INDIANA Advance Directive
Planning for Important Health Care Decisions

New Serenity Personal Care Services
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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

Note: The following is not a substitute for legal advice. While New Serenity updates the following information and form to keep 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.**

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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. If you have it witnessed by a notary, Part One also empowers your health-care representative as your attorney-in-fact to make other advance planning decisions, such as those regarding organ donation and final disposition of your body.

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.

In order for you to grant your health-care representative the additional powers listed on page 3 of the form, your witness must be a notary public.

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.

If you fill out both parts, and want to grant your health care representative the additional powers listed on page 3 of the form, you should have your form notarized in addition to having it witnessed.

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	
	PART ONE: APPOINTMENT OF HEALTH-CARE REPRESENTATIVE AND POWER OF ATTORNEY
PRINT YOUR NAME AND ADDRESS	I, ____________________ (name)
	of ____________________ (address)
PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR HEALTH-CARE REPRESENTATIVE	hereby appoint ____________________ (name of health-care representative)
	____________________ (address)
	____________________ (home telephone number) (work telephone number)
	as my health-care representative — and attorney-in-fact, if I have had this document notarized on page 7 — ("health-care representative") to make health-care decisions on my behalf whenever I am incapable of making my own health-care decisions.
PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR SUCCESSOR HEALTH-CARE REPRESENTATIVE	In the event the person I appoint above is unable, unwilling or unavailable to act as my health-care representative, I hereby appoint:
	____________________ (name of successor health-care representative)
	of ____________________ (address)
	____________________
	____________________ (home telephone number) (work telephone number)
© 2005 National Hospice and Palliative Care Organization. 2020 Revised.	as my successor health-care representative.

THESE POWERS CAN BE GRANTED TO YOUR HEALTH-CARE REPRESENTATIVE WITHOUT HAVING A NOTARY PUBLIC WITNESS YOUR SIGNATURE

PART ONE: APPOINTMENT OF HEALTH-CARE REPRESENTATIVE AND POWER OF ATTORNEY (Continued)

Powers Granted to my Health-Care Representative

I grant my health-care representative all powers available under Indiana Code, Title 16, Article 36, Chapter 1 to make health-care decisions for me in the event I am unable to make such decisions myself. These powers include, but are not limited:

(1) to consent to or refuse health care for me;
(2) to admit or release me from a hospital or health-care facility; and
(3) to have access to my records, including medical records, concerning my condition.

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.

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.

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IN ORDER TO GRANT YOUR HEALTH-CARE REPRESENTATIVE THESE ADDITIONAL POWERS TO SERVE AS YOUR ATTORNEY-IN-FACT, YOU MUST HAVE YOUR SIGNATURE WITNESSED BY A NOTARY PUBLIC ON PAGE 7 OF THIS FORM

REVOCATION OPTIONS

YOU MAY REVOKE ALL POWERS GRANTED TO YOUR HEALTH-CARE REPRESENTATIVE IN THIS FORM, INCLUDING THOSE AS YOUR ATTORNEY-IN-FACT, AS DESCRIBED HERE

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PART ONE: APPOINTMENT OF HEALTH-CARE REPRESENTATIVE AND POWER OF ATTORNEY (Continued)

Additional Powers Granted to my Health-Care Representative as my Attorney-in-Fact (Notary Required)

If my signature of this document is witnessed by a notary public, I further grant my health-care representative all powers available as my attorney-in-fact under Indiana Code §§ 30-5-5-16 and 30-5-5-17 to make health-care decisions for me in the event I am unable to make such decisions myself, including, but not limited to:

(1) to employ or contract with servants, companions, or health care providers involved in my health care;
(1) to make anatomical gifts on my behalf;
(3) to request an autopsy; and
(4) to make plans for the disposition of my body.

Revocation of Health-Care Representative's Power and Appointment

I may revoke the authority of my health-care representative, including any powers granted to my health-care representative as my attorney-in-fact, and all of the powers granted in this document, whenever I am capable of consenting to health care by notifying my health-care provider or my health-care representative orally or in writing.

I may revoke the appointment of my health-care representative, and all of the powers granted in this document, whenever I am capable of consenting to health care by notifying my health-care representative orally or in writing.

PART ONE: APPOINTMENT OF HEALTH-CARE REPRESENTATIVE AND POWER OF ATTORNEY (Continued)

Guidance for my Health-Care Representative
When making health-care decisions for me, my health-care representative should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health-care representative should make decisions for me that my health-care representative believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

In addition, my health-care representative should consider the following instructions in making health-care decisions on my behalf: (attach additional pages if needed.)

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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PRINT THE DATE

PRINT YOUR NAME

INITIAL ONLY ONE OF THE FOLLOWING TWO CHOICES

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

INITIAL HERE IF YOU WANT LIFE-PROLONGING PROCEDURES WITHHELD OR WITHDRAWN UNDER THE CONDITIONS LISTED

IF YOU INITIALED THE LIVING WILL DECLARATION ABOVE, INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES ABOUT ARTIFICIAL NUTRITION (FEEDING) AND HYDRATION (FLUIDS)

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PART TWO: DECLARATION

Declaration made this __________ day of ______________________________.
(day) (month, year)

I, ____,
(name)

being at least eighteen (18) years old and of sound mind, willfully and voluntarily exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions. If at any time I have an incurable injury, disease, or illness determined to be a terminal condition and am unable to make decisions, I declare that:

______ (Life-Prolonging Procedures Declaration) I want the use of life-prolonging procedures that would extend my life under all circumstances. 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.

______ (Living Will Declaration) I request that my dying shall not be artificially prolonged. If my death will occur within a short time and 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.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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PART TWO: DECLARATION (Continued)

I further declare that: (add additional instructions, if any, adding additional pages, if needed.)

____

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. My health-care representative, under Indiana Code 16-36-1-7 or my attorney-in-fact, under Indiana Code 30-5-5, if I have appointed one, is responsible for interpreting this declaration if there is a disagreement as to its applicability.

PART THREE: EXECUTION

PRINT YOUR NAME

I, ____, the principal and/or declarant, sign my name or direct another person to sign my name to this

PRINT THE DATE

instrument this _______ day of ________________ 20_____, and do hereby declare to the undersigned witness(es) that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am of sound mind, and under no constraint or undue influence. I understand the full importance of this declaration.

SIGN YOUR NAME

Signed ____

PRINT YOUR CITY, COUNTY, AND STATE OF RESIDENCE

City, County, and State of Residence ________________________________

____

Notary

YOUR FORM MUST BE WITNESSED BY A NOTARY IN ORDER TO GRANT YOUR HEALTH-CARE REPRESENTATIVE THE ADDITIONAL POWERS OF AN ATTORNEY-IN-FACT LISTED ON PAGE 3 IN PART ONE (APPOINTMENT OF HEALTH-CARE REPRESENTATIVE)

Subscribed and acknowledged before me by __________________________,

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

____
(notary public)

My Commission expires ___________________

IF SOMEONE IS SIGNING THE FORM FOR YOU AT YOUR DIRECTION BECAUSE YOU ARE UNABLE TO SIGN, THE NOTARY MUST NOTE THAT HERE

I further confirm that ____________________________, signing on behalf of

______________________________, the principle and/or declarant, did so at the principle and/or declarant's direction.

____
(notary public)

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YOUR FORM MUST BE WITNESSED

TWO WITNESSES ARE REQUIRED IF YOU FILLED OUT PART TWO (DECLARATION)

ONLY ONE WITNESS — WHO MAY BE A NOTARY PUBLIC SIGNING ON THE PREVIOUS PAGE — IS REQUIRED IF YOU FILLED OUT ONLY PART ONE (APPOINTMENT OF HEALTH-CARE REPRESENTATIVE)

IF YOU CHOSE THE LIVING WILL DECLARATION IN PART TWO, YOUR TWO WITNESSES MUST ALSO SIGN HERE

PART THREE: EXECUTION (continued)

Witness(es)

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________________

I further attest that 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.

Witness

_____________________________________Date________________

Witness

_____________________________________Date________________

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Courtesy of
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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 ____

____

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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. **New Serenity Personal Care does not distribute these forms.**