matters.
(j) Claims and litigation, including institute bankruptcy proceedings.
(k) Commodity and option transactions.
(l) Business operations.
(m) Borrowing transactions.
(n) Estate transactions.
(o) All other property transactions.

(NOTE: Limitations on and additions to the agent's powers may be included in this power of attorney if they are specifically described below.)

2. The powers granted above shall not include the following powers or shall be modified or limited in the following particulars:
(NOTE: Here you may include any specific limitations you deem appropriate, such as a prohibition or conditions on the sale of particular stock or real estate or special rules on borrowing by the agent.)
_____
_____

3. In addition to the powers granted above, I grant my agent the following powers:
(NOTE: Here you may add any other delegable powers including, without limitation, power to make gifts, exercise powers of appointment, name or change beneficiaries or joint tenants or revoke or amend any trust specifically referred to below.)
_____
_____

_____Initial

(NOTE: Your agent will have authority to employ other persons as necessary to enable the agent to properly exercise the powers granted in this form, but your agent will have to make all discretionary decisions)

(_____) 4. My agent shall have the right by written instrument to delegate any or all of the foregoing powers involving discretionary decision-making to (*select one and strike the others*):
A) No Delegation, only Agent can make decisions for me.
B) _____ (name of authorized delegate) only **OR**
C) any person or persons whom my agent may select,
but such delegation may be amended or revoked by any agent (including any successor) named by me who is acting under this power of attorney at the time of reference.

(NOTE: Your agent will be entitled to reimbursement for all reasonable expenses incurred in acting under this power of attorney.)

(_____) 5. Compensation (*select one and strike the others*):
A) My agent shall NOT be entitled to reasonable compensation for services rendered as agent under this power of attorney, and will be entitled to reimbursement for all reasonable expenses only,
B) My agent shall be entitled to reasonable compensation, not exceed $_____ (amount) per _____ (time period), **OR**
C) My agent shall be entitled to reasonable compensation at the Agent's discretion.

(NOTE: This power of attorney may be amended or revoked by you at any time and in any manner. Initial and complete paragraphs 6 and 7:)

(_____) 6. This power of attorney shall become effective on (*select one and strike the other*):
A) _____ (*date of signing)* although I can make decisions for as long as I choose, or
B) Doctor's written statement that I can no longer make financial decisions.
Agent shall have the authority as personal representative under HIPAA to speak with my doctor and request a written statement whether or not I can make financial decisions.

(_____) 7. This power of attorney shall terminate on *my death* .
(NOTE: Insert a future date or event if you want this power to terminate prior to your death.)

(NOTE: If you wish to name one or more successor agents, insert the name, relationship and address of each successor agent in paragraph 8.)

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

_____
(Successor agent #1 name, relationship, and address)

_____
(Successor agent #2 name, relationship, and address)

For purposes of this paragraph 8, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to business matters, as certified by a licensed physician.

_____Initial

(NOTE: If you wish to, you may name your agent as guardian of your estate if a court decides that one should be appointed. To do this, retain paragraph 9, and the court will appoint your agent if the court finds that this appointment will serve your best interests and welfare. Strike out paragraph 9 if you do not want your agent to act as guardian.)

9. If a guardian of my estate (my property) is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

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

(NOTE: This form does not authorize your agent to appear in court for you as an attorney-at-law or otherwise to engage in the practice of law unless he or she is a licensed attorney who is authorized to practice law in Illinois.)

11. The Notice to Agent is incorporated by reference and included as part of this form.

Dated: _____

Signed _____
(principal)

(NOTE: This power of attorney will not be effective unless it is signed by at least one witness and your signature is notarized, using the form below. The notary may not also sign as a witness.)

The undersigned witnesses certifies that _____, known to me to be the same person whose name is subscribed as principal to the foregoing power of attorney, appeared before me and the notary public and acknowledged signing and delivering the instrument as the free and voluntary act of the principal, for the uses and purposes therein set forth. I believe him or her to be of sound mind and memory. The undersigned witness also certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.

Dated: _____

Printed Name:_____

Signed _____
(Witness)

Dated: _____

Printed Name:_____

Signed _____
(Second Witness)

(NOTE: Illinois requires only one witness, but other jurisdictions may require more than one witness.)

_____Initial

State of Illinois)
) SS.
County of Cook)

The undersigned, a notary public in and for the above county and state, certifies that _____, known to me to be the same person whose name is subscribed as principal to the foregoing power of attorney, appeared before me and the witnesses _____ and _____ in person and acknowledged signing and delivering the instrument as the free and voluntary act of the principal, for the uses and purposes therein set forth.

Dated: _____

_____
Notary Public

(NOTE: You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.)

Specimen signatures of agent (and successors).	I certify that the signatures of my agent (and successors) are correct.
_____ (agent)	_____ (principal)
_____ (successor agent)	_____ (principal)
_____ (successor agent)	_____ (principal)

(NOTE: The name, address, and phone number of the person preparing this form or who assisted the principal in completing this form should be inserted below.)

This document was prepared by:
Center for Disability & Elder Law
205 W. Randolph
Suite 1610
Chicago, IL 60606
(312) 376-1880

_____Initial

NOTICE TO AGENT

When you accept the authority granted under this power of attorney a special legal relationship, known as agency, is created between you and the principal. Agency imposes upon you duties that continue until you resign or the power of attorney is terminated or revoked.

As agent you must:
(1) do what you know the principal reasonably expects you to do with the principal's property;
(2) act in good faith for the best interest of the principal, using due care, competence, and diligence;
(3) keep a complete and detailed record of all receipts, disbursements, and significant actions conducted for the principal;
(4) attempt to preserve the principal's estate plan, to the extent actually known by the agent, if preserving the plan is consistent with the principal's best interest; and
(5) cooperate with a person who has authority to make health care decisions for the principal to carry out the principal's reasonable expectations to the extent actually in the principal's best interest.

As agent you must not do any of the following:
(1) act so as to create a conflict of interest that is inconsistent with the principles in this Notice to Agent;
(2) do any act beyond the authority granted in this power of attorney;
(3) commingle the principal's funds with your funds;
(4) borrow funds or other property from the principal, unless otherwise authorized;
(5) continue acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney, such as the death of the principal, your legal separation from the principal, or the dissolution of your marriage to the principal.

If you have special skills or expertise, you must use those special skills and expertise when acting for the principal. You must disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name "as Agent" in the following manner:

"(Principal's Name) by (Your Name) as Agent"

The meaning of the powers granted to you is contained in Section 3-4 of the Illinois Power of Attorney Act, which is incorporated by reference into the body of the power of attorney for property document.

If you violate your duties as agent or act outside the authority granted to you, you may be liable for any damages, including attorney's fees and costs, caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice from an attorney."

The requirement of the signature of a witness in addition to the principal and the notary, imposed by Public Act 91-790, applies only to instruments executed on or after June 9, 2000 (the effective date of that Public Act).

_____Initial

AGENT'S CERTIFICATION AND ACCEPTANCE OF AUTHORITY
(To be completed by Agent
Should be left blank until such time as Agent begins to act)

I, _____ **(insert name of agent)**, certify that the attached is a true copy of a power of attorney naming the undersigned as agent or successor agent for _____ **(insert name of principal)**.

I certify that to the best of my knowledge the principal had the capacity to execute the power of attorney, is alive, and has not revoked the power of attorney; that my powers as agent have not been altered or terminated; and that the power of attorney remains in full force and effect.

I accept appointment as agent under this power of attorney.

This certification and acceptance is made under penalty of perjury.*

Dated: _____

_____
(Agent's Signature)

_____
(Print Agent's Name)

_____
(Agent's Address)

*(NOTE: Perjury is defined in Section 32-2 of the Criminal Code of 2012, and is a Class 3 felony.)

_____Initial

MY POWER OF ATTORNEY FOR HEALTH CARE

This Power of Attorney revokes all previous Powers of Attorney for Health Care

My 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: _____ (Relationship) _____

Agent address: _____

Agent phone number: _____

If a guardian of my person is to be appointed, I nominate the agent acting under this Power of Attorney to serve 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, relationship, address and phone number)

_____

(Successor agent #2 name, relationship, 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. I intend for the person named as my agent to serve as my "personal representative" as that term is defined by HIPAA and regulations thereunder.

(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 initial any one box):

____ Make health care 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 health care 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

____ While I am still able to make my own health care decisions, I can still make my own health care decisions. However, at any time I can choose to appoint my Agent to make health care decisions for me and continue to make health care decisions after I am no longer able to make them for myself.

____Initial Here

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, 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, make anatomical gifts or dispose of remains, you may do so specifically in this form.

_____

_____

I Prefer and Authorize Burial _____ Cremation _____ No Preference_____ (Initial One)

_____ I have pre-planned the disposition of my remains _____

Today's date: _____

My signature: _____

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

I am at least 18 years old and I saw the principal sign this document. I believe the principal to be of sound mind and memory. 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, 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.

Witness printed name**:**_____
Witness address: 205 W. Randolph Suite 1610
City, State, Zip Chicago, IL 60606

Witness signature: _____

Today's date: _____

Witness printed name:_____
Witness address: 205 W. Randolph Suite 1610
City, State, Zip Chicago, IL 60606 .

Witness signature: _____

Today's date: _____

____Initial Here

State of Illinois)
) SS.
County of Cook)

The undersigned, a notary public in and for the above county and state, certifies that _____, known to me to be the same person whose name is subscribed as principal to the foregoing power of attorney, appeared before me and the witnesses _____ and _____ in person and acknowledged signing and delivering the instrument as the free and voluntary act of the principal, for the uses and purposes therein set forth.

Dated: _____

_____
Notary Public

____Initial Here

AGENT'S CERTIFICATION AND ACCEPTANCE OF AUTHORITY
(To be completed by Agent
Should be left blank until such time as Agent begins to act)

I, _____ **(insert name of agent)**, certify that the attached is a true copy of a power of attorney naming the undersigned as agent or successor agent for _____ **(insert name of principal)**.

I certify that to the best of my knowledge the principal had the capacity to execute the power of attorney, is alive, and has not revoked the power of attorney; that my powers as agent have not been altered or terminated; and that the power of attorney remains in full force and effect.

I accept appointment as agent under this power of attorney.

This certification and acceptance is made under penalty of perjury.*

Dated: _____

_____
(Agent's Signature)

_____
(Print Agent's Name)

_____
(Agent's Address)

*(NOTE: Perjury is defined in Section 32-2 of the Criminal Code of 2012, and is a Class 3 felony.)

____Initial Here

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

____Initial Here

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) 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, but you may wish to have it 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.

____Initial Here

ILLINOIS LIVING WILL DECLARATION

This Declaration is made this _____day of _____, 20____.

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 (and not intended to make me better) 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, my physician, and my agent under my Power of Attorney for Healthcare as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed _____

Address _____
_____
_____

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 Signature) (Witness Signature)

_____ _____
(Print Witness Name) (Print Witness Name)

*For purposes of this Declaration, "Death Delaying Procedure" means any medical procedure or intervention which, when applied to a qualified patient, in the judgment of the attending physician would serve only to postpone the moment of death.

In appropriate circumstances, such procedures include, but are not limited to, assisted ventilation, artificial kidney treatments, intravenous feeding or medication, blood transfusions, tube feeding and other procedures of greater or lesser magnitude *that serve only to delay death*.
However, this does not affect the responsibility of the attending physician or other health care provider to provide treatment for a patient's comfort care or alleviation of pain.

Center for Disability & Elder Law

SENIOR CENTER INITIATIVE FREQUENTLY ASKED QUESTIONS

The Center for Disability & Elder Law is providing you with the attached Power(s) of Attorney and/or Living Will. Please read the following information carefully. It is recommended that you keep this information with the documents, and you are encouraged to share this information with your Agent.

You and Your Agent

Who are the Principal and Agent? You are the Principal – this is the person who authorizes the Power of Attorney. The Agent is the person you select to act as your "attorney-in-fact" to make decisions for you. You should know your Agent well and trust your Agent implicitly.

Who qualifies as an Agent? The person you select as your Agent must be at least 18 years old, must be competent, and cannot be your primary health care provider (i.e., physician or other licensed caregiver).

Can I name two Agents at the same time? No, you may not name co-Agents to share Power of Attorney. However, you may designate one person as Agent with Power of Attorney for Health Care and a different person as Agent with Power of Attorney for Property. You may also designate a "Successor Agent", who can act in the event that your Agent is unable or unwilling to act on your behalf.

What are the duties of the Agent for the Power of Attorney for Health Care? The Power of Attorney for Health Care gives your Agent broad powers to make health care decisions for you, e.g. the power to authorize or withdraw medical treatment, speak to your physicians, admit you to or discharge you from a hospital, and make end of life decisions. You may limit or restrict the broad powers that are granted to your Agent. Your Agent must use due care to act for your benefit and to act in accordance with the Power of Attorney for Healthcare.

What are the duties of the Agent for the Power of Attorney for Property? The Power of Attorney for Property gives the Agent broad powers to handle your property, e.g. the power access your bank accounts, to pay your bills using your funds, and pledge, sell or dispose of your real estate and personal property. You may expressly limit or restrict the broad powers that are granted to your Agent. The Agent must use due care to act for your benefit and to act in accordance with the Power of Attorney for Healthcare.

Is the Agent personally liable for your bills? No, the Agent is not personally liable for your bills. The Agent is also not liable for losses due to errors of judgment or for the acts or defaults of any other person. However, the Agent shall be liable for any fraudulent or negligent exercise of his powers.

Will the Agent be compensated? Under the Power of Attorney for Property, the Agent may be entitled to reasonable compensation, if you so authorize. The Agent may also hire other people to perform certain duties under the Power of Attorney (e.g., hiring a tax preparer to prepare taxes).

Is a Power of Attorney for Property the Same Thing as a Last Will and Testament? No, the Power of Attorney for Property authorizes your Agent to act for you in times you cannot act for yourself or if you choose to let your Agent act.
However, the Power of Attorney ends at your passing. The Agent does NOT automatically receive your possessions nor can your Agent make any decisions about your possessions after you pass away.

Your will or trust would determine who receives what after your passing. If you pass without an estate plan, the Illinois Intestate Succession Act would control.

Center for Disability & Elder Law

Keeping Records and Distributing Copies

Where do I keep the signed documents? You should keep the original signed documents in a safe place. If you expect that your Agent is not going to be exercising the powers granted in the Powers of Attorney immediately, you should keep the ORIGINALS and provide your Agent with the COPIES. However, if you do this, you **MUST** tell your Agent the exact location of the originals. In the alternative, you may provide the ORIGINALS to your Agent and keep the COPIES yourself.

Who else gets copies of the documents? You may wish to bring the original signed documents to your physician and bank to notify them that you have signed these documents and allow them to make COPIES and place in your medical and financial records. However, make sure that you keep the ORIGINALS. Note that your Agent will have to provide the ORIGINALS to any service provider in order for your Agent to act.

Enforcing the Power of Attorney

When does the Power of Attorney take effect? The Power of Attorney takes effect on the date signed, unless you choose a different date or future life event.

When does the Power of Attorney terminate? The Power of Attorney ends under one of the following:

- You pass away (NOTE: An exception exists in the Power of Attorney for Healthcare for residual powers, including: anatomical gifts, authorizing an autopsy and disposition of your remains);
- You designate a termination date and it arrives
- You formally revoke the Power of Attorney
- Your Agent dies or becomes incompetent and there is no Successor Agent
- Your Agent terminates the agency or
- A court removes your Agent for not properly fulfilling the duties of an agent.

Changing or Revoking the Power of Attorney

How do I change the Power of Attorney? You have the right to modify the Power of Attorney at any time while you have capacity by changing its terms or changing your agent. Please note: all changes **MUST** be written, signed, witnessed, and notarized. If you wish to modify the Power of Attorney, it is highly recommended that you revoke the old one and have a new one created.

How do I revoke the Power of Attorney? You may formally revoke a Power of Attorney by:

- Writing a revocation letter to your Agent and sending it to the Agent via certified mail;
- Destroying the original document (burning, tearing, obliterating, etc.) and notifying your Agent of the document's destruction; and/or
- Making an oral revocation in the presence of a witness who then puts the revocation into writing (NOTE: this is not recommended).

Is capacity required to revoke the Power of Attorney? No, capacity is not required for you to revoke a Power of Attorney for Healthcare; however, a court may rule on whether you have capacity to enter into a new Power of Attorney. If a court finds that you lack capacity, the court may appoint a guardian who may revoke agency on your behalf.

Living Will Declaration

What is a Living Will Declaration? Unlike Powers of Attorney, a Living Will Declaration does not vest power in an Agent to make decisions on your behalf. A Living Will is a declaration made by you to your physician that you do not want your moment of death to be artificially postponed. If your attending physician determines that your death is imminent except for death delaying procedures, a Living Will Declaration directs your physician to withhold any procedures that would prolong the dying process, so that you are permitted to die naturally, but to provide you with comfort care.

A Living Will Declaration will not be valid while there is also a valid Power of Attorney for Healthcare. Also, if there is a conflict between a Power of Attorney for Healthcare and Living Will Declaration, the Power of Attorney for Healthcare would control.