ADVANCE DIRECTIVE
for Health Care Decisions

I, _____ [*insert name*] am an adult resident of _____ County, Indiana. I currently have the capacity to make my own decisions about my health care. Under Indiana Code 16-36-7, I am signing this Advance Directive in order to (a) appoint one or more Health Care Representatives who are named below *and* (b) give written instructions and state my wishes and preferences about life prolonging procedures and other treatment, if I later become terminally ill or suffer from a chronic or incurable condition and if I am unable to personally give my own instructions and make my own health care decisions.

If this Advance Directive does not specifically address a specific issue, then I intend that the rules and principles in I.C. 16-36-7 will apply and control, but in a manner consistent with my known wishes and preferences. If this Advance Directive is silent on an issue and if my wishes and preferences cannot be reliably determined, I intend that my Health Care Representative and health care providers act in a manner consistent with my best interests.

Effective Date

This Advance Directive and my Health Care Representative(s)' power and authority under it are [*choose and initial only one; if no space is initialed or checked, this document will be effective immediately upon signing*]:

_____ Effective upon signing	_____ Effective only when a licensed doctor later determines that I am incapacitated	_____ Effective on and after this date: _____

After this Advance Directive becomes effective, then unless I state a specific expiration date below, it will remain in effect even if I later become incapacitated, disabled, or incompetent.

My Health Care Representative(s)

I appoint the following person(s) as my Health Care Representative(s), with full authority to make and communicate health care decisions and give informed consent on my behalf, but subject to the conditions stated in the next section ("My Continuing Right to Act and Decide Personally") below:

Priority (if any)	Name of Representative and Telephone Number(s)	Mailing Address and e-mail address (if any)
_____		
_____		

*Initial or check **ONE** space below. If no space below is initialed, each Health Care Representative will have authority to act individually and independently.*

_____ The Representative with the lowest priority number (filled in above) and who is able and available to act has the exclusive authority to act

_____ Each Representative may act individually and independently on my behalf and has no duty to consult with my other Representatives

If I have listed 2 or more Health Care Representatives in order of priority, and if the Representative with the highest priority (lowest number) is not reasonable able or reasonably available to act, I intend that the Representative who has the next highest priority who is reasonably able and available to act will have authority to act for me.

I understand that if I am not capable of giving informed consent to health care and if no Health Care Representative listed above and no person holding validly-delegated authority is reasonably able and available to act for me, then the relatives and other individuals (proxies) who are defined or listed in Ind. Code § 16-36-7-42 will have authority, in the priority indicated, to make or issue health care decisions and instructions for me.

My Continuing Right to Act and Decide Personally

Even if I have made this Advance Directive effective immediately upon signing, I have the right and the power to act personally to make my own health care decisions, and to issue my own instructions and consents to health care providers. All health care providers must first communicate with me, unless a licensed health care provider who has treated or examined me has concluded in writing that I am not able to personally give informed consent to treatment or to make my own health care decisions. Until I have been determined to be incapacitated under the preceding sentence, I have the right to overrule, block or veto any health care decision that any Health Care Representative (named above) makes or attempts to make for me.

Decision-Making Standards for My Health Care Representative(s)

Whenever a Health Care Representative named above makes health care decisions or issues instructions or consents on my behalf, I expect my Health Care Representative to act in good faith and in my best interests, on the basis of what my Health Care Representative believes I would decide to do if I were capable of making decisions and giving consents myself and if I had all the pertinent information available to my Health Care Representative.

I understand that under applicable law, a physician or other health care provider has the right to refuse to comply with any health care decision or instruction made or issued by me personally or by my Health Care Representative if that decision or instruction requests treatment that the physician or other health care provider concludes is medically inappropriate for me.

Discontinuing or Refusing Life-Prolonging Procedures

_____ Unless I have initialed this space at the left, the following paragraph will apply.

I also authorize my Health Care Representative to make decisions in my best interests concerning withdrawal or withholding of health care. If, at any time and 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 to me or that such health care would be excessively burdensome, then my Health Care Representative may express my will 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. In his or her best judgment about what is appropriate, my Health Care Representative may (but is not required to) discuss any decision under this paragraph with members of my family who are available.

My Wishes and Preferences About Specific Life-Prolonging Procedures

[*Insert the signer's customized statement of wishes and preferences and/or specific instructions for end-of-life care, based on the signer's personal values and concepts for quality of life and dignity, etc.*]

If my treating physician or other licensed health care provider has determined with reasonable certainty that I am terminally ill or in a persistent and irreversible coma:

- If I have no pulse and if am not breathing, do not attempt resuscitation (DNR).
- Maximize my comfort through symptom management and relieve my pain and suffering through available measures, including the administration of medication to me through any route.
- Do not provide artificial nutrition or hydration (tube feeding) to me, except for the provision of fluids to the extent necessary to deliver pain medication.
- Do not transfer me from my current location to a hospital for life-sustaining treatment unless my comfort needs cannot be satisfied in my current location.

Optional Provisions and Restrictions

_____ Unless I have initialed this space at left, then after my death, each Health Care Representative is authorized to make or carry out instructions for the disposition of my remains (burial or cremation), to complete anatomical gifts, and to authorize an autopsy.

_____ I designate and appoint _____ [*name an adult individual or another person*] as my advocate, who has all the authority stated in IC 16-36-7-29(10), including the authority to monitor, audit and evaluate the actions of my Health Care Representative(s), to receive my health information, and to take remedial actions for me and in my best interests.

_____ To any friend or relative or friend of mine who could act as my proxy under IC 16-36-7-42 and -43, I give the authority to demand and to receive, from my Health Care Representative(s), a narrative description or other appropriate accounting of the actions taken and decisions made by my Health Care Representative(s).

_____ A later revocation of or amendment to this Advance Directive, even if signed personally by me, will not be valid unless the revocation or amendment contains the signed written approval of my following professional advisor or other individual [*Name the other individual who must approve a future amendment or revocation*] _____.

_____ I specifically disqualify the following individual(s): _____ _____ from later being appointed as a Health Care Representative for me, and from receiving delegated authority from any of my Health Care Representative(s), and from acting as my proxy under IC 16-36-7-42 and -43.

_____ My Health Care Representative(s) named above are **NOT** authorized to delegate authority to other persons. *If this space is NOT initialed, any Health Care Representative may delegate his or her authority to a competent adult or other person in a written document that the Representative signs in the same manner as this Advance Directive.*

_____ My Health Care Representative(s) are **NOT** authorized to consent to mental health treatment for me. *If this space is NOT initialed, each Health Care Representative will have authority to consent to mental health treatment for me if I am not capable of consenting.*

_____ My Health Care Representative(s) are **NOT** entitled to receive compensation from my money or property for the acts and services that they perform on my behalf. *If this space is NOT initialed, each Health Care Representative will be entitled to receive reasonable compensation from my money or property.*

Initial not more than one of the next two paragraphs*. If neither of the next two paragraphs is initialed, my Health Care Representative(s) will have full authority to apply for public benefits for me and to have access to the necessary financial records.*

_____ My Health Care Representative(s) are **NOT** authorized to apply for public benefits (such as Medicaid and the CHOICE program) on my behalf.

_____ My Health Care Representative(s) ARE authorized to apply for public benefits (such as Medicaid and the CHOICE program) on my behalf, but my Health Care Representative(s) are **NOT** authorized to have access to information about my income, assets and financial records unless such information is provided by me or by my attorney-in-fact acting under a separate power of attorney.

Signature

Sign below with a written signature OR an electronic signature. You may direct another adult (who is not one of your named Health Care Representatives, and not the Notary Public or one of the witnesses) to make your signature for you in your "presence." See IC § 16-36-7-19 for a definition and explanation of the "presence" requirement.

Your signature must be made in the "presence" of a Notary Public OR in the "presence" of two adult witnesses. Either the countersigning by two witnesses OR notarization is sufficient; both are not required. If you use two witnesses, at least one witness cannot be your spouse or another relative.

Please initial one space below to confirm the signing method used:

Signed on paper in direct presence of witnesses or notary public _____	Signed electronically with 2-way audio-visual interaction with witnesses _____	Signed by Declarant and witnesses or notary in 2 or more paper counterparts _____	Signed by Declarant and witnesses or notary with telephonic interaction _____

Signed on this _____ day of _____ 20_____.

_____
Signature of Declarant (signer)

_____
Printed name of adult (if any) who signs for Declarant

_____
Printed name of Declarant

Date of birth: _____ [*optional*]

Complete ONE of the two following blocks

Signatures of 2 Adult Witnesses

Notarization

_____
Signature of Adult Witness 1

_____
Printed Name of Adult Witness 1

_____
Signature of Adult Witness 2

_____
Printed Name of Adult Witness 2

STATE OF INDIANA)
) SS:
COUNTY OF_____)

Before me, a Notary Public, personally appeared _____ [*name of signing Declarant*], who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this _____ day of _____, 20____.

_____
Signature of Notary Public

_____
Notary's Printed Name (*if not on seal*)

_____
Commission Number (*if not on seal*)

_____
Commission Expires (*if not on seal*)

_____
Notary's County of Residence

Prepared by:

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