

Illinois Department on Aging
**Illinois Long-Term Care Ombudsman Program
Supplemental Training Curriculum**

**Supplemental Module # 10
Advance and Court/Operation of Law Directives**

TEACHING TIPS

Pre-publication Edition I

Funded by the Retirement Research Foundation

**Developed by Margaret Niederer and Erin Strotheide
Contributions by David Sutterfield, Attorney at Law**

**Field Editors:
Statewide Regional Ombudsmen**

Rod R. Blagojevich, Governor

Charles D. Johnson, Director

SUPPLEMENTAL MODULE # 10 ADVANCE AND COURT/OPERATION OF LAW DIRECTIVES TEACHING TIPS

The supplemental modules for ombudsmen have been created to accommodate different learning styles and are based on research about how most people learn. The premise on which this module is based is the idea that new information is learned best when there is an opportunity for discussion and to ask questions. This module incorporates individual reading, group discussion, questions on what is not clear to you and an evaluation of what you have learned.

This module is designed to be adaptable to various teaching methods and settings: training/ in-services for ombudsmen or presentations to families or facility staff. This module can be divided into as many training sessions as needed and a variety of methods can be used, including a lecture method.

This module is also intended to be an **advance and court/operation of law directive reference** after training is complete.

If, after completing this module, the trainees do not clearly understand advance and court/operation of law directives and related issues, it is suggested that the module be used for training until the concepts are understood.

An ombudsman that is not prepared to handle advance and court/operation of law directive cases should be instructed to contact her supervisor before taking action on such cases.

You may need:

- Copies of the accountability exercises.
- Copies of the advance directive and other forms converted into transparencies.
- Every trainer should obtain a copy of the Power of Attorney forms (Health Care and Property), available free of charge from the Department on Aging. Obtaining copies of the forms for all trainees is at the trainer's discretion.
- Overhead projector.

Accountability

After the discussion, ombudsman participants will be asked to work as a group to

- 1) Develop a chart that lists all the advance and court/operation of law directives; identify each by its common attributes, e.g., if the execution of the advance directive requires a witness or notary, who appoints the decision maker, the amount of decision-making authority, if court supervision is required, requirements for revocation; etc., and
- 2) List at least five questions, but as many questions as the group has, about the information in this module.

Resources and Forms (all forms are unofficial except those specified)

Guardianship Petitions when a POA Agent Exists.....page 6

Recommendations for POA Safeguards.....page 7

Forms Developed by David Sutterfield, Attorney at Law:

Physician’s Guardianship Assessment Tool..... page 8

Standard Questions of Petition in Adult Guardianship Cases.....page 10

***Health Care Surrogate Act Appointment of Surrogate—
Medical Decisions other than Termination of Life Support: Adult***.....page 16

***Health Care Surrogate Act Appointment of Surrogate—
Termination of Life-Sustaining Treatment: Adult***.....page 19

Other forms:

Power of Attorney for Health Care Revocation Form.....page 22

Illinois Living Will Declaration (Official).....page 23

Declaration for Mental Health Treatment Form (Official).....page 25

List of Forms Used in Guardianship Cases.....page 30

DNR form (Official).....page 31

Chart developed by Lee Beneze, Department on Aging

Decision-Making Tools.....page 32

Resources.....page 35

MODULE # 10 ACCOUNTABILITY EXERCISE 1

After the discussion, develop a chart listing all the advance and court/operation of law directives. Identify each by its common attributes, e.g., execution of the directive requires a witness or notary, who appoints the decision maker, the amount of decision-making authority, court supervision is/is not required, requirements for revocation, etc.

MODULE # 10 ACCOUNTABILITY EXERCISE 2

List at least five questions, but as many questions as the group has, about the information in this module.

1

2

3

4

5

6

7

8

9

10

GUARDIAN PETITIONS WHEN AN POA AGENT EXISTS

The following information is provided as background for trainers concerning questions about petitioning the court for a guardianship when a resident who has a Power of Attorney agent does not have the capacity to make an informed decision.

Both powers of attorney make a provision for the principal to name a potential guardian in the event guardianship proceedings are initiated.

An ombudsman could be questioned about guardianship proceedings when there is a power of attorney. The only sound reason for initiating guardianship proceedings when a valid durable power of attorney is in place is that the agent has failed to act responsibly or committed wrongdoing. This does not include the power of attorney advocating vigorously for quality care, which has, allegedly, insulted professional health care providers, facility staff, and others.

By the same token, there is no reason for guardianship proceedings to be initiated when a valid power of attorney is in place and there is no indication that the agent has not been prudently handling the principal's affairs.

Section 11a-3(b) of the Probate Act provides specific instructions as follows:
"Guardianship shall be utilized only as is necessary to promote the well-being of the disabled person, to protect them from neglect, exploitation or abuse, and to encourage development of its maximum self-reliance and independence. Guardianship shall be ordered to the extent necessitated by the individual's actual mental, physical and adaptive limitations [emphasis added]."

A guardianship petition that fails to allege irresponsibility of the agent, or wrong doing by an agent, or some defect in the power of attorney making it invalid, should be vigorously contested. Allowing a court to step into the life of the principal and appoint someone other than the agent designated by the principal could be challenged as one kind of elder abuse and exploitation. The ombudsman would always contact the supervisor in cases such as this for guidance.

RECOMMENDATIONS OF THAT WOULD PROVIDE SAFEGUARDS FOR THE PRINCIPAL AND POWER OF ATTORNEY AGENT

(This is provided to emphasize why POA agents may not be aware of their responsibilities and what improvements may be needed in Illinois law.)

1. State durable power of attorney statutes should be amended to include formal execution requirements.
2. States should include simple cautionary language in all pre-printed power of attorney forms warning principals of the powers being conveyed.
3. When using the statutory short form durable power of attorney, require that the principal affirmatively signify the powers he/she wishes to convey to the agent rather than to eliminate those powers not wanted.
4. Recordation of all durable powers of attorney should be required to protect principals and enable third parties to ascertain the validity of a durable power of attorney.
5. Durable power of attorney statutes should provide clearly specified procedures for revocation.
6. Permit interested parties to petition a court to terminate the durable power of attorney if the agent is acting improperly.
7. Power of attorney agents should be held to statutory fiduciary standards similar to other statutory fiduciaries such as trustees and executors, and therefore, as recognized statutory fiduciaries, agents should be entitled to a statutory commission if the durable power of attorney instrument fails to address compensation.
8. Require notification to principal (or designated third party) whenever the durable power of attorney is used by the agent for a transaction over the amount specified by the principal in the document.
9. States should consider revising criminal statutes to proscribe enhanced sentences for those who commit crimes such as durable power of attorney abuse.
10. Create a public registry-listing individuals who have been convicted of durable power of attorney abuse.
11. Require that agents post a surety bond.
12. Require that a third party be given the power to revoke the durable power of attorney in the event the principal is unable to do so.
13. Require principals to name successor agents.
14. Require the agent to provide an annual accounting to a court of law.
15. Require mandatory reporting by certain third parties of known or suspected durable power of attorney abuse.

Credit: Government Law Center of Albany Law School, New York

PHYSICIAN'S GUARDIANSHIP ASSESSMENT TOOL

To:

Re:

This will certify that I am a practicing physician duly licensed by the State of Illinois and that _____, age _____ was last examined by me on: _____.

He/she has been a patient of mine since: _____

Diagnosis: _____

Major Diagnosis: _____

Severity: _____

Is the patient housebound?	Yes	No
Is the patient bedridden?	Yes	No
Is there a loss of bowel control?	Yes	No
Is there a loss of bladder control?	Yes	No
Does the patient need assistance toileting?	Yes	No
Can the patient ambulate unassisted?	Yes	No
Does the patient need assistance rising from a chair?	Yes	No
Can the patient dress and undress without assistance?	Yes	No
Can the patient perform grooming tasks unassisted?	Yes	No
Can the patient manage medications without assistance?	Yes	No
Is the patient physically and mentally able to protect self from hazards of daily living?	Yes	No
Is the patient oriented to person?	Yes	No
Is the patient oriented to place?	Yes	No
Is the patient oriented to time?	Yes	No
Does the patient require 24-hour supervision?	Yes	No
Does the patient have a known caregiver?	Yes	No
Is the patient in need of nursing home placement?	Yes	No

STANDARD QUESTIONS OF PETITION IN ADULT GUARDIANSHIP CASES

1. Name: _____

2. Address: _____

3. Over Age 18? Yes No

4. Occupation: _____

5. Has he/she ever been convicted on a crime? Yes No

6. Has he/she ever been adjudged by a court to be mentally ill, incompetent, or disabled? Yes No

7. Relationship to ADP (alleged disabled person): _____

8. Date of birth of ADP: _____

9. Present residence of ADP (make sure to establish proper venue by establishing county of residence.):

10. Does the ADP have a living spouse? Yes No

11. Does the ADP have any living children? Yes No
If so, list names and addresses

12. If answers to items #10 and #11 are both negative,
Does ADP have any living brothers or sisters? ____ Yes ____ No
If so, list names, ages, and addresses:

13. If answers to items #10, 11 and 12 are all negative,
Who are ADP's closest relatives? List names, relationships, ages, and addresses:

14. How often do you see the ADP? _____

15. When is the last time you saw the ADP? _____

16. Describe the ADP's present living arrangements (Type of residence, with whom,
ADP lives, etc.):

17. What is ADP's present physical condition?

a. Able to get around the house ____ Yes ____ No

b. Able to get around in the house by him/herself ____ Yes ____ No

c. Bedfast ____ Yes ____ No

d. Able to dress him/herself ____ Yes ____ No

Explain _____

- e. Able to prepare meals Yes No
Explain _____
- f. Able to bathe him/herself Yes No
- g. Continent of urine and stool Yes No
- h. Able to clean house/apartment Yes No
- i. Explain any limitations _____

18. How often does the ADP see a physician? _____

- a. Name of doctor(s) _____
- b. Present medical problems (diagnoses) _____
- c. When did ADP last see a doctor? _____
- d. Does the ADP currently take any medications? Yes No
If so, list by name, purpose, number and dosage _____
- e. Does the ADP take medication by him/herself, or s/he forgetful?
 Yes No
- f. Has the doctor placed any limitation on the ADP's activity? Yes No
If so, what are the limitations? _____

19. What is the ADP's present mental status?

a. Is he/she aware of who he/she is? Yes No

b. Is he/she aware of where he/she is? Yes No

c. Is he/she aware of time (day, dates, year, time of day)? Yes No

Can you have a coherent conversation with the ADP? Yes No

Explain _____

d. Can the ADP take care of money and pay bills? Yes No

Explain _____

If no, who does it? _____

f. Any other details, re: mental status? _____

20. Does the ADP presently receive any in-house care or assistance?

Yes No

If so, describe _____

21. Are there any other facts which lead you to conclude that the ADP's current living arrangements are unsafe, dangerous, or not appropriate? Yes No

Explain _____

22. What property does the ADP own

a. Real estate (description, value): _____

b. Bank accounts (which bank, savings, C.D.'s, checking, how much in each):

c. Stocks or bonds (description and evaluation): _____

d. Other significant property: _____

23. What is the ADP's current income?

- a. Social Security (how much): _____
- b. VA, black lung, pension (how much): _____
- c. Interest on investments (description, how much): _____

- d. Other: _____
- e. Identify any of the benefits which are paid directly to the nursing home:

24. Why do you believe a guardianship is necessary? (Explain in appropriate detail):

25. If you are appointed guardian, what kind of living arrangements do you intend to make for the ADP? _____

26. If residential care is to be requested, do you believe that the ADP could:

- a. Live by him/herself alone? ___ Yes ___ No
- b. Live by him/herself with in-home care? ___ Yes ___ No
- Explain (specifically state if in-home care is not available): _____

- c. Live with someone else? ___ Yes ___ No

27. (If someone other than the petitioner is proposed guardian)

Who do you propose be guardian? (Explain if necessary) _____

28. You are requesting to be (or that _____ be) named guardian of the ADP's estate and person? ____Yes ____No

29. Why? (Here also, express any limitations on scope of guardianship.) _____

30. (If residential placement is requested)

You are requesting that the court authorize you (or guardian) to place the ADP in a residential care facility (nursing home)? ____Yes ____No

*31. Do you understand that, as guardian of the ADP's person, you will have the legal responsibility and obligation to make personal care, medical, and placement decisions for the ADP? ____Yes ____No
Are you prepared to make such decisions? ____Yes ____No

**32. Do you understand that as the guardian of the ADP's estate, you will have to safeguard the ADP's property and money, inform the court of how you spend or use the ADP's money and property for his/her best interest? ____Yes ____No
Are you prepared to do that? ____Yes ____No

*33. You understand that being guardian is a serious matter for which you will not be compensated? ____Yes ____No
Do you willingly accept this responsibility? ____Yes ____No

* Questions to be asked when the petitioner is also proposed guardian.

** Questions to be asked when seeking guardian of state (as well as person).

In cases in which the ADP is going to be living with the guardian, ask questions about the size of the guardian's home and living arrangements. Also, elicit testimony on any in-home care.

**HEALTH CARE SURROGATE ACT
APPOINTMENT OF SURROGATE
MEDICAL DECISIONS OTHER THAN TERMINATION OF LIFE SUPPORT
ADULT**

CAVEAT: DO NOT use this form for decisions by the surrogate to forego life-sustaining treatment of a minor, non-adult patient.

Patient's Name: _____

Date of Birth: _____

Date of Admission: _____

Attending Physician: _____

Does the Patient have an authorized agent pursuant to an operative and unrevoked power of attorney for health care that is applicable to the patient's medical condition?

____ Yes ____ No.

If Yes, is the agent available and willing to fulfill his/her responsibilities?

____ Yes ____ No.

If Yes, stop here and do not permit a surrogate to make a decision.

Diagnoses: _____

Is it your opinion that, within a reasonable degree of medical certainty, the patient lacks the ability to understand and appreciate the consequences of a decision regarding forgoing medical treatment? ____ Yes ____ No.

If Yes, set forth the cause, nature, and duration of the patient's lack of decisional capacity.

Is it your opinion that, within a reasonable degree of medical certainty, the patient lacks the ability to reach and communicate an informed decision regarding forgoing medical treatment?
_____Yes _____No.

If Yes, set forth the cause, nature, and duration of the patient's lack of decisional capacity.

Surrogate's Name, Address, and Telephone Number
(This information is required by Illinois law):

Name: _____

Address: _____

Phone: _____

Surrogate's Relationship to Patient (Circle One):

1. Guardian of the Person;
2. Spouse;
3. Adult Child;
4. Parent;
5. Adult Sibling;
6. 6. Adult Grandchild;
7. Close Friend;
8. Guardian of the Estate.

NOTE: These are listed in order of priority. Illinois law requires a reasonable inquiry as to the availability of possible surrogates listed 1 through 4. Describe the nature and extent of the reasonable inquiry and the person making said inquiry.

Describe the decision of the surrogate decision maker regarding medical treatment and the information provided to them by the physician in the course of making that decision.

REQUIRED SIGNATURES

_____ DATE	_____ SIGNATURE OF ATTENDING PHYSICIAN _____ PRINTED NAME OF ATTENDING PHYSICIAN
_____ DATE	_____ PRINTED NAME OF ATTENDING PHYSICIAN
_____ DATE	_____ HEALTH CARE SURROGATE
_____ DATE	_____ PRINTED NAME OF HEALTH CARE SURROGATE

Developed by David Sutterfield, Attorney at Law, P.O Box 836, Effingham, IL 62401 Phone: (217) 342-3100
for the ICARE Ombudsman Program

**HEALTH CARE SURROGATE ACT
APPOINTMENT OF SURROGATE
TERMINATION OF LIFE-SUSTAINING TREATMENT
ADULT**

CAVEAT: DO NOT use this form for decisions by the surrogate to forego life-sustaining treatment of a minor, non-adult patient.

Patient's Name: _____

Date of Birth: _____

Date of Admission: _____

Attending Physician: _____

Does the Patient have an authorized agent pursuant to an operative and unrevoked power of attorney for the health care that is applicable to the patient's medical condition?

_____ Yes _____ No.

If Yes, is the agent available and willing to fulfill his/her responsibilities?

_____ Yes _____ No.

If Yes, stop here and do not permit a surrogate to make a decision.

Diagnoses: _____

Is it your opinion that, within a reasonable degree of medical certainty, the patient lacks the ability to understand and appreciate the consequences of a decision regarding forgoing medical treatment? _____ Yes _____ No.

If Yes, set forth the cause, nature, and duration of the patient's lack of decisional capacity.

Is it your opinion that, within a reasonable degree of medical certainty, the patient lacks the ability to reach and communicate an informed decision regarding forgoing medical treatment?
_____Yes _____No.

If Yes, set forth the cause, nature, and duration of the patient's lack of decisional capacity.

Surrogate's Name, Address, and Telephone Number
(This information is required by Illinois law):

Name: _____

Address: _____

Phone: _____

Surrogate's Relationship to Patient (Circle One):

1. Guardian of the Person;
2. Spouse;
3. Adult Child;
4. Parent;
5. Adult Sibling;
6. Adult Grandchild;
7. Close Friend;
8. Guardian of the Estate.

NOTE: These are listed in order of priority. Illinois law requires a reasonable inquiry as to the availability of possible surrogates listed 1 through 4. Describe the nature and extent of the reasonable inquiry and the person making said inquiry.

Has the patient been informed by the attending physician that it has been determined that the patient lacks decisional capacity and that a surrogate decision maker will be making the life-sustaining treatment decisions on behalf of the patient? _____Yes _____No.

Proceed no further if the answer is No.

Has the patient been informed of the identity of the surrogate decision maker?
_____Yes _____No. Proceed no further if the answer is No.

Has the patient objected to the appointment of the surrogate decision maker?
_____Yes _____No. Proceed no further if the answer is Yes.

Has the patient been informed of the decision(s) of the surrogate decision maker?
_____ Yes _____ No. Proceed no further if the answer is No.

Has the patient objected to the decision(s) of the surrogate decision maker?
_____ Yes _____ No. Proceed no further if the answer is Yes.

Describe the decision of the surrogate decision maker to forgo life-sustaining treatment and the information provided to them by the physician in the course of making that decision.

REQUIRED SIGNATURES

_____ DATE	_____ SIGNATURE OF ATTENDING PHYSICIAN
_____ DATE	_____ PRINTED NAME OF ATTENDING PHYSICIAN
_____ DATE	_____ SIGNATURE OF CONCURRING PHYSICIAN
_____ DATE	_____ PRINTED NAME OF CONCURRING PHYSICIAN
_____ DATE	_____ HEALTH CARE SURROGATE
_____ DATE	_____ PRINTED NAME OF HEALTH CARE SURROGATE
_____ DATE	_____ WITNESS TO HEALTH CARE SURROGATE'S DECISION
_____ DATE	_____ PRINTED NAME OF WITNESS TO HEALTH CARE SURROGATE'S DECISION

Developed by David Sutterfield, Attorney at Law, P.O Box 836, Effingham, IL 62401 Phone: (217) 342-3100
for the ICARE Ombudsman Program

POWER OF ATTORNEY FOR HEALTH CARE REVOCATION FORM

I, _____, being the Principal of a Power of Attorney for Health Care executed on the _____ day of _____, 200_ granting authority to _____ as Agent and _____ as Successor Agent(s) do hereby revoke said Power or Attorney as of the date of this Revocation.

Signed this _____ day of _____, 200_

Principal

ILLINOIS LIVING WILL DECLARATION

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

I, _____ being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death-delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

Special Instructions:

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. At the date of this instrument, I am not

entitled to any portion of the estate of the declarant according to the laws of interstate succession or to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death or directly financially responsible for declarant's medical care.

Witness

(Name and Address)

Witness

(Name and Address)

DECLARATION FOR MENTAL HEALTH TREATMENT
755 Illinois Compiled Statutes 43/75

I _____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by 2 physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

____ I consent to the administration of the following medications:

____ I do not consent to the administration of the following medications:

Conditions or limitations: _____

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

____ I consent to the administration of electroconvulsive treatment.

____ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: _____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

_____ I consent to being admitted to a health care facility for mental health treatment.

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations: _____

SELECTION OF PHYSICIAN
(OPTIONAL)

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose

Dr. _____ of _____ to be one of the 2 physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

Conditions or limitations: _____

ATTORNEY-IN-FACT

I hereby appoint:

NAME _____

ADDRESS _____

TELEPHONE # _____

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

NAME _____

ADDRESS _____

TELEPHONE # _____

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interest.

(Signature of Principal/Date)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence that neither of us is:

A person appointed as an attorney-in-fact by this document;

The principal's attending physician or mental health service provider or a relative of the physician or provider;

The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or

A person related to the principal by blood, marriage or adoption.

Witnessed By:

(Signature of Witness/Date)

(Printed Name of Witness)

(Signature of Witness/Date)

(Printed Name of Witness)

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I

understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or 2 physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

(Signature of Attorney-in-fact/Date)

(Printed Name)

(Signature of Attorney-in-fact/Date)

(Printed Name of Witness)

NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about 3 types of mental health treatment: psychotropic medication, electroconvulsive therapy, and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if 2 physicians or the court believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time.

This document will continue in effect for a period of 3 years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to your attending physician in writing and is signed by you and a physician. The revocation may be in a form similar to the following:

REVOCATION

I, _____ willfully and voluntarily revoke my declaration for mental health treatment as indicated

I revoke my entire declaration

I revoke the following portion of my declaration

Date _____ Signed _____
(Signature of principal)

I, Dr. _____, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

Date _____ Signed _____
(Signature of physician)

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by 2 qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Decision-Making Tools-A Comparative Chart

Type of Decision Making Status or Tool (Decision-Maker)	Legal Authority	Who Appoints Decision-maker?	Witnesses, Notarization Required?	Decision Making Authority	Limitations	Court Supervision?	Revocable?
Autonomy (Self)	N/A	N/A	N/A	Fullest possible	None	No	Only if individual determined to be incompetent By judge
Finance Power of Attorney (Agent)(see note)	755 ILCS 45/1-1 et seq.	Principal	Yes, notarization and two witnesses	As broad as set by principal, on financial matters	As set by principal	No	Yes, by principal
Health Care Power of Attorney (Agent)(see note)	755 ILCS 45/1-1 et seq.	Principal	One witness required, notarization desirable	As broad as set by principal, on health care matters	As set by principal	No	Yes, by principal
Living Will (Attending physician based on advance direction)	755 ILCS 35/1 et seq.	Principal gives advance direction to attending physician on life support issues only	Two witnesses required, notarization desirable	Attending physician executes principal's decision under specific medical circumstances	As set by principal, decisions limited to life support issues under specific medical circumstances	No	Yes, by principal

Type of Decision Making Status or Tool (Decision-Maker)	Legal Authority	Who Appoints Decision-maker?	Witnesses, Notarization Required?	Decision Making Authority	Limitations	Court Supervision?	Revocable?
Surrogate Health Care Decision-Making (Relative or friend as surrogate Decision-maker)	755 ILCS 40/1 et seq.	State Law	N/A	Set by state statute, but broad	As set by state law, but broad authority granted	No	No, but statute does not apply if principal has guardian of person or health care agent
Temporary Guardianships (Temporary guardian)	755 ILCS 5/11a-1 et seq.	Judge, upon a petition. Can be done without notice to the person alleged to need guardian	N/A	Set by judge, but usually very limited and specific, may be for a specific purpose, e.g., consenting to medical treatment	As set by judge, usually very limited and specific, sufficient to solve immediate health or personal care crisis	Yes	Only by judge
Limited Guardianship of Estate (financial issues) (Guardian)	755 ILCS 5/11a-1 et seq.	Judge, upon petition, but may be contested	N/A	Set by judge, but limited and specific	As set by judge, usually specific	Yes	By judge, or upon expiration at sixty days, or upon establishment of a limited or plenary guardianship

Type of Decision Making Status or Tool (Decision-Maker)	Legal Authority	Who Appoints Decision-maker?	Witnesses, Notarization Required?	Decision Making Authority	Limitations	Court Supervision?	Revocable?
Limited Guardianship of Person (personal and health care issues) (Guardian)	755 ILCS 5/11a-1 et seq.	Judge, upon petition, but may be contested	N/A	Set by judge, but limited and specific	As set by judge, usually specific	Yes	Only by judge
Plenary Guardianship of Estate (financial issues) (Guardian)	755 ILCS 5/11a-1 et seq.	Judge, upon petition, but may be contested	N/A	Set by judge, but broad	As set by judge, but broad authority granted	Yes	Only by judge
Plenary Guardianship of Person (personal and health care issues) (Guardian)	755 ILCS 5/11a-1 et seq.	Judge, upon petition, but may be contested	N/A	Set by judge, but broad	As set by judge, but broad authority granted, specific authority needed for placement in facility	Yes	Only by judge

NOTE: For practical purposes, health care powers of attorney become effective when the principal is unable to make or communicate decisions regarding their own care. However, financial powers of attorney (unless a specific future date or condition is entered on the document) become effective immediately and allow the financial agent to transact the business of the principal. Accordingly, they should be used with great caution.

9/02

Developed by Lee Beneze, Legal Services Provider, Department on Aging

RESOURCES

(See also the appendix of the Involuntary Transfers and Discharges
Level II Training Module)

American Bar Association—Commission on Legal Problems of the Elderly

740 15th Street, NW
Washington, D.C. 20005
(202) 662-8690

American Medical Association

<http://www.ama-assn.org>

Chicago Bar Association

321 S. Plymouth Court
Chicago, Illinois 60604-3997
(312) 554-2000
Fax: (312) 554-2054

Equip for Equality

Provides protection and advocacy for persons with developmental disabilities or mental illness. www.equipforequality.org

Central/Southern Region

427 East Monroe
P.O. Box 276
Springfield, Ill. 62705
(217) 544-0464 (Voice/TTY)
(800) 758-0464 (Voice/TTY)
(217) 523-0720 (Fax)

Northwestern Region

1612 Second Avenue
P.O. Box 3753
Rock Island, Ill. 61204
(309) 786-6868 (Voice/TTY)
(800) 758-6869 (Voice/TTY)
(309) 786-2393 (Fax)

Northeastern Region

11 E. Adams, Suite 1200
Chicago, Illinois 60603
(312) 341-0022 Se Habla Espanol
(800) 537-2632 (Voice)
(800) 610-2779 (TTY)
(312) 341-0295 (Fax)

**Illinois Guardianship and Advocacy Commission
Office of the Director**

160 N. LaSalle St., Suite S-500
Chicago, Illinois 60601
(312) 793-5900
Fax: (312) 793-4311

421 E. Capitol Ave., Suite 205
Springfield, Illinois 62701
(217) 785-1540
Fax: (217) 524-0088

Statewide Toll Free: 1-866-274-8023
Emergency After Hours on Call—Toll Free: 1-866-503-9078
Statewide TTY—Toll Free: 1-866-333-3362
<http://www.state.il.us/igac/>

Illinois State Bar Association

Illinois Bar Center
Springfield, Illinois 62701
217/525.1760
Fax: 217/525-0712
Chicago phone: 312/726-8755

National Guardianship Association

<http://www.guardianship.org/index.htm>