

# Indiana Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

## **Part 1** Choose your health care representatives, Page 3

A health care representative is a person who can make health care decisions for you if you are not able to make them yourself.

You can choose one or more health care representatives to be your advocate.

Sometimes, they are also called a medical decision maker, surrogate, health care power of attorney, agent, or proxy.

## **Part 2** Make your own health care choices, Page 7

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

## **Part 3** Sign the form, Page 13

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out **only** the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on Page 14, or a notarial officer on Page 15.

Your Name



www.prepareforyourcare.org

## **This is a legal form that lets you have a voice in your health care.**

It will let your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

### **What should I do with this form?**

- Please share this form with your health care representatives, family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.

### **What if I have questions about the form?**

- It is OK to skip any part of this form if you have questions or do not want to answer.
- Ask your doctors, nurses, social workers, family, or friends to help.
- Lawyers can help too. This form does not give legal advice.

### **What if I want to make health care choices that are not on this form?**

- On Page 12, you can write down anything else that is important to you.

### **When should I fill out this form again?**

- If you change your mind about your health care choices
- If your health changes
- If you want to change your health care representatives
- If your spouse is your health care representative, and you divorce, that person will no longer be your health care representative.



Give the new form to your health care representatives and medical providers.  
Destroy old forms to show they are no longer your wishes.

**Share this form and your choices with your family, friends, and medical providers.**

# Part 1

## Choose your medical decision maker

Choose one or more health care representatives. They can make health care decisions for you if you are not able to make them yourself.

**A good health care representative is a family member or friend who:**

- is 18 years of age or older
- can talk to you about your wishes
- can be there for you when you need them
- you trust to follow your wishes and do what is best for you
- you trust to know your medical information
- is not afraid to ask doctors questions and speak up about your wishes



**What will happen if I do not choose a health care representative?**

If you are not able to make your own decisions, your doctors will turn to adult family or friends (listed in order in Indiana law) or a judge to make decisions for you. **This person may not know what you want.**

**If you are not able, your health care representatives can choose these things for you:**

- doctors, nurses, social workers, caregivers
- hospitals, clinics, nursing homes
- medications, tests, or treatments
- who can look at your medical information
- what happens to your body and organs after you die
- who can look at your financial information to apply for benefits that would pay for your health care



**End of life decisions your health care representatives can make:**

- call in a religious or spiritual leader
- decide if you die at home or in the hospital
- decide about autopsy or organ donation
- decide about burial or cremation

Here are more decisions your health care representatives can make:

Start or stop life support or medical treatments, such as:

- **CPR or cardiopulmonary resuscitation**  
 cardio = heart • pulmonary = lungs • resuscitation = try to bring back

**This may involve:**

- pressing hard on your chest to try to keep your blood pumping
- electrical shocks to try to jump start your heart
- medicines in your veins



- **Breathing machine or ventilator**  
 The machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.



- **Dialysis**  
 A machine that tries to clean your blood if your kidneys stop working.

- **Feeding Tube**  
 A tube used to try to feed you if you cannot swallow. The tube can be placed through your nose down into your throat and stomach. It can also be placed by surgery into your stomach.

- **Blood and water transfusions (IV)**  
 To put blood and water into your body.

- **Surgery**

- **Medicines**

- **Mental health treatment**



By signing this form, you allow your health care representatives to:

- agree to, refuse, or withdraw any life support or medical treatment if you are not able to speak for yourself
- decide what happens to your body after you die, such as organ donation, autopsy, and funeral plans

If there are decisions you do not want them to make, write them here:

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**When can my health care representatives make decisions for me?**

- ONLY after I am not able to make my own decisions
- NOW, right after I sign this form. If I am able to choose, I can always say no to their decision.

If you want, you can write why you feel this way.

\_\_\_\_\_

\_\_\_\_\_

**Write the name of one or more health care representatives.**

I want these people to make my medical decisions if I am not able to make my own:

**#1:** \_\_\_\_\_  
 first name last name  
 \_\_\_\_\_  
 phone #1 email or phone #2 relationship state

**#2:** \_\_\_\_\_  
 first name last name  
 \_\_\_\_\_  
 phone #1 email or phone #2 relationship state

**If you chose more than one health care representative:****Do you have a main health care representative?**

- I want my #1 health care representative to make all the decisions. The #2 health care representative is only a back up.
- I want my #1 and #2 health care representatives to make decisions together.

**How do you want your health care representative to work together?**

- They must always talk and make decisions together and agree.
- Whoever your doctor can reach first can decide.

Sometimes health care representatives do not agree. If they cannot agree and it is an emergency, your doctor may make the final decision. Your doctor will only decide after checking with another medical provider.

\_\_\_\_\_  
 Your Name

## Why did you choose your health care representatives?

If you want, you can write why you chose your #1 and #2 health care representatives.

Write down anyone you would NOT want to help make medical decisions for you.

## How strictly do you want your health care representatives to follow the wishes on this form if you are not able to speak for yourself?

Flexibility allows your health care representatives to change your prior decisions if doctors think something else is better for you at that time.

Prior decisions may be wishes you wrote down or talked about with your health care representatives. You can write your wishes in Part 2 of this form.

Check the **one** choice you most agree with.

- Total Flexibility:** It is OK for my health care representatives to change any of my medical decisions if my doctors think it is best for me at that time.
- Some Flexibility:** It is OK for my health care representatives to change some of my decisions if the doctors think it is best. But, these wishes I NEVER want changed:
- \_\_\_\_\_
- \_\_\_\_\_
- No Flexibility:** I want my health care representatives to follow my medical wishes exactly. It is NOT OK to change my decisions, even if the doctors recommend it.

If you want, you can write why you feel this way.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To make your own health care choices, go to Part 2 on Page 7. If you are done, you must sign this form on Page 13.

Please share your wishes with your family, friends, and medical providers.

# Part 2

## Make your own health care choices

Fill out only the questions you want.

### How do you prefer to make medical decisions?

Some people prefer to make their own medical decisions. Some people prefer input from others (family, friends, and medical providers) before they make a decision. And, some people prefer other people make decisions for them.

**Please note:** Medical providers cannot make decisions for you. The only time they can is if it is an emergency and your health care representatives cannot agree.

#### How do you prefer to make medical decisions?

- I prefer to make medical decisions on my own without input from others.
- I prefer to make medical decisions only after input from others.
- I prefer to have other people make medical decisions for me.

If you want, you can write why you feel this way, and who you want input from.

### What matters most in life? Quality of life differs for each person.

**What is most important in your life?** Check as many as you want.

- Your family or friends \_\_\_\_\_
- Your pets \_\_\_\_\_
- Hobbies, such as gardening, hiking, and cooking  
Your hobbies \_\_\_\_\_
- Working or volunteering \_\_\_\_\_
- Caring for yourself and being independent
- Not being a burden on your family
- Religion or spirituality: Your religion \_\_\_\_\_
- Something else \_\_\_\_\_

**What brings your life joy? What are you most looking forward to in life?**

**What matters most for your medical care? This differs for each person.**

For some people, the main goal is to be kept alive as long as possible even if:

- They have to be kept alive on machines and are suffering
- They are too sick to talk to their family and friends

For other people, the main goal is to focus on quality of life and being comfortable.

- These people would prefer a natural death, and not be kept alive on machines

Other people are somewhere in between. **What is important to you?**

Your goals may differ today in your current health than at the end of life.

**TODAY, IN YOUR CURRENT HEALTH**

**Check one choice along this line to show how you feel today, in your current health.**

My main goal is to live as long as possible, no matter what.

Equally important

My main goal is to focus on quality of life and being comfortable.

**If you want, you can write why you feel this way.**

**AT THE END OF LIFE**

**Check one choice along this line to show how you would feel if you were so sick that you may die soon.**

My main goal is to live as long as possible, no matter what.

Equally important

My main goal is to focus on quality of life and being comfortable.

**If you want, you can write why you feel this way.**

\_\_\_\_\_  
Your Name



**Quality of life differs for each person at the end of life.  
What would be most important to you?**

**AT THE END OF LIFE**

Some people are willing to live through a lot for a chance of living longer.

Other people know that certain things would be very hard on their quality of life.

- Those things may make them want to focus on comfort rather than trying to live as long as possible.

**At the end of life, which of these things would be very hard on your quality of life?**

Check as many as you want.

- Being in a coma and not able to wake up or talk to my family and friends
  - Not being able to live without being hooked up to machines
  - Not being able to think for myself, such as severe dementia
  - Not being able to feed, bathe, or take care of myself
  - Not being able to live on my own, such as in a nursing home
  - Having constant, severe pain or discomfort
  - Something else \_\_\_\_\_
- OR**, I am willing to live through all of these things for a chance of living longer.



If you want, you can write why you feel this way.

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**What experiences have you had with serious illness or with someone close to you who was very sick or dying?**

- If you want, you can write down what went well or did not go well, and why.

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**If you were dying, where would you want to be?**

- at home
- in the hospital
- either
- I am not sure

**What else would be important, such as food, music, pets, or people you want around you?**

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\_\_\_\_\_  
Your Name

## How do you balance quality of life with medical care?

Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.

Please **read this whole page** before making a choice.

**AT THE END OF LIFE**, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

Life support treatment can be CPR, a breathing machine, feeding tubes, dialysis, or transfusions.



Check the **one** choice you most agree with.

If you were so sick that you may die soon, what would you prefer?

- Try all life support treatments** that my doctors think might help. I want to **stay on life support** treatments even if there is little hope of getting better or living a life I value.
- Do a **trial of life support treatments** that my doctors think might help. But, I **DO NOT** want to **stay on life support** treatments if the treatments do not work and there is little hope of getting better or living a life I value.
- I **do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a **natural death**.

What else should your medical providers and health care representatives know about this choice? Or, why did you choose this option?

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### Artificial food and water:

Check the **one** choice you most agree with.

If you were so sick that you may die soon, what would you prefer?

- I **want** food and water by feeding tubes and transfusions (IV) even if there is little hope of getting better or living a life I value.
- Do a **trial** of food and water by feeding tubes and transfusions (IV) if my doctors think they might help. But, I **want to stop them** if the treatments do not work and there is little hope of getting better or living a life I value.
- I **do not want** food and water by feeding tubes and transfusions (IV) if there is little hope of getting better or living a life I value.
- I want my **health care representatives to decide** about food and water by feeding tubes and transfusions (IV) for me.



If I am not able to share my wishes, I want the wishes on this form to be honored.

I fully understand what these options mean.

**What else should your medical providers and health care representatives know about this choice? Or, why did you choose this option?**

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\_\_\_\_\_  
Your Name

**Your health care representatives may be asked about organ donation and autopsy after you die. You can tell your health care representatives what you want below.**

## ORGAN DONATION

**Some people decide to donate their organs or body parts. What do you prefer?**

- I **want** to donate my organs or body parts.

Which organ or body part do you want to donate?

- Any organ or body part  
 Only \_\_\_\_\_

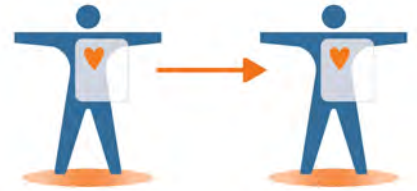
- I **do not** want to donate my organs or body parts.

What else should your medical providers and health care representatives know about donating your organs or body parts?

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## AUTOPSY

**An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.**

- I **want** an autopsy.  
 I **do not** want an autopsy.  
 I **only** want an autopsy if there are questions about my death.



## FUNERAL OR BURIAL WISHES

**What should your medical providers and health care representatives know about how you want your body to be treated after you die, and your funeral or burial wishes?**

- Do you have religious or spiritual wishes?
  - Do you have funeral or burial wishes?
- 
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**What else should your medical providers and health care representatives know about you and your choices for medical care?**

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**OPTIONAL: How do you prefer to get medical information?**

Some people may want to know all of their medical information. Other people may not.

**If you had a serious illness, would you want your doctors and medical providers to tell you how sick you are or how long you may have to live?**

- Yes, I would want to know this information.
- No, I would not want to know. Please talk with my health care representatives instead.

**If you want, you can write why you feel this way.**

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\* Talk to your medical providers so they know how you want to get information.

# Part 3

## Sign the form



### Before this form can be used, you must:

#### 1. Sign this form

2. Have 2 people or a notarial officer witness that you signed this form. You and your witnesses must be 18 years of age or older.

Your witnesses:

- cannot be your health care representatives
- cannot help you sign your name on this form
- cannot both be related to you, but one witness can be related to you

**You and your witnesses or notarial officer must sign at the same time.**

### You have 3 options to sign this form with your witnesses.

A notarial officer can do the first 2 options, but not the 3<sup>rd</sup> option.

**Option 1** In person

**Option 2** By live video on a computer, phone, or other device. You can see and hear everyone, and they can see and hear you sign the form.

**Option 3** By audio only on a phone, tablet or computer (witnesses only). You can hear everyone, and they can hear you, but you cannot see each other. **A notarial officer cannot do this option.**

### When everyone is ready to witness you signing this form, write your name and write the date below.

- You can tell someone to sign for you if you cannot sign yourself.
- The person helping you sign the form cannot be a witness or notarial officer.
- You, your witnesses, and a notarial officer can also sign this form electronically.

\_\_\_\_\_

sign your name

\_\_\_\_\_

today's date

\_\_\_\_\_

print your first name

\_\_\_\_\_

print your last name

\_\_\_\_\_

date of birth

\_\_\_\_\_

address

\_\_\_\_\_

city

\_\_\_\_\_

state

\_\_\_\_\_

zip code

**If you do not have witnesses, a notary must sign on Page 15.**

## Witnesses

By signing, we promise that \_\_\_\_\_ signed this form,  
(the person named on Page 13)

they were thinking clearly, and were not forced to sign. We also **promise** that:

- We know this person, or they proved who they were
- We are 18 years of age or older
- We are not their health care representative
- We did not help them sign their name to this form
- At least one of us is not related to them by blood, marriage, or adoption

We also **promise** that they signed this form while we (mark only one):

- Met in person
- Saw and heard them sign on a live video call using a computer, phone, or other device. They could also see and hear us.
- Heard them sign while we listened on a phone, computer, or other device

**If we could hear but not see them**, we also promise we followed Indiana law because we asked them questions to make sure it was really them. Here are the questions we asked and their answers:

- What is your birthday? \_\_\_\_\_
- What is your address? \_\_\_\_\_
- Other question: \_\_\_\_\_  
Answer: \_\_\_\_\_

**If we were not in person**, we signed different copies of the form and will send our copies to them to put them together

### Witness #1

\_\_\_\_\_  
sign your name \_\_\_\_\_ date

\_\_\_\_\_  
print your first name \_\_\_\_\_ print your last name

\_\_\_\_\_  
address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip code

### Witness #2

\_\_\_\_\_  
sign your name \_\_\_\_\_ date

\_\_\_\_\_  
print your first name \_\_\_\_\_ print your last name

\_\_\_\_\_  
address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip code

**Notarial Officer**

You can only use a notarial officer if they can see and hear you when you sign in person or on live video. You must also be able to:

- prove who you are with a photo ID (driver's license or passport)
- **or**, answer the notarial officer's questions to confirm who you are

**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

**You are now done with this form.**

**Share this form with your family, friends, and medical providers. Talk with them about your medical wishes. To learn more go to [www.prepareforyourcare.org](http://www.prepareforyourcare.org).**