

INDIANA

Advance Directive

Planning for Important Healthcare Decisions

Courtesy of CaringInfo

www.caringinfo.org

800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. 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.
4. Once the form is completed and signed, photocopy, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR INDIANA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, an **Indiana Advance Health Care Directive**, that protects 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.

Your Indiana Advance Directive has three parts. Part One is the **Appointment of Health-Care Representative and Power of Attorney** which lets you name someone, called a Health Care Representative (Agent), to make decisions about your medical care if you can no longer speak for yourself. Part Two, the **Indiana Declaration** lets you state your wishes with regard to life-prolonging procedures in the event you develop a terminal condition and can no longer make your own decisions. Part Three contains the signature and witness provisions so that your document will be effective. Following the Advance Directive form is an **Indiana Organ Donation Form**.

Depending on your advance planning needs, you may complete either or both of the first two parts. However, **you must complete Part Three**.

How do I make my Indiana Advance Health Care Directive legal?

Indiana law requires that you have your signature witnessed in different ways, depending on the powers you are granting to your health-care representative and/or the declarations you make.

If you fill out Part One, **Appointment of Health-Care Representative and Power of Attorney**, you must sign this form in the presence of one adult, age 18 or older, who is not your health-care representative.

Part Two requires that you sign 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. If you choose in your declaration to have life- prolonging procedures withheld or withdrawn, your witnesses **cannot** be:

- a person signing the Declaration on your behalf if you are unable to sign it yourself,
- your parent, spouse, or child,
- a person entitled to any part of your estate, or
- a person directly financially responsible for your medical care.

If you fill out both parts, you must sign your form 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.

If you choose in your declaration to have life-prolonging procedures withheld or withdrawn, your witnesses **cannot** be:

- a person signing the Declaration on your behalf if you are unable to sign it yourself,
- your parent, spouse, or child,
- a person entitled to any part of your estate, or
- a person directly financially responsible for your medical care.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

You can appoint a second person as your alternate agent. An alternate agent will step in if the person you name as agent is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your appointment of health-care representation and power of attorney becomes effective when your doctor determines that you are no longer able to make or communicate decisions about your health care.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent will be bound by the current laws of Indiana as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your health-care representative's powers under Part One by telling your representative or your health-care provider, either orally or in writing, that you are revoking those powers.

You may revoke the instructions you have set out in Part Two 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 of Part Two becomes effective once you notify your doctor.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

INSTRUCTIONS

PRINT YOUR
NAME,
BIRTHDATE, AND
ADDRESS

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF YOUR
HEALTH-CARE
REPRESENTATIVE

SIGN AND PRINT
YOUR NAME AND
THE DATE

HAVE YOUR
WITNESS SIGN
AND PRINT THEIR
NAME AND THE
DATE

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**PART ONE: APPOINTMENT OF HEALTH-CARE REPRESENTATIVE
AND POWER OF ATTORNEY**

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday <i>(mm/dd/yyyy)</i>	Medical Record Number of Healthcare Facility or Provider <i>(optional)</i>	Healthcare Facility or Provider <i>(optional)</i>
Appointment of Health Care Representative		
<p>I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).</p> <p>I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. 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.</p> <p>I specify the following terms and conditions <i>(if any)</i>:</p>		
Name of Representative Appointed	Address of Representative <i>(number and street, city, state, and ZIP code)</i>	Telephone Number of Representative
Signature of Patient / Appointor or Designee <i>(must be signed in the appointor's presence)</i>	Printed Name of Patient / Appointor or Designee	Date of Appointment <i>(mm/dd/yyyy)</i>
Signature of Witness	Printed Name of Witness	Date <i>(mm/dd/yyyy)</i>

INDIANA ADVANCE DIRECTIVE – PAGE 2 OF 3

PART TWO: DECLARATION

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

LIFE PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____ being at least eighteen (18) years of age 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 import of this declaration.

Signed _____

City, County, and State of Residence

WITNESSES

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 of age.

Witness _____ Date (month, day, year) _____

Witness _____ Date (month, day, year) _____

PRINT THE DATE

PRINT YOUR NAME

SIGN HERE IF YOU WANT LIFE-PROLONGING PROCEDURES UNDER ALL CIRCUMSTANCES

YOUR TWO WITNESSES MUST SIGN AND DATE

INDIANA ADVANCE DIRECTIVE — PAGE 3 OF 3

PART TWO: DECLARATION

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

PRINT THE DATE

PRINT YOUR NAME

INITIAL ONLY ONE
OF THE FOLLOWING
THREE CHOICES

SIGN YOUR NAME

PRINT YOUR CITY,
COUNTY, AND STATE
OF RESIDENCE

HAVE YOUR TWO
WITNESSES SIGN
AND DATE

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Palliative Care
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**LIVING WILL
DECLARATION**

Declaration made this _____ day of _____ (month, year). I, _____ being at least eighteen (18) years of age 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 IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

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.

I understand the full import of this declaration.

Signed _____

City, County, and State of Residence

WITNESSES

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.

Witness _____ Date (month, day, year) _____

Witness _____ Date (month, day, year) _____

ORGAN DONATION
(OPTIONAL)

INITIAL THE
OPTION THAT
REFLECTS YOUR
WISHES

ADD NAME OR
INSTITUTION (IF
ANY)

PRINT YOUR NAME,
SIGN, AND DATE
THE DOCUMENT

YOUR
WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES

AT LEAST ONE
WITNESS MUST BE
A DISINTERESTED
PARTY

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INDIANA ORGAN DONATION FORM — PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your health-care representative, attorney for health care, proxy, or other agent, or your family may have the authority to make a gift of all or part of your body under Indiana law.

I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution: _____

Pursuant to Indiana law, I hereby give, effective on my death:

Any needed organ or parts.

The following part or organs listed below:

For (initial one):

Any legally authorized purpose.

Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____ Date _____

Address _____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____ Date _____

Address _____
