~ Indiana ~

Advance Directive
Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your health care representative. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care representative. If your health care representative is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your representative broad powers to make health care decisions for you. It revokes any prior advance directive that you may have made. If you wish to change your advance directive, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your representative, your health care provider(s), and any other person(s) to whom you have given a copy. If your representative is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior document of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care representative, close family, or friends, if needed.

STATE OF INDIANA
ADVANCE DIRECTIVE

Written in accordance with Indiana § 16-36-1-7; §§ 30-5-5

Document made this _________ day of ____________________, ____________.
Month Year

PART 1. CREATION OF ADVANCE DIRECTIVE

I, ______________________________, ____,
Print full legal name Address

______/_____/_____, being at least eighteen (18) years old and of sound mind, intend by this document to create
Date of birth
an advance directive. My executing this advance directive is voluntary. Despite the creation of this advance directive, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

PART 2. APPOINTMENT OF HEALTH CARE REPRESENTATIVE AND POWER OF ATTORNEY

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate

______________________________________, ____,
Health care representative Address

(_____) ___________________, to be my health care representative – and attorney-in-fact, if I have had this
Phone
document notarized on page 7 – for the purpose of making health care decisions on my behalf.

If he or she is ever unable or unwilling to do so, I hereby designate _____________________________________,
Alternate health care representative

____, (_____) ____________, to be my alternate health care
Address Phone
representative for the purpose of making health care decisions on my behalf. Neither my health care representative nor my alternate health care representative whom I have designated, is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if two (2) physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

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GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care representative, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care representative and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care representative under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my health care representative is instructed to make the health care decision for me, but my health care representative should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care representative shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care representative shall base his or her health care decision on what he or she believes to be in my best interest.

ADDITIONAL POWERS GRANTED TO MY HEALTH CARE REPRESENTATIVE AS MY ATTORNEY-IN-FACT (NOTARY SIGNATURE 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) employing or contracting with servants, companions, or health care providers involved in my health care; 2) making anatomical gifts on my behalf; 3) requesting an autopsy; 4) making plans for the disposition of my body.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care representative may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My health care representative may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES

My health care representative may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked “Yes” to the following, my health care representative may admit me for a purpose other than recuperative care or respite care, but if I have checked “No” to the following, my health care representative may not so admit me:

A nursing home: **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 9-13)

If I have not checked either “Yes” or “No” immediately above, my health care representative may only admit me for short–term stays for recuperative care or respite care.

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PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care representative may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care representative may not have a feeding tube withheld or withdrawn from me.

My health care representative may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes ❑** **No ❑** (SEE ADDENDUM – pages 9-13)

If I have not checked either "Yes" or "No" immediately above, my health care representative may not have a feeding tube withheld or withdrawn from me.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my health care representative shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that the attached Addendum (pages 9-13) be included as a valid part of this Advance Directive document.

2. I request, but not as a requirement, that my health care representative consult my clergy regarding health care decisions.

3. I ❑ authorize ❑ do not authorize my health care representative to be given full rights to authorize an autopsy in compliance with current state laws after my death.

4. I ❑ authorize ❑ do not authorize my health care representative to be given full rights to direct the disposition of my remains upon death.

5. ____

____

____

____

____

[Attach additional pages, if needed]

HIPAA RELEASE STATEMENT

I intend for my health care representative to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my representative the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

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INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care representative has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

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The principal and the witnesses must sign the document at the same time. If granting additional powers of an attorney-in-fact as listed on page 3 ("Additional Powers Granted to My Health Care Representative as My Attorney-in-Fact"), this document must be witnessed by a notary public.

SIGNATURE OF PRINCIPAL

(Person creating this Advance Directive)

Signature: ______________________________ Date: ______________

(The signing of this document by the principal revokes all previous advance directive documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind. I believe that his or her execution of this advance directive is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee of an inpatient health care facility in which the declarant is a patient. I am not the principal's health care representative. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness #1

Print name: ______________________________ Date: ______________

Address: ____

Signature: ______________________________

Witness #2

Print name: ______________________________ Date: ______________

Address: ____

Signature: ______________________________

STATEMENT OF HEALTH CARE REPRESENTATIVE AND POWER OF ATTORNEY

I understand that ______________________________ has designated me to be his or her health
Name of principal
care representative if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

______________________________ has discussed his or her desires regarding health
Name of principal
care decisions with me.

Representative's signature: ______________________________

Address: ____

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STATEMENT OF ALTERNATE HEALTH CARE REPRESENTATIVE AND POWER OF ATTORNEY

I understand that ______________________________ has designated me to be his or
Name of principal
her alternate health care representative if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care representative is unable or unwilling to make those decisions.

______________________ has discussed his or her desires regarding health care decisions
Name of principal
with me.

Alternate representative's signature: ______________________________

Address: ____

NOTARY

(Required by Indiana Law Only When Granting Additional Powers of an Attorney-In-Fact as Listed on Page 3 of This Document)

Subscribed and acknowledged before me by ____,
Name of principal

the principal, this ____ day of ______________________, _________.
Month Year

____
Notary Public

My Commission expires ______________________

I further confirm that ______________________________________, signing on behalf of

__________________________, the principal and/or declarant, did so at the principal's and/or
Name of principal
declarant's direction.

____
Notary Public

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INDIANA ORGAN DONATION FORM

(Optional)

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 representative, 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 have an organ or tissue donation and I do not want my attorney for health care, proxy, or other representative 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 (if any): ____

_______ 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's name: ____

Declarant's 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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ADDENDUM TO THE STATE OF INDIANA ADVANCE DIRECTIVE

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

HEALTH CARE DIRECTIVES

1. I direct my health care representative to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care representative has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care representative to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care representative may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care representative may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care representative may consent to the withholding or withdrawal of

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life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care representative may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Advance Directive document, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

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The principal and the witnesses must sign the document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Advance Directive)

Signature: ______________________________ Date: ____________________

(The signing of this document by the principal revokes all previous advance directive documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind. I believe that his or her execution of this advance directive is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, or an employee of an inpatient health care facility in which the principal is a patient. I am not the principal's health care representative. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness #1

Print name: ______________________________ Date: ____________________

Address: ____

Signature: ______________________________

Witness #2

Print name: ______________________________ Date: ____________________

Address: ____

Signature: ______________________________

STATEMENT OF HEALTH CARE REPRESENTATIVE AND POWER OF ATTORNEY

I understand that ______________________________ has designated me to be his or her health
Name of principal
care representative if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

______________________________ has discussed his or her desires regarding health care decisions
Name of principal
with me.

Representative's signature: ______________________________

Address: ____

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STATEMENT OF ALTERNATE HEALTH CARE REPRESENTATIVE AND POWER OF ATTORNEY

I understand that ____ has designated me to be his or her
Name of principal
alternate health care representative if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care representative is unable or unwilling to make those decisions.

____ has discussed his or her desires regarding health care
Name of principal
decisions with me.

Alternate representative's signature: ____

Address: ____

NOTARY

(Required by Indiana Law Only When Granting Additional Powers of an Attorney-In-Fact as Listed on Page 3 of This Document)

Subscribed and acknowledged before me by ____,
Name of principal

the principal, this ______ day of ________________________, ____________.
Month Year

____
Notary Public

My Commission expires ________________________

I further confirm that ____, signing on behalf of

____, the principal and/or declarant, did so at the principal's and/or
Name of principal
declarant's direction.

____
Notary Public

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CLERGY
Optional

The declarant has requested that the health care representative consult me, as the declarant's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the representative to help meet the directives as described in this Advance Directive document and attached Addendum.

Clergy's signature: ____ Phone: (_____) __________________

Church address: ____

I have given copies of this Advance Directive – Christian Version to:

____

____

____

____

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