

## DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, “the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a ‘scientific’ process.” Because of “political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective” (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that “The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow,” and suggesting that revised and enhanced documents “may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes” (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

*Lifecare Directives* staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic professionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or “health care instruction” or “declaration”) and medical power of attorney (or “proxy”) forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, “*Should I Use a Shorter Standard Directive?*” available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~



*Statutory  
Advance Directive  
For  
Indiana Residents*



*Standard State Statutory  
Advance Directive for  
Health Care Choices*



~ Lifecare Directives ~



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Advance Directive  
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*Standard State Statutory  
Advance Directive for  
Health Care Choices*

***Important Notice:***

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warranted to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

# Statutory Advance Directive For Indiana Residents

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Print Full Name

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Date of Birth

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**Your right** (when age 18 or older): To Document Your Personal Wishes,  
and to have these wishes followed ~~

The Indiana state legislature designed a Living Will for use by the public, and provided statutes guiding the construction of a Power of Attorney for Health Care. As these documents were designed/structured by your state government, each is in full compliance with all applicable laws, statutes, and ordinances.

There is an introduction that summarizes the scope and purpose of the document, as well as providing directions for its completion. Read it carefully to ensure that your Advance Directive is fully and properly filled out.

*By completing these documents, you can have the peace of mind that your wishes can be known and followed. It is also a meaningful gift to those you love, who will have to make fewer difficult choices for you without an understanding of what you would want done.*

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## ***Understanding Your Directive:***

To make the *best* choices for your medical care, your physician needs to know your wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to speak due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want, if you cannot speak for yourself.

You can **revoke** (cancel) this directive at any time by: **1)** writing “revoked” across the front of the directive, followed by your signature and date, and the signature of at least one witness age 18 years or older ; or **2)** by completing a Notice of Revocation; or **3)** by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4)** by *simply completing a new directive* in which you state that any prior directive is no longer valid.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them.

Remember, unless you direct otherwise, this directive will only be used to guide your family and doctors if you are unable to make and communicate medical decisions yourself.

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**Instructions for Completing the Directive:**

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only **Section I**, leaving just a statement of your values and wishes. Or you may complete only **Section II**, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete the document, you should initial in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write “No,” “None,” or “Does Not Apply” in areas that would otherwise be left blank.

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**SECTION I:  
LIVING WILL DECLARATION  
and Personal Instructions**

(State Code, Title 16: Art. 36: Ch. 4: §16-36-4-1 to §16-36-4-21)

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1. INTRODUCTION: *There are two statutory versions of the Indiana Living Will, and both are included here. The first is designed primarily to refuse “life prolonging procedures” in the event an individual has been diagnosed with a terminal condition. The second is for use by those wanting to request continued treatment in a terminal condition.*

*A **terminal condition** is defined as “a condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty: 1) there can be no recovery; and 2) death will occur from the terminal condition within a short period of time without the provision of life prolonging procedures” (§16-36-4-5). **Life-prolonging procedures** are defined as, “any medical procedure, treatment, or intervention that does the following: 1) uses mechanical or other artificial means to sustain, restore, or supplant a vital function; 2) serves to prolong the dying process” (§16-36-4-1). The term does not include the “provision of any medical procedure or medication necessary to provide comfort care or to alleviate pain” (§16-36-4-1).*

*Finally, there is specific provision made in the statutes for adding personal information to your Living Will document (§16-36-4-9). Doing so can further aid those making any future decisions about your care. To this end, Lifecare staff have produced a “Living Will Addendum” which includes information that the overwhelming majority of the public has pronounced as being of importance to them. Completing the addendum can be of significant importance to you and those you love, should further information about your health care wishes be needed.*

**OPTION A: LIVING WILL DECLARATION  
(Terminal Treatment Refusal):**

*(Complete this section only if you wish to refuse life-prolonging medical treatment if you become terminally ill. If you know that you want to request terminal treatment, skip to the “Life-Prolonging Procedures Declaration,” in the section which follows)*

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.  
2. I, \_\_\_\_\_, being at least 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:

3. I declare that, if at any time my attending physician certifies in writing that: a) I have an incurable injury, disease, or illness; b) my death will occur within a short time; and, c) the use of life prolonging procedures would only artificially prolong the dying process – then 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.

**Regarding Tube Feeding and Hydration:**

4. My wishes regarding the use of artificial nutrition and hydration are recorded here.  
(Indicate your choice, below, by initialing 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.

**OR,**

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

**OR,**

\_\_\_\_\_ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to any health care representative I may have appointed under IC §16-36-1-7 or to my attorney-in-fact with health care powers under IC §30-5-5.

**Additional Instructions:**

5. I also wish to add the following additional instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Declaration Intent:**

6. 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 I accept the consequences of the refusal. I understand the full import of this declaration.

(Do not sign until in the presence of two qualified witnesses; see below)

7. Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Residence: \_\_\_\_\_

***Living Will Witnesses:***

8. 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 a legally competent individual and at least eighteen (18) years of age.

9. Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

10. Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

**OPTION B:  
LIFE PROLONGING PROCEDURES DECLARATION  
(Terminal Treatment Request):**

*(Complete this section only if you wish to request life prolonging medical treatment if terminally ill. If you know you want to refuse terminal treatment, or are unsure, return to the "terminal treatment refusal" section, above)*

11. I, \_\_\_\_\_ Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.  
\_\_\_\_\_, being at least 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 effective medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

***Additional Instructions:***

12. I also wish to add the following additional instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Declaration Intent:***

13. 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 I accept the consequences of the request. I understand the full import of this declaration. *(Do not sign until in the presence of two qualified adult witnesses; see below)*

14. Signed: \_\_\_\_\_  
Date: \_\_\_\_\_  
Residence: \_\_\_\_\_

***Living Will Witnesses:***

15. 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 a legally competent individual and at least eighteen (18) years of age.

16. Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name: \_\_\_\_\_  
Address: \_\_\_\_\_

17. Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name: \_\_\_\_\_  
Address: \_\_\_\_\_

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**SECTION II:**  
**DURABLE POWER OF ATTORNEY**  
***For Health Care Decisions***

[Pursuant to IC Title 30: Art.5: Ch.5: §30-5-1-1 to §30-5-10-4]

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18. INTRODUCTION: *This section lets you name a person (called an “agent” or “attorney-in-fact”) to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice.*

19. ***Be it known that I:***

Full Legal Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

~~ By this document do create a durable power of attorney for health care. This power of attorney shall not be affected by my later disability, incompetency, or incapacity (as the “principal” herein). I am of sound mind, and state that execution of this document is voluntary and without duress. Creation of this power of attorney is for the purpose of designating someone to act as my health care agent (also known as my attorney-in-fact), to act in my place to make medical and other decisions for me if I become unable to make them for myself. It also grants my agent the authority to make other legal and personal care decisions as outlined in this document. This designation is effective when, in the opinion of at least one licensed medical doctor who has personally examined me, I am no longer able make personal medical treatment decisions for myself. By creating this document I revoke any prior power of attorney for health care.

20. I understand that I am not required to choose an agent, but that I am advised to do so to ensure that my wishes are fully represented and followed. Therefore:

*(initial only one)*

\_\_\_\_\_ I do not want to choose a health care agent at this time (or I have no one appropriate to the task). However, I instruct that my Living Will (if any) in Section I of this document be recognized (by statutory law, common law, and/or federal law) as a declaration of my wishes within this Advance Health Care Directive (*proceed now to page 5 for your confirming signature*);

***OR,***

\_\_\_\_\_ I do wish to appoint a health care agent. I recognize that this person should not be my health care provider nor an employer of my health care provider, nor an operator, administrator, or an employee of or health provider in, any facility in

which I currently reside or have applied for admission – unless related to me by blood, marriage or adoption. The person I have chosen to act as my agent and to whom I give **full** authority to make all medical and health care decisions for me at any time during which I am unable to make them for myself, is:

21. **Name of Agent:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

22. If for any reason I revoke the authority of my agent, or this individual is unavailable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternate proxies:

23. **Name of Alternate #1:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

24. **Name of Alternate #2:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

25. Each alternate successor designated shall be vested with the same power and duties as if originally named as my health care agent. These persons, *in priority of the order presented*, are to have binding authority over any and all other persons to make my personal and health care decisions. In making decisions in my behalf *if my wishes are not clear*, I direct my agent to act in his/her best understanding of what my wishes would have been. And, where not reasonably sure of what I would have wanted, to act according to his/her belief in my interests as determined from his/her knowledge of my personal and family affairs, and other goals and values in life. The authority of my agent shall not be terminated *unless* it appears that he or she is clearly and obviously not acting in accordance with my known wishes, or is overwhelmingly ignoring my best interests if my wishes are not otherwise known.

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**SPECIFIC AGENT AUTHORITY AND GENERAL INTENT:**

26. My agent shall have the same authority to make health care decisions for me as I would if I had the capacity to make them myself, subject to any limitations imposed through this document. Below are listed further specific authorities given to my agent as named in this document:

- A. I authorize my health care agent to make decisions in my best interest concerning withdrawal or withholding of health care, *including but not limited to the provision of artificial nutrition and hydration*. 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 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.
- B. Consent, refuse consent, renew or withdraw consent to any treatment, tests, medications, care, services, surgery or therapies used to diagnose or treat any physical or mental condition.
- C. To employ or contract with medical and personal care providers necessary for my health care.
- D. To admit and discharge me from any hospital or other health care facility.
- E. To request, review, receive, and disclose any medical information, verbal or written, needed to follow and manage my physical or mental health treatment and general care, and to authorize the release of my medical records or any other documentation needed to continue my treatment in or outside of any health care setting or service. This release authority applies to any information governed by the *Health Insurance Portability and Accountability Act of 1996 (HIPPA), 42 U.S.C. 1320d and 45 CFR 160 through 164*.
- F. To make anatomical gifts on my behalf.
- G. To authorize autopsy, if desired by my physicians or by my agent.

***Additional Agent Instructions:***

27. I also wish to add the following instructions to my agent: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**STATEMENT AND SIGNATURE OF PRINCIPAL/GRANTOR:**

28. This document is governed by Indiana law, although I request that it be honored in any state in which I may be found.

By signing below, I indicate that I am fully aware of the contents of this document, and

understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

*(Do not sign until in the presence of a notary, below)*

29. Signed: \_\_\_\_\_ Date: \_\_\_\_\_

At: (City) \_\_\_\_\_ (State) \_\_\_\_\_

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**CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:**

30. State of Indiana,

County of \_\_\_\_\_ }  
Place: \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_, before me (insert officer name/title): \_\_\_\_\_, personally appeared (insert name of Principal on line here): \_\_\_\_\_, personally known to me (or proved to me on the basis of satisfactory evidence (describe: \_\_\_\_\_)) to be the person(s) whose name(s) is/are subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

\_\_\_\_\_  
Signature of Notary Public

**Notary Seal:**

\_\_\_\_\_  
Date Commission Expires