

INDIANA Advance Directive Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
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 at the end of life.

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:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Copyright © 2005 National Hospice and Palliative Care Organization. All rights reserved. Revised 2022. Reproduction and distribution by an organization or organized group without the written permission of the National Hospice and Palliative Care Organization is expressly forbidden.

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

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 the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care 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 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 DIRECTIVE

This packet contains the Indiana Advance Directive for Health Care, which 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. The form contains three parts.

Part One. The **Appointment of Health-Care Representative and Power of Attorney** lets you name someone, called your health-care representative, 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.

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.

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. The Declaration allows you to choose between Indiana's Living Will Declaration, which allows you to state your preference for the withdrawal or withholding of life-prolonging procedures, and Indiana's Life-Prolonging Procedures Declaration, which allows you to state your preference for receiving life-prolonging procedures if you are terminally ill.

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**.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: The Power of Attorney and Indiana Declaration documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

COMPLETING YOUR INDIANA ADVANCE DIRECTIVE

How do I make my Indiana Advance 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 are 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 health-care representative?

Your health-care representative — who is also your attorney-in-fact for purposes of your power of attorney — is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your health-care representative

may be a family member or a close friend whom you trust to make serious decisions. The person you name as your health-care representative should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second person as your successor health-care representative. The successor will step in if the first person you name as a health-care representative is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my Indiana Advance Directive

One of the strongest reasons for naming a health-care 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 it may help your representative carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your representative about your future medical care and describe what you consider to be an acceptable "quality of life."

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.

What other important facts should I know?

A pregnant patient's wishes to have life-prolonging procedures withheld or withdrawn will not be honored due to restrictions in state law.

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

© 2005 National Hospice and Palliative Care Organization. 2022 Revised.

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

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

© 2005 National Hospice and Palliative Care Organization. 2022 Revised.

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

© 2005 National
Hospice and
Palliative Care
Organization.
2022 Revised.

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 _____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314

You Have Filled Out Your Advance Directive, Now What?

1. Your Indiana Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your health-care representative and successor, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. 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 health-care representative and successor, 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. You may also want to save a copy of your form in 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.
5. If you want to change your document after it has been signed and witnessed, you should complete a new form.
6. Remember, you can always revoke your Indiana document.
7. Be aware that your Indiana document 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. Indiana law provides for a "Physician Orders for Scope of Treatment" (POST) form. A POST form includes additional information than a standard do-not-resuscitate order relating to life-sustaining measures. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

We suggest you speak to your physician for more information about the POST form. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.


Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of \$35, \$50 or \$100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.




YES! I want to support the important work of the National Hospice Foundation.

\$35	helps us provide webinars to hospice professionals
\$50	helps us provide free advance directives
\$100	helps us maintain our free InfoLine
\$_____	to support the mission of the National Hospice Foundation.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

2022AD



OR donate online today: www.NationalHospiceFoundation.org/donate