Advanced Directive and Durable Power of Attorney

Living Will Declaration and Appointment of a Health Care Representative

State of Indiana

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advanced Directive or Durable Power of Attorney.

Recap. What Is?
Advanced Directive

An Advanced Directive is a legal document that specifically spells out how you want to be cared for as the end draws near.

This is a legal document and needs to be in accord with your local State laws.

This must be completed and notarized and/or signed by witnesses. Until electronic signatures are more common, the signed form must be in a defined location which is known to the Health care proxy, the attorney, the doctor.

Recap. What Is?
Durable Power of Attorney

An Advanced Directive is not enough. It must be known to your caregivers.

You will need someone to see that your Advanced Directive is adhered to if you are not in a position to do so.

This person is designated by a document called a durable power of attorney for health matters.

You must choose your proxy/surrogate wisely.

The document designating the proxy/surrogate must be notarized and signed

Until electronic signatures are more common, the signed form must be in a defined location which is known to the Health care proxy, the attorney, the doctor.

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procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort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 initialling 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

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 _____

Witness _____ Date _____

Reference: IC 16-36-4-10 *As added by P.L.2-1993, SEC.19. Amended by P.L.99-1994, SEC.2.*

INDIANA APPOINTMENT OF A HEALTH CARE REPRESENTATIVE

I, _____, of
(Name)

_____,
(Address)

hereby voluntarily appoint _____, of
_____ (Name of Health Care Representative)

_____
_____(Address & Telephone Number)

as my health care representative.

In the event that the person I appoint above as health care representative is unable, unwilling or unavailable to serve, I hereby

appoint _____
(Name of Successor Health Care Representative)

of _____
(Address & Telephone Number)

as my substitute representative hereunder.

I authorize my health care representative to make decisions in my best interest concerning my health care including the consent to health care, as well as the withdrawal or withholding of health care. I understand health care to include medical care, treatment, service, or procedure to maintain, diagnose, treat or provide for my physical or mental well-being. Pursuant to the Indiana Health Care Consent Act, I authorize my health care representative to make decisions to withhold or withdraw artificial nutrition and hydration to the extent it is in my best interest to do so. 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, my health care representative may express my will that such health care be withheld or withdrawn and consent on my behalf that any and 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 that they are available.

This appointment becomes effective and remains effective if I am incapable of consenting to my health care.
I DO, DO NOT (**circle one**) authorize my health care representative hereby appointed to delegate decision making power to another.

APPOINTER SIGNATURE

I, _____, the Appointer, sign my name to this instrument this _____ day of _____ (day)

_____ (month), _____ (year), and do hereby declare the undersigned witness that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am eighteen (18) years of age or older, of sound mind, and under no constraint or undue influence.

_____ (Signature)

_____ (Date)

_____ (Printed Name)

_____ (Address)

_____ (County)

_____ (City/State/Zip)

WITNESS SIGNATURE

I declare that the Appointer who signed this document appears to be of sound mind and acting of his/her own free will. He/She signed (or asked another to sign for him/her) this document in my presence.

I further declare that I am an adult at least eighteen (18) years of age, and I am not the Representative or Successor Representative appointed in this document.

_____ (Signature of Witness)

_____ (Printed Name)

_____ (Witness Address)

_____ (City/State/Zip)

_____ (Telephone Number)