INDIANA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

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

5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

INTRODUCTION TO YOUR INDIANA ADVANCE DIRECTIVE

This packet contains three legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. This document is especially useful because it allows you to appoint someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

2. The **Indiana Living Will Declaration (Declaration A)** lets you refuse life-prolonging procedures in the event that you develop a terminal condition and can no longer make your own medical decisions. The Declaration goes into effect only when your doctor certifies in writing that you have an injury, disease or illness from which, to a reasonable degree of medical certainty, there can be no recovery, and death will occur within a short period of time without the use of life prolonging procedures.

3. The **Indiana Life-Prolonging Procedures Declaration (Declaration B)** lets you request the use of all life-prolonging procedures in the event that you develop a terminal condition and can no longer make your own medical decisions.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

COMPLETING YOUR INDIANA POWER OF ATTORNEY FOR HEALTHCARE DECISIONS AND APPOINTMENT OF HEALTHCARE REPRESENTATIVE

Whom should I appoint as my attorney-in-fact and healthcare representative?

Your attorney-in-fact and healthcare representative is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your attorney-in-fact and healthcare representative can be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney-in-fact and healthcare representative should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A healthcare representative and attorney-in-fact may also be called an "agent" or "proxy.") Your attorney-in-fact and healthcare representative must be an adult, eighteen years of age or older.

You can appoint a second person as your alternate attorney-in-fact and healthcare representative. The alternate will step in if the first person you name as attorney-in-fact and healthcare representative is unable, unwilling or unavailable to act for you.

How do I make my Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative legal?

The law requires that you sign the document in the presence of a notary public.

Should I add personal instructions to my Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative?

One of the strongest reasons for naming an attorney-in-fact and healthcare representative is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your attorney-in-fact and healthcare representative's power to act in your best interest.

Talk with the person you appoint about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to refuse specific treatments or conditions, you should use your Indiana Living Will (Declaration A).

What if I change my mind?

Unless otherwise stated in your document, you may revoke your Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative only in writing that:

- Identifies the Power of Attorney revoked; and
- Is signed by you.
- A revocation is not effective unless the attorney-in-fact or other person has actual knowledge of the revocation.

COMPLETING DECLARATION A: INDIANA LIVING WILL DECLARATION

How do I make my Indiana Living Will Declaration legal?

State law requires that you sign your Declaration, or direct another to sign it in your presence, in the presence of two competent witnesses, 18 years of age or older, who must also sign the document and state that they personally know you and believe you to be of sound mind, and that they do not fall into any of the categories of people who cannot be witnesses. These witnesses **cannot** be:

- the person who signed the Declaration on your behalf,
- your parent, spouse or child,
- entitled to any part of your estate, or
- directly financially responsible for your medical care.

Note: You do not need to notarize your Indiana Living Will Declaration.

Can I add personal instructions to my Declaration?

Yes. You can add personal instructions to your Living Will Declaration in the part of the document called “Other directions.”

If you have appointed an attorney-in-fact and healthcare representative, it is a good idea to write a statement such as, “Any questions about how to interpret or when to apply my Declaration are to be decided by my attorney-in-fact and healthcare representative.”

What if I change my mind?

You may revoke your Declaration at any time by:

- signing and dating a written revocation,
- orally expressing your intent to revoke your Declaration, or
- physically canceling or destroying the Declaration or directing another to do so in your presence.

Your revocation becomes effective once you notify your doctor.

What other important facts should I know?

A pregnant patient’s Living Will Indiana Declaration will not be honored due to restrictions in the state law.

COMPLETING DECLARATION B: INDIANA LIFE-PROLONGING PROCEDURES DECLARATION

How do I make my Indiana Life-Prolonging Procedures Declaration legal?

State law requires that you sign your Life-Prolonging Procedures Declaration, or direct another to sign it, in the presence of two competent witnesses, 18 years of age or older, who must also sign the document to show that they personally know you and believe you to be of sound mind.

Note: You do not need to notarize your Indiana Life-Prolonging Procedures Declaration.

What if I change my mind?

You may revoke your Declaration by:

- signing and dating a written revocation,
- orally expressing your intent to revoke your Declaration, or
- physically canceling or destroying the Declaration or directing another to do so in your presence.

Your revocation becomes effective once you notify your doctor.

INSTRUCTIONS

PRINT YOUR NAME AND ADDRESS

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ATTORNEY-IN-FACT

POWERS OF YOUR ATTORNEY-IN-FACT

INDIANA POWER OF ATTORNEY FOR HEALTH CARE DECISIONS AND APPOINTMENT OF HEALTH CARE REPRESENTATIVE – PAGE 1 OF 3

1) I, _____
(name)

of _____
(address)

hereby appoint _____
(name of attorney-in-fact)

_____
(address)

_____
(home telephone number) (work telephone number)

as my attorney-in-fact to make health care decisions on my behalf whenever I am incapable of making my own health care decisions.

I grant my attorney-in-fact the following powers in matters affecting my health care:

(1) to employ or contract with servants, companions, or health care providers involved in my health care;
(2) to admit or release me from a hospital or health care facility;
(3) to have access to my records, including medical records; concerning my condition;
(4) to make anatomical gifts on my behalf;
(5) to request an autopsy; and
(6) to make plans for the disposition of my body.

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE ATTORNEY-IN-FACT

2) In the event the person I appoint above is unable, unwilling or unavailable to act as my attorney-in-fact, I hereby appoint:

_____
(name of successor attorney-in-fact)

of _____
(address)

_____

_____
(home telephone number) (work telephone number)

as my successor attorney-in-fact.

APPOINTMENT AND POWERS OF HEALTH CARE REPRESENTATIVE

Appointment of my Attorney-in-Fact as my Health Care Representative; Decisions Regarding Withdrawing or Withholding Health Care

In addition to the powers granted above, I appoint my attorney-in-fact as my **health care representative**, and authorize my attorney-in-fact and health care representative to make decisions in my best interest concerning the consent, withdrawal or withholding of health care. I understand health care to include any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well-being. Health care also includes the providing of nutrition and hydration through intravenous, gastrostomy or nasogastric tubes.

If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

PRINT YOUR NAME AND THE DATE

I, _____, the principal, sign my name to this instrument this _____ day of _____ 20_____,
(date) (month) (year)
and do hereby declare to the undersigned witness that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am eighteen years of age or older, of sound mind, and under no constraint or undue influence.

SIGN THE DOCUMENT

_____
(principal)

A NOTARY PUBLIC MUST COMPLETE THIS SECTION OF YOUR DOCUMENT

Subscribed and acknowledged before me by _____,

the principal, this _____ day of _____, 20_____.

_____
(notary public)

My Commission expires _____

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INDIANA LIVING WILL DECLARATION – PAGE 1 OF 2

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES ABOUT ARTIFICIAL FEEDING

ADD PERSONAL INSTRUCTIONS (IF ANY)

DECLARATION A
TO WITHHOLD OR WITHDRAW LIFE-PROLONGING PROCEDURES

Declaration made this _____ day of _____.
(day) (month, year)

I, _____,
(name)
being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under Indiana Code 16-36-1-7 or my attorney in fact with health care powers under Indiana Code 30-5-5.

Other directions:

INDIANA LIVING WILL DECLARATION - PAGE 2 OF 2

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration 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 of the refusal.

SIGN THE DOCUMENT AND PRINT YOUR PLACE OF RESIDENCE

I understand the full importance of this declaration.

Signed _____

City, County, and State of Residence _____

_____

WITNESSING PROCEDURE

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

WITNESSES MUST SIGN AND DATE THE DOCUMENT

Witness _____

Date _____

Witness _____

Date _____

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

SIGN AND PRINT YOUR PLACE OF RESIDENCE

WITNESSING PROCEDURE

WITNESSES MUST SIGN AND DATE YOUR DOCUMENT

INDIANA LIFE-PROLONGING PROCEDURES DECLARATION
- PAGE 1 OF 1

DECLARATION B
TO REQUEST THE USE OF LIFE-PROLONGING PROCEDURES

Declaration made this _____ day of _____.
(day) (month, year)

I, _____,
(name)
being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition, I request the use of life-prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full importance of this declaration.

Signed _____

City, County, and State of Residence _____

_____

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years old.

Witness _____

Date _____

Witness _____

Date _____

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You Have Filled Out Your Advance Directive, Now What?

1. Your Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative, Living Will Declaration and Life-Prolonging Procedures Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.

2. Give photocopies of the signed originals to your attorney-in-fact and healthcare representative and alternate, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.

3. Be sure to talk to your attorney-in-fact and healthcare representative and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. If you want to change your documents after they have been signed and witnessed, you should complete new forms.

5. Remember, you can always revoke one or both of your Indiana documents.

6. Be aware that your Indiana documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called “non-hospital do-not-resuscitate orders,” are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**