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August 20-21, 2021
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Feature Release 4.1
August 2020

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ADVANCED
ELDER LAW
2021

August 20-21, 2021

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ADVANCED ELDER LAW 2021

Agenda

August 20, 2021

1:30 P.M. **Registration outside of the Overlook Ballroom**

2:00 P.M. Program Begins

3:30 P.M. **15 Minute Refreshment Break**

5:15 P.M. Hosted Reception on Back Patio

August 21, 2021

7:45 A.M. Breakfast Time

8:30 A.M. **Program Continues**

10:30 A.M. 15 Minute Break

11:45 A.M. **Adjourn**

ADVANCED ELDER LAW 2021

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August 20-21, 2021

Claire E. Lewis
Law Office of Claire E. Lewis, Indianapolis

Claire Lewis has more than thirty years of experience in the field of elder law. A founding member and first Chair of the Indiana State Bar Association's Elder Law Section, she currently serves as Chair of its Public Policy Committee. An active member of the National Academy of Elder Law Attorneys (NAELA), Lewis was a founding member and first President of the Indiana chapter of NAELA and was re-elected as President of the organization for 2016. She recently completed her term on the Executive Committee of the Estate Planning Section of the Indianapolis Bar Association. Lewis completed six years of service on the Board of Directors of CICOA Aging and In-Home Solutions (formerly the Central Indiana Council on Aging), serving as Secretary of the Board during her last two year term. She also completed a term of six years on the Board of Directors of the Alzheimer's Association of Indiana for which she chaired its Mission and Outreach Committee.

Lewis was called upon by the State of Indiana to provide the initial review of the exams to be given to attorneys seeking the CELA (Certified Elder Law Attorney) certification. As a member of the Advisory Panel on Attorney Specialization for the Indiana Commission for Continuing Legal Education, she was involved in the initial approval of the elder law certification in the state of Indiana.

As former Director of the Senior Law Project of the Legal Services Organization of Indiana, Lewis headed the Indiana sub-state Ombudsman Program for Central Indiana, promoting quality of care and nursing home residents' rights for Indiana's most vulnerable citizens.

Editor of the Indiana State Bar Association's popular book, the Laws of Aging (formerly the Legal Reference for Older Hoosiers), Lewis has authored or co-authored numerous papers and booklets on elder law issues including Medicaid in Indiana, Advance Directives, Medicaid for the Aging and Disabled in Indiana, Guardianship and Alternatives, The Legal Rights of Indiana Nursing Home Residents, and Housing Alternatives for the Older Person.

Lewis is a regular faculty member and program chair for the Indiana Continuing Legal Education Forum (ICLEF). For the past several years, she has chaired ICLEF'S Elder Law Institute, Advanced Medicaid Forum, and Advanced Elder Law Forum. Lewis is also a regular faculty member for educational seminars presented by the Indianapolis Bar

Association (IBA), chairing the Medicaid Updates seminar in both 2002 and 2003 and Long Term Care Updates in 2004 and providing the Medicaid updates segment of its "What's New?" annual workshop in 2005 and 2006. She has also chaired seminars from 2006 through the present for the IBA covering such topics as Medicaid Estate Recovery, the effect of the Deficit Reduction Act on Medicaid eligibility issues, and Special Needs Trusts. She has been a guest professor at the McKinney School of Law in Indianapolis, focusing primarily on topics that relate to elder law. Lewis has served in an advisory capacity to Medicaid workers throughout the state and trained caseworkers, attorneys, and elder care professionals on Medicaid rules and regulations and other issues impacting older adults.

Lewis was named a Super Attorney in Elder Law by Indianapolis Monthly magazine for 2005 through 2016. Lewis was also named one of the Top 25 Women Lawyers in Indiana for 2008 and 2011 by Indianapolis Monthly and a Five Star Wealth Manager from 2008 through 2014 by Indianapolis Monthly. She was selected by her peers as one of the "Best Lawyers in America" in the area of elder law for more than ten years as announced by "Best Lawyers" and U.S. News Media Group, the publisher of U.S. News and World Reports and the nation's leading source of rankings and service journalism, and she is the lawyer of the year in elder law for 2016. Lewis was awarded the Indiana State Bar Foundation's Law Related Education Award in October of 2005 and received the Indiana State Bar Association's GP and Solo Practice Hall of Fame Award for 2009. Lewis was named most valuable attorney of the year by the Indiana Chapter of the National Academy of Elder Law Attorneys for 2013.

Lewis was named as a Fellow of Indiana State Bar Foundation in 2010 and a Master Fellow in 2014. Established in 1979, the Fellows are an elite group of Indiana attorneys who demonstrate commitment to the ideals of the Foundation in advancing justice, promoting public understanding of the law, and enhancing the legal professions' performance of its ethical responsibilities. Only 1,000 Indiana attorneys are currently members of this select group. In 2012, she was also inducted as a Fellow of the Indianapolis Bar Foundation.

Kristin Steckbeck Bilinski
Dale, Huffman & Babcock, Bluffton

Kristin Steckbeck Bilinski received her undergraduate degree Magna Cum Laude from the University of Notre Dame in 2004, and graduated Cum Laude from the Indiana University Maurer School of Law in 2007. She is a certified trust and estate specialist, as certified by the Indiana State Bar Association's Trust & Estate Specialty Board since 2017, a member of the Board of Directors of Indiana Legal Services, and a past President of the Board of Directors of the Allen County Bar Association. She has focused on estate planning, probate administration, and related areas of the law since 2007.

Dennis Frick
Director of the Senior Law Project, Indianapolis

DENNIS FRICK is the Director of the Senior Law Project of Indiana Legal Services, Inc., Indianapolis, which represents older adults in 20 central Indiana counties. He has represented clients in administrative appeals and in state and federal court. He is Past Chair of the Elder Law Section of the Indiana State Bar Association and is also a member of the National Academy of Elder Law Attorneys and the American Bar Association. He is a Director of the Indiana Chapter of the National Academy of Elder Law Attorneys and of the Indiana State Guardianship Association. He has been a frequent trainer on elder law issues for Indiana Continuing Legal Education Forum and for the Senior Law Project. He is a contributing author of the Laws of Aging published by the Indiana Bar Foundation.

Anna M. Howard
Severns & Howard, P.C., Indianapolis

Anna M. Howard is VA Accredited attorney focusing her practice in VA and Medicaid planning, as well as basic Asset Protection Planning. She received her law degree from Barry University in Orlando, where her studies focused on Estate Planning and Elder Law.

Anna was admitted to the Indiana State Bar in 2009, and is a member of the American Bar Association, the Indiana Bar Association, the National Academy of Elder Law Attorneys and the Elder Law Section of the Indiana Bar Association and the Indianapolis Bar Association.

Prior to law school, Anna earned a BA in Criminal Justice and Political Science from Indiana University - Bloomington, where she met her husband Scott. Anna grew up in Kokomo, Indiana and currently lives on the South Side of Indianapolis with her husband and 16-year old son. She has a special interest in VA cases, as her father and two siblings are veterans of the armed forces, including service during the Vietnam Era, and in Iraq and Afghanistan.

Keith P. Huffman
Dale, Huffman & Babcock, Bluffton

Keith P. Huffman received his undergraduate education from Adrian College and his legal education from Indiana University. He is a member of the National Academy of Elder Law Attorneys and served as the President of the Indiana Chapter of NAELA. Mr. Huffman is a Past Chairperson for the Elder Law Section of the Indiana Bar Association, a member of the Ethics Committee at Bluffton Regional Medical Center, Chairperson of the Aging & In-Home Services Board of Directors, a member of the Board of Directors of Visiting Nurse Hospice, a member of the Board of Directors of PACE for Northeast Indiana, and a member of the Fort Wayne Lutheran Hospital Institutional Review Committee. Mr. Huffman was named the Citizen of the Year by the Wells County Chamber in 2003 and was named as the outstanding member of the Indiana National Academy of Elder Law Attorneys in 2009. Mr. Huffman was named the Powley Award winner for 2016. This national award is given to a National Academy of Elder Law Attorneys member who has demonstrated a commitment to promote in the minds of the general public a general understanding of the rights and needs of the elderly and disabled.

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Section One

A Potpourri of Current Medicaid Issues

Dennis Frick
Senior Law Project
Indiana Legal Services, Inc.

Claire Lewis
Law Office of Claire Lewis

Section One

A Potpourri of Current Medicaid Issues..............................Dennis Frick
Claire Lewis

I. Case Processing in the AVS Era 1

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I. Case Processing in the AVS Era

A. How are you entering information?

The online application process screen prompts you to enter all information for client (*e.g.* name, address, date of birth, and sex). DFR is indicating that several firms are listing their office address as the client's household address so that the applications they are submitting are all going to one specific office. DFR states that this results in one specific group of DFR Staff working their applications, creating additional work for these offices and leading to a delay in case processing. The DFR is asking that this practice cease immediately, and it is going as far as saying that firms are intentionally submitting inaccurate/false applications. DFR expects and requests that all applications reflect accurate and current information. DFR will also be reaching out to those specific firms that are implementing this practice.

B. Document Cover Sheets, Authorized Representative Forms and Interview Scheduling

It ***is*** possible to get a Document Cover Sheet before you finish the application process, and it is ideal for you to use these cover sheets with each submission. However, **before** you run out of pages that say "save and close" at the bottom of the page, you should click "save and close." At that point, you should be prompted to create a user account or to log in to your existing account to gain access to the "home" screen which, in turn, allows you to access your saved application. You can then print a Document Cover sheet (See Appendix A) and have access to the same application summary information you would have obtained if you had not exited the original application process. You Tube offers an application process tutorial which inexperienced practitioners may find helpful when first trying to navigate the online system. The following link www.youtube.com/watch?v=MSaGBwdT6wo&feature=youtu.be takes you to the tutorial.

In order to represent an applicant in the Medicaid process, the attorney must be an ***Authorized Representative***. FSSA allows your entire law office to be named as Authorized Representative instead of naming each individual from your office who may have contact with the case. The Authorized Representative form is at Appendix B. Generic, non-bar-coded forms are also available at www.in.gov/fssa/dfr/forms-documents-and-tools/forms.

Once your authorized representative form is on file with FSSA, you **may** be able to obtain the member's bar-coded authorized representative form and cover sheet online so long as you have the client's case number. You typically will not have the case number until you receive the appointment notice. Access to the portal before the interview is inconsistent, though. Once the interview has occurred, access is more reliable. The attorney must have the authorized representative forms on file in order to receive any requests for information from FSSA after the interview. An applicant/member can name more than one authorized representative, such as a family member, a second family member, and the law office. A separate form is needed for each authorized representative with the exception of the law office as noted above. The Eligibility Specialist (ES) or State Eligibility Consultant (SEC) will not talk to anyone other than those persons named on the authorized representative form.

Once the online application is completed, the attorney should receive a call from the Document Center to schedule an interview. This typically happens within two or three days of the submission of the application. Shortly after that call, a written notice of interview is sent. Interviews are most often conducted by SECs or by ESs by telephone or in person. **No in person interviews are being conducted during the COVID-19 emergency**. The interview should be scheduled within two weeks of when the application was filed. Often, only short notice is

provided. Because of this, you can consider faxing the Authorized Representative forms into the Document Center, always referencing the case number that appears on the written notice of interview.

C. How are you submitting information?

With an online application, verifications cannot be submitted with the initial application. Instead, you can use the same process described above to access a cover sheet so that you can send all of the application verifications as well as the Authorized Representative forms prior to the interview. Typically though, the interviewer will not have the verifications or will not have had a chance to review the verifications prior to the interview. Verifications are often submitted by mail to:

FSSA Document Center
Post Office Box 1810
Marion, Indiana 46952

Verifications can also be faxed to 1-800-403-0864. As stated above, you should use a Document Cover Sheet with any submission. When faxing documents, it is recommended that you number the pages and place the applicant's name and case number or Social Security Number on each page. Some programs such as Adobe Professional and some copiers will do this. Some applicants will choose to wait until after the interview has been completed to submit the verifications. Some attorneys have arranged to take the verifications to their local office which then scan small batches of materials. They use UPS to send large batches of materials to the service center to be scanned. The availability of this option will depend upon the cooperativeness of the local office staff. If you have already sent your packet of verifications to the Document

Center and have scanned the material to your computer, you should offer during the interview to e-mail your scanned packet to the interviewer. In a meeting that Dennis Frick and Claire Lewis had with the Director of the DFR Central Office, Adrienne Shields, in 2016, Director Shields confirmed that it is acceptable for workers to receive verification packets by e-mail **so long as the verifications have already been received by the Document Center.**

The DFR recently revisited this issue and the DFR chiefs are again indicating that all verifications should be submitted to the Document Center. Several regions are instructing workers not to accept verifications by email. In a recent email, Adrienne Shields stated that "These documents may not reach the DFR Staff if utilizing the assumption that all DFR employees have this naming convention. This naming convention [referring to 'first name.last name@fssa.in.gov"] is not utilized for all DFR employees. Secondly, there is no record of the documents being received. If the DFR employee is on vacation, out on leave, quit, was terminated, etc., the documents would not be indexed to the case timely or maybe not at all."

D. What items do you submit?

You should have all verifications necessary to support your case before the application is filed. Try to anticipate everything the system will now require including proof of any asset that was owned within the last five years. Sample checklists showing the documents generally needed for a single applicant in a nursing home and for a married couple are included at Appendices C and D.

Once the interview has been completed, the applicant will then be given a notice called **Pending Verifications** (**Form 2032)** listing any additional information needed to complete the application process.

Although the applicant is responsible for obtaining the information requested, the worker ***must*** assist the applicant as needed. IHCPPM §§ 2015.05.00, 2025.15.00. If the applicant will need more time to obtain verifications, the applicant should request additional time, as an application can be denied for non-cooperation if requested information is not submitted within the time limit given. If neither FSSA staff nor the applicant can obtain needed information, FSSA should then accept a statement from the applicant. IHCPPM §2015.05.00, §2025.10.00. A written statement must be accepted if information cannot be obtained due to the COVID-19 pandemic.

FSSA stated that during the COVID-19 public health emergency, eligibility is granted based on information provided on the application, in the interview, and from the Asset Verification System, and that supporting documentation is not required. www.in.gov/fssa/files/Changes-to-Indiana-health-coverage-application-processing-during-public-health-emergency.pdf. See Appendix E. Despite this memo, the DFR has continued to request verifications, and it is recommended that verifications be provided. But the DFR should be flexible in what verification is required, as some documentation may not be available, or it may not be available within the time limits requested by the DFR. Beware, though, that information will be requested at redetermination time once the Covid-19 emergency is over, so you should submit verifications as you normally would, to the extent possible.

Documents are scanned in and saved with the electronic file; a hard file is not kept in the local offices or at the Document Center. Applicants are provided with bar coded Cover Sheets that should be sent with any submissions so they can be linked to the proper file. Documents can be faxed or mailed to the service center or taken to a local office for the local office to scan and transmit to the service center.

E. Asset Verification System (AVS)

As required by 42 U.S.C. § 1396w, in December, 2020, the DFR began using an Asset Verification System (AVS) to search for assets. AVS is explained in IHCPPM § 2612.00.00. AVS uses the applicant's name and Social Security Number to search electronically using records from Experian, the Bureau of Motor Vehicles, and real estate records. AVS searches financial institutions within 65 miles. See Appendix F for information on obtaining a free credit report.

For new applications, a five year look back is made. For reapplications, a four month look back is completed. For redeterminations, the AVS reviews assets for one month prior to the redetermination date, which is ninety days before it is made.

When a worker completes the "wrap-up" in IEDSS, the AVS system is "pinged," and it should return electronic verification within 13 days. The applicant will also be given a 2032 pending verifications form. The application will be processed as follows:

1. Even if the applicant provides verifications before 13 days, the worker is not to process the case until the AVS is returned or after 13 days, if the AVS does not produce results within 13 days.

2. If an unreported or unverified resource is found by the AVS, the AVS information will be used.

3. If the verifications provided by the applicant do not match the AVS, the higher balance is used unless the hard copy verification rebuts the AVS information. The worker must document in notes why AVS information was not used. For example, the AVS first of the month bank balance may include monthly income that was deposited early into a bank account.

4. If the applicant does not provide verification but AVS information is received, the AVS information is used.

5. If the applicant fails due to AVS information, the application will be denied and an AVS discrepancy notice will be mailed, giving the applicant an opportunity to provide rebuttal information.

Although the worker is required to wait for an AVS report, this is not a basis for not processing an application within the time limit. The worker needs to process the case quickly enough so that there is time to receive an AVS report within the processing time limits.

One should carefully interview the applicant to determine if there is information that may be disclosed through AVS that one should verify in advance in an effort to avoid a denial and discrepancy notice. Was a bank or other financial account closed within the past five years? If so, provide verification and an explanation. Was a vehicle sold, gifted, or junked within the past five years? If so, provide verification and an explanation.

The AVS is still new, so there will be issues to be resolved. *Mismatched and Mistaken: How the Use of an Inaccurate Private Database Results in SSI Recipients Unjustly Losing Benefits*, a report by the National Consumer Law Center and Justice in Aging, at www.nclc.org/images/pdf/credit_reports/RptMismatchedFINAL041421.pdf, reports on substantial problems that have arisen with the Social Security Administration's use of Lexis reports on real estate. One hopes that FSSA's use of discrepancy notices before taking action will avoid similar problems, but one should be aware that errors can occur.

F. Expedited Eligibility Pilot Program

Expedited Eligibility is being piloted to address a serious shortcoming of the current waiver system, which is the time it takes for eligibility to be approved and for services to begin. The typical process requires the following steps:

- Person needing services, family member, other interested person, or other provider contacts the local AAA.
- AAA schedules and conducts an assessment of the applicant to determine if she meets nursing home level of care and can safely receive services. AAA obtains medical information as a part of this process.
- Once AAA determines person is appropriate for waiver, AAA submits to the Division of Aging, which must approve the waiver.
- Once waiver is approved, Medicaid application can be filed and waiver financial eligibility criteria will be applied. Even though for most applications, Medicaid can potentially be approved for the three months before the month of application, Medicaid will not cover waiver services before the date of the waiver approval.
- Once Medicaid application is approved, then waiver providers will begin providing services. Most waiver providers are not willing to provide services until the Medicaid approval is in place.

This entire process can take several months to complete, which may result in the applicant needing to enter a nursing home rather than wait for waiver services to begin. In contrast, many nursing homes are willing to accept a resident as “Medicaid pending.” Most nursing homes are larger than waiver providers and can more easily absorb denials. Further, the “deviation of liability” process can often be used to eventually obtain payment for a nursing home even if Medicaid is initially, but later, approved. The “deviation of liability” process is not available for most waiver recipients because many waiver recipients do not have a liability.

To address these delays, FSSA is piloting an Expedited Waiver Eligibility program under which some AAAs and some waiver providers are given the authority to not only assess waiver eligibility but also to assess eligibility for Medicaid. When a waiver provider assesses eligibility, the AAA completes the processing. The AAA can then obtain immediate Medicaid eligibility without going through the full Medicaid application process, though full verification of all eligibility factors will eventually be required. The AAA's goal is to confirm the service plan and obtain approvals within ten days of the assessment. See Appendix G for a list of providers.

Eligibility for this expedited process is limited to the following applicants:

- Persons age 65 or above not already receiving Medicaid benefits or who have limited Medicaid, such as coverage under one of the Medicare Savings Programs such as QMB or SLMB. It is not available to younger disabled persons.
- Persons with income below the waiver Special Income Level, currently $2,382.
- Persons who do not have complex financial assets and who have countable resources below $2,000. It is not available to a married person utilizing spousal impoverishment criteria.

II. Medicaid Changes Due to COVID

On January 31, 2020 HHS declared a national public health emergency, effective January 27, 2020, as a response to COVID-19. The Biden Administration announced that it expects the emergency to last at least through 2021 and that it will give sixty days notice before ending the emergency.

https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf?eType=EmailBlastContent&eId=0c810e5f-9eff-4073-863b-efbccb49650b.

Indiana is receiving a temporary increase of 6.2% in the Federal Medical Assistance Percentage (FMAP), which is the share of expenses that the federal government pays. This increase continues until the end of the calendar quarter in which the public health emergency as declared by HHS ends. (§ 6008, Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127 (2020). Indiana's FMAP is now 72.03% (65.83% + 6.2%).

No Medicaid cases are being terminated effective March 31, 2020 until the end of the month in which the public health emergency ends. The only cases being terminated are due to death, voluntary withdrawal, or moving out of the state. § 6008(b)(3), FFCRA. Persons receiving benefits pending appeal as of March 18, 2020 are also protected from termination during the emergency. The requirement to continue benefits has now been promulgated in 42 CFR § 433.400.

In addition to not terminating benefits, Medicaid benefits must be maintained and not reduced. 42 CFR § 433.400. Initially, FSSA was not making any adjustments in nursing home or waiver liabilities even when there was a change a change of income. Because 42 CFR § 433.400 allows changes to be made in liabilities, effective March 1, 2021 FSSA is now adjusting liabilities for recipients.

Because of the requirements in Medicaid's rules, 42 CFR § 431.211, that advance notice must be given of any adverse action to terminate or reduce benefits, FSSA acknowledges that it will not be able to take retroactive action against recipients once the national health emergency ends. For example, suppose that the emergency ends December 31, 2021, and the DFR is aware that Samantha had excess resources from April 1, 2020 forward. The DFR can issue a notice terminating Samantha's benefits effective January 1, 2022, but it cannot take any action,

including processing an overpayment claim, against her for being over resources from April, 2020 through December, 2021.

The non-reduction of benefits means that transfer penalties are not currently being assessed against recipients. (Be aware that transfer penalties are being assessed against applicants.) The authors have asked the DFR to clarify how penalties will be addressed once the emergency ends; a response was still pending as of publication of this paper. The authors posed the following hypothetical to DFR. Suppose Sam resides in a nursing home and receives Medicaid (MA A). Sam's brother dies, leaving him an inheritance. The attorney for the estate persuades Sam to disclaim his inheritance, and Sam disclaims on July 2, 2021. The estate attorney tells Sam he needs to promptly report the disclaimer to the DFR, so he does. Suppose the amount disclaimed would result in a penalty period of 10 months, 22 days, using the appropriate divisor for the year Sam applied for Medicaid, which would have been assessed for July 1, 2021 – May 22, 2022, but for the national health emergency. Suppose the national health emergency does end on December 31, 2021.

> - Once the emergency ends, will there be any action taken by DFR as the result of the transfer, and if so, what action will be taken? Will the penalty that still remains after the end of the emergency (January 1, 2022 - May 22, 2022) be imposed, or will no penalty be imposed?
>
> - DFR stated it is keeping track of cases that would have been terminated but for the emergency. Does that include transfer penalty cases?

The authors hope to have answers to these questions by the time the Advanced Seminar meets.

FSSA reports that fewer applications are being filed because recipients are not being terminated, with a need to reapply. This will likely change once the national health emergency ends, and current recipients will be subject to being terminated. See the Washington Post article

“Medicaid boasts record enrollment, but a purge is coming,” June 22, 2021, Appendix H. HHS plans to publish a proposed rule in November, 2021 to streamline the application, eligibility determination, and renewal processes, which may eventually help with new applications depending on what HHS proposes and depending on its implementation, though it is unlikely to be in effect when the emergency ends unless HHS promulgates it as an emergency interim rule pending comments.

https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202104&RIN=0938-AU00

Workers should be less stringent on verification requirements and more willing to accept written statements when it is difficult to obtain documentation. Workers may be less willing to do this now that Covid restrictions have eased.

Eligibility standards, methodologies, or procedures cannot be more restrictive than what was in place on January 1, 2020. This continues until the end of the quarter in which the public health emergency ends.§ 6008(b)(1), FFCRA.

Stimulus payments are not counted as income when received and are not counted as a resource for the 12 months after the month of receipt. In effect, the resource limit is increased by the amount(s) of the stimulus for the 12 months after the month of receipt. New applications should provide proof of the receipt of stimulus funds, as DFR staff does not appear to be asking about this.

There was a supplement to unemployment compensation benefits in addition to the base benefit. The CARES Act provided for a $600 per week supplement, which has now been reduced to $300 per week. This does not count as income for Medicaid but the base benefit does count. § 2104(h), Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Pub. L. No. 116-

136 (2020). The $300 per week payments are continuing in Indiana due to a preliminary injunction, currently under appeal in the Indiana Court of Appeals. These extra benefits are currently scheduled to end September 6, 2021.

All cost-sharing is suspended for the duration of the public health emergency. Members who typically had copayments will not have any copayments applied, starting April 1, 2020. This applies to all IHCP programs, and includes pharmacy copayments. POWER account payments for HIP members were suspended. The FSSA plans to send out multiple notices and provide at least sixty days notice before these payments resume.

Many of the Prior Authorization requirements have been suspended. This includes the 20 one-way trip limitation and 50-mile restriction for all in-state ground transportation. All in-state ground transports must be medically necessary, and the transportation provider must maintain the supporting documentation.

Pharmacies are allowed to fill prescriptions with name-brand drugs if the generic drug is out of supply. Pharmacies can also fill some prescriptions early and can fill maintenance prescriptions for 90-days, if requested.

FSSA is now conducting administrative appeal hearings by telephone.

III. Community Spouse Qualified Retirement Accounts

The general rule is that retirement accounts, including funds held in IRAs, in work-related pension plans administered by an employer or union, or in Keogh plans for self-employed persons, that are owned by an ineligible spouse are not counted. IHCPPM § 2615.15.00, 20 CFR

§ 416.1202(a)(1). The SSI regulation at 20 CFR § 416.1202(a)(1) refers to an ineligible spouse who is living with an eligible spouse.

Example:

> Joe, age 82, and Jill, age 78, are married and live together. Joe and Jill apply for standard Medicaid for the Aged, Blind, and Disabled. They are not seeking waiver services. Jill has a 401k account containing $50,000. Her 401k account counts as a resource for her application and will make her ineligible for Medicaid. Her 401k account will not be counted when considering Joe's eligibility for Medicaid.

Since Indiana became an SSI state in 2014, the DFR has applied this rule in spousal impoverishment cases and not counted an IRA or other qualified retirement account owned by a community spouse as a countable resource at the snapshot date or at the eligibility date. In January, 2020, with no advance notice, the DFR suddenly began counting a community spouse's retirement accounts. After the NAELA Chapter protested, the DFR suspended the change but stated that it still intended to proceed with this change in policy. It stated that it did not intend to promulgate a rule but instead intended to revise the IHCPPM in June, 2020 and begin counting community spouse accounts on July 1, 2020. The NAELA Chapter provided the DFR with its objections to this change and continued to assert that, even if a change can be made, the DFR must do it through a rule change. See Appendix I for NAELA's response to FSSA, which includes a discussion of various cases around the country. The DFR agreed to review NAELA's response before proceeding. **The DFR then agreed not to change its policy until it goes through the rulewriting process.** The DFR may have agreed in part because it cannot adopt more restrictive eligibility rules during the pandemic. See Section II, above. The DFR has not yet published any notice of intent to promulgate a rule and recently stated that it is still considering the materials submitted by NAELA and has not made a final decision.

IV. 529 College Saving Plans

Funds in a 529 education savings plan are not countable as a resource in determining eligibility. I.C. § 12-15-3-8; IHCPPM § 2615.10.20. The IHCPPM does not address whether withdrawals from a 529 plan to be used for education expenses are exempt from a transfer penalty.

FSSA on June 11, 2021 published a new final rule addressing 529 plans:

> 405 IAC 2-3-25 College savings accounts
>
> Authority: IC 12-13-7-3; IC 12-15-1-10
> Affected: IC 12-15-3-8; IC 21-9-2-2; IC 21-9-2-11
>
> Sec. 25. (a) Subject to subsection (b) and any applicable federal law, any money deposited in an account (as defined in IC 21-9-2-2) of an education savings program (as defined in IC 21-9-2-11) may not be considered as a resource or asset in determining an applicant's or recipient's eligibility for Medicaid.
>
> (b) Any money withdrawn from an account described in subsection (a) shall be used for eligible educational expenses, as determined by 26 U.S.C. 529, for the designated beneficiary.
>
> (c) Any money withdrawn from an account described in subsection (a) that is not used in accordance with subsection (b) may be considered one (1) of the following:
>
> (1) An invalid transfer subject to a penalty as described in section 1.1 of this rule.
> (2) A converted resource countable in the month of the withdrawal unless the converted resource is otherwise exempt.
>
> (Office of the Secretary of Family and Social Services; 405 IAC 2-3-25; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

The rule provides that money deposited into a 529 plan and is not countable as a resource, and funds withdrawn from the plan will not be treated as a penalizable transfer so long as the withdrawn funds are used for eligible educational expenses.

The authors of this papers have asked FSSA for clarification whether this result depends at all on the ownership of the account. Suppose a grandparent contributes funds to a 529 plan for the benefit of a grandchild, and either the grandchild or the grandchild's parent is the owner of the plan. We asked FSSA to affirm our understanding that so long as the funds are not withdrawn and used for expenses that are not eligible education expenses, depositing funds into a 529 plan for the grandchild would not be a penalizable transfer. As of the publication of this paper, we are still waiting for FSSA's response.

V. Increased Funding for Home and Community Based Services

Section 9817 of the American Rescue Plan Act of 2021, Pub. Law 117-2, (ARP) provides for a 10% increase in the share the federal government pays through March, 2022 for Medicaid Home and Community Based Services programs. States are permitted to use the increased funding through March 31, 2024. The increased funding must supplement, not supplant, existing funding, and the state must "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program." § 9817(b)(2). CMS issued State Medicaid Director letter #21-003 on May 13, 2021 giving states direction on allowable use of this increased funding. https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf. In addition to giving guidance, the Letter at p. 1 explained that its purpose also was:

> to describe opportunities for states to strengthen the HCBS system in response to the COVID-19 Public Health Emergency (PHE), increase access to HCBS for Medicaid beneficiaries, adequately protect the HCBS workforce, safeguard financial stability for HCBS providers, and accelerate long-term services and supports (LTSS) reform under section 9817 of the ARP. This increased federal

> funding can help states increase community living options for people with disabilities... .

See Appendix J for a copy of Appendices B, C, and D of the Letter, which list allowable services and activities.

CMS requires states to submit an initial spending plan and narrative, followed by quarterly updates. FSSA submitted its Proposed Spending Plan on July 9, 2021. See Appendix K. FSSA determined it will have over $877,000,000 available for this project. *Id.*, p. 25. Its plan includes stabilizing community provider networks, supporting the provider workforce, expanding expedited eligibility statewide, building provider capacity, and providing caregiver training and support.

APPENDIX A

*FSS408AE0(

DOCUMENT COVER SHEET
State Form 53677 (R / 1-11) / DFR 1010 / IEDSS

Case Information

Client Name:

Case Number: 601

Address:
Avon, IN 46123-6668

Instructions

- This form is provided to help you when sending documents back to us for the case shown above. Return this form with your documents to assist us in processing your documents more quickly.
- **When you have documents to return, please fill out this form and place it on top of the documents or copies you are sending. Mail or fax this form and the documents you are sending to:**

Mailing Address:	FSSA Document Center PO Box 1810 Marion, IN 46952	Fax Number:	1-800-403-0864

- If you are unable to send all documents together, you may copy this form for future use.
- **If you have questions, please call us toll-free at 1-800-403-0864 between 8:00 AM and 4:30 PM Monday through Friday.**

Comments or Documents Included

G000000100000100000

DFRAZAE01

AUTHORIZED REPRESENTATIVE FOR HEALTH COVERAGE
State Form 55366 (R2 / 12-14) / DFR 2123HC

Section 1

If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed. Be sure to select the function(s) that the representative is being authorized to do. You can select more than one representative and choose the same or different functions. The representative may be an individual or an organization. Complete ONE form per authorized representative. Both you and your representative must sign and date this form.

Section 2

Name of Representative (*Please print clearly*)

Law Office of Claire E. Lewis

Check association with applicant/recipient. Please select ONE *(1)*.

☑ Attorney	☐ Eligibility Assistance Company	☐ Friend	☐ Family
☐ Institution of Residence	☐ Waiver Case Manager	☐ Other (*Specify*): ______	

Mailing Address (*number and street, city, state, and ZIP code*)

115 North Girls School Road, Indianapolis, Indiana 46214

FUNCTION	FUNCTION DESCRIPTION	SELECT THE FUNCTION(S) THE AUTHORIZED REPRESENTATIVE WILL DO: HEALTH COVERAGE
APPLY	• Sign application and be interviewed. • Provide all required proof of information necessary to determine eligibility for benefits. • Receive the Notice of the application decision. • Speak on applicant's behalf at a hearing if the application decision is appealed.	Apply ☑
ONGOING	• Report changes. • Attend periodic redeterminations. • Receive the appointment notices and any redetermination mail-in forms. **NOTE:** Do not check this function if the representative will not continue to act on recipient's behalf after the application decision is made.	Ongoing ☑

In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. I agree to maintain or be legally bound to maintain the confidentiality of any information regarding the applicant/recipient provided by the Division of Family Resources.

Signature	Date (*mm/dd/yyyy*)	Telephone ((###) ###-####)
Claire E. Lewis		(317) 484-8115

Section 3

I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above. (If applicant/recipient is medically incapable to sign authorization, provide medical documentation.) I understand that I am responsible for the information anyone acting as my authorized representative gives, including any information that may be incorrect. I also understand that if at any time I wish to stop the person(s) I chose from being my authorized representative, it is my responsibility to contact the Division of Family Resources.

Applicant/Recipient Name	Applicant/Recipient Signature	Date (*mm/dd/yyyy*)
Minnie A. Mouse	X	

Case Number (*Optional*)	Applicant/Recipient Date of Birth (*mm/dd/yyyy*)	Applicant/Reciipient Social Security Number
	06/28/34	XXX-XX-0000

APPENDIX C

CHECKLIST OF DOCUMENTS YOU WILL NEED
FOR MINNIE A. MOUSE'S MEDICAID CASE

PLEASE NOTE: In order for Medicaid to pay the per diem cost of care in a nursing home, the Medicaid applicant must be in a MEDICAID-CERTIFIED BED.

If you purchased an immediate annuity or annuitized an annuity on or after November 1, 2009 OR if you have made withdrawals (other than minimum required distributions from an IRA annuity), then, if you are keeping the annuity, you MUST change the contingent (secondary) beneficiary designation to read: "The State of Indiana in an amount not to exceed the amount expended for medical assistance for the institutionalized individual under Subchapter XIX, Chapter 7, of Title 42 of the United States Code." You, as the spouse, should still be named the primary beneficiary. If the annuity company asks, the State of Indiana EIN is: 356000158. See below for further information on annuities.

Your targeted date of eligibility is September 1, 2021.

1. **Birth certificate and photo ID card (such as driver's license).** If there is no birth certificate, then provide **one other proof** of date of birth, such as passport, baptismal record, insurance policies, Social Security record which states date of birth, health care record (from doctor or other health care provider). You also may request a birth certificate by telephone, mail, or online at https://www.vitalchek.com/birth-certificates

2. **Copy of death certificate or divorce decree**, if applicable or any other credible evidence of the event.

3. **Copies of Social Security, Medicare, health care insurance supplement, Medicare Advantage Plan, and Medicare Part D (prescription drug plan) cards**. Please copy both the front and back of your health care supplement and Part D cards. Replacement Social Security cards can be obtained at the mysocialsecurity portal at socialsecurity.gov/myaccount

4. **Health Insurance:** Verification of the amount of monthly health care insurance premium. The premium stub is an ideal proof. If you do not have a premium stub, please request a letter from the company. A notation on a bank statement is NOT sufficient. Please include premium information for Medicare Part D (prescription drug benefits). If you have a Medicare advantage plan, Medicaid requires you to have a statement from the company showing which part of the premium is attributable to Part C and which is attributable to Part D.

5. **Legal Documents:** Copy of power of attorney and copy of trust (if applicable). If there is a guardianship in place, we will need the "Letters of Guardianship." If the power of attorney requires a letter of incapacity, please get this statement from your doctor.

6. **Proof of 2021 Social Security income**. You will need the "Your New Monthly Benefits Amount" letter for 2021 showing the gross monthly benefit, deduction for the Medicare Part B

premium, and the net deposit. **A notation on the bank statement is not sufficient proof.** *You can also get the proper form by setting up an online account by following the prompts under "Get your benefit verification letter online" section of the SSA website at www.ssa.gov.

7. **Proof of Veterans benefits**: the check or letter of notification (if within 12 months) or call 1-800-827-1000. If you receive a non-service connected pension from the VA, please request a letter which gives a breakdown of what part of the pension is for aid and attendance or is awarded due to unreimbursed medical expenses. Medicaid is now requiring this information. You can also contact the VA at 1-877-294-6380 which is the National VA Pension Line. Please call at a time when you can afford to be on hold for a half hour or more.

8. **Proof of Railroad Retirement benefits**: the check or letter of notification (if within 12 months) or call 1-877-772-5772.

9. **Proof of pension income**: the check stub or a statement from the company showing gross and net income. **A notation on a bank statement is not sufficient proof.**

10. **Income from rental of property** along with the expenses of ownership (real estate tax, real estate insurance, utilities, routine maintenance, interest on mortgage payments). We will need a copy of your tax return showing income received from farming or rental properties in the past year.

11. **Fair Market Rental Value:** Medicaid will request proof that your real estate is earning a fair market income. You should not have to pay for an appraisal. Instead, please request that a realtor (or perhaps a farm bureau, if the property is agricultural) give you a free fair market analysis of the income your property should be receiving.

12. **Earnings**: name of employer, pay stubs covering the last 3 months or one pay stub with year-to-date totals.

13. **Proof of any other income received.**

14. **Proof of date of admission to the nursing home**. (The nursing home can typically give you an admission face sheet.)

15. **Proof of any long term care (nursing home) insurance**. We will need information regarding the policy term (length of coverage) and how much the policy will pay, if applicable. The policy information face sheet typically provides this information. If the Medicaid applicant is already receiving payments for services, we will need copies of the last three check stubs and proof that the medical service provider (e.g., nursing home or home care agency) is receiving the payments. If the policy is an Indiana Partnership policy, we will need the service summary report showing the benefits paid out and the asset disregard.

16. **Prepaid funeral arrangement and deed to burial plot.** In order for the funeral to be exempt, the amount paid must be linked to a statement of funeral goods and services. In other words, if you pay $10,000.00, you must have a statement from the funeral home that shows you have purchased $10,000.00 worth of goods and services. For prepaid funerals, we need the following:
    - A copy of the Statement of Goods and Services
    - Proof of the irrevocable nature of the agreement. If the funeral plan is being purchased within the month before our targeted date for Medicaid, the funeral paperwork should also contain a statement similar to the following: "IRREVOCABILITY: Indiana law requires that pre-need funeral agreements be made irrevocable after 30 days. By initialing here (______) the pre-need funeral agreement will be made irrevocable immediately."
    - A statement within the funeral paperwork that indicates that if there are excess funds in the trust at the time of the individual's death, that the excess amount will be paid to the individual's estate or to Medicaid office (or State of Indiana or Division of Family Resources). **THIS IS A CRITICAL COMPONENT OF THE PROOF WE NEED TO SATISFY THE MEDICAID REQUIREMENTS.**

17. **Verification of life insurance policies**:
    - Written verification from the company of the cash surrender value of the policy.
    - Copy of the face sheet which shows the issue date of the policy and the face amount of the policy.
    - Since you are cash surrendering the policy, please copy the cash surrender check and accompanying paperwork
    - Since you are changing ownership on a policy, we will proof of the ownership change, including date of change and new owner name.
    - For policies that have only a death benefit, you will need a statement from the company indicating there is no cash surrender value for the policy.

18. **Bank statements** showing the balance in any and all accounts owned (checking, savings, C.D.s, Christmas Club, etc.) covering the following dates: ________________________

    - We also need proof of closing of any account and proof of disposition of the proceeds (e.g., deposited into checking account, etc.). **This applies to any account closed within the last five years.**
    - If you have written large checks or have large deposits in the material you provide to us, as requested above, please provide copies of those checks (if not included in the bank statement) and explanations of large deposits.
    - We need all numbered pages of any bank statement, even if those pages are blank or contain only reconciliation information.

19. **Verification of ownership and value of any stocks or bonds** (including U.S. Savings Bonds) covering the following dates: ________________________. We also need proof of closing of any account and proof of disposition of the proceeds (e.g., deposited into checking account, etc.). **This applies to any account closed within the last five years.**

20. **Special Requirements for annuities, depending on date of purchase and activity on annuities:**
    a.) For any annuity purchased prior to November 1, 2009, Medicaid is requiring either a statement from the company that says there has been no activity on the annuity such as change of ownership, withdrawals, or deposits since on or after November 1, 2009 OR you will need to produce all statements of activity on the annuity from November 1, 2009 through the time of withdrawal of the annuity proceeds or the filing date of the Medicaid application, whichever is applicable.
    b.) If there *has* been activity on the annuity such as change of ownership, withdrawals, or deposits since on or after November 1, 2009, you will need to change the beneficiary to the state of Indiana as specifically detailed on page one of this checklist.
    c.) If the annuity was purchased on or after November 1, 2009, you will need to change the beneficiary to the state of Indiana as specifically detailed on page one of this checklist.

21. **Property deeds for all real estate**, including the home, if there is a home. Please also provide the real estate tax notice which shows the assessed value of the real estate.

22. **The registration or title** as well as verification of the current market value of any non-motorized recreational vehicle, camper trailer, boat, etc. owned by applicant.

23. **The registration or title** to all vehicles owned by the Medicaid applicant. We can assist you in getting values so long as we know the make, model, and approximate number of miles on the vehicle. However, if the vehicle is older than 1992, you will need a written statement by a licensed dealer of the value.

24. A **listing of the contents of any safety deposit box** rented by the Medicaid applicant.

25. **Copy of the last federal income tax return** filed on behalf of the Medicaid applicant.

26. **Proof of gifts made in the last five years**. (Copies of checks are ideal proof.)

27. **Your most recent credit bureau report:** Go to: https://www.experian.com and you will be prompted on how to obtain your free credit report.

CHECKLIST OF DOCUMENTS YOU WILL NEED
FOR MICKEY A MOUSE'S MEDICAID

PLEASE NOTE: In order for Medicaid to pay the per diem cost of care in a nursing home, the Medicaid applicant must be in a MEDICAID-CERTIFIED BED. Please check with the nursing home to ensure that this is the case.

If you purchased or annuitized an annuity on or after November 1, 2009 OR if you have made withdrawals (other than minimum required distributions from an IRA annuity), then, if you are keeping the annuity, you MUST change the contingent (secondary) beneficiary designation to read: "The State of Indiana in an amount not to exceed the amount expended for medical assistance for the institutionalized individual under Subchapter XIX, Chapter 7, of Title 42 of the United States Code." You, as the spouse, should still be named the primary beneficiary. If the annuity company asks, the State of Indiana EIN is: 356000158. See below for further information on annuities.

Your two key dates are: ____________& ______________

1. **Birth certificate for both spouses and photo ID for both spouses**. If there is no birth certificate, then provide **two proofs** of date of birth, such as passport, baptismal record, insurance policies, driver's license or i.d. card, Social Security record which states date of birth, health care record (from doctor or other health care provider). You also may request a birth certificate by telephone, mail, or online at https://www.vitalchek.com/birth-certificates.

2. **Record of marriage**, such as certificate or license. You also may request a marriage certificate by telephone, mail, or online at https://www.vitalchek.com/marriage-records.

3. **Copies of Social Security, Medicare, health care insurance supplement, Medicare Advantage Plan, and Medicare Part D (prescription drug plan) cards for both spouses.** Please copy both the front and back of your advantage plan OR health care supplement and Part D cards. Replacement Social Security cards can be obtained at the mysocialsecurity portal at socialsecurity.gov/myaccount

4. **Legal Documents:** Copy of power of attorney and copy of trust for the Medicaid applicant spouse. If there is a guardianship in place, we will need the "Letters of Guardianship." If the power of attorney requires a letter of incapacity, please get this statement from your doctor.

5. **If there has been a prior 30 consecutive day stay in a facility (hospital, rehab, nursing home or any of those facilities combined), then we will need proof of date of admission to the hospital and proof of date of admission into the nursing home**. (The nursing home can typically give you an admission face sheet with the "qualifying hospital stay.")

OR **Proof of date of admission to the hospital and also proof of date of admission to the nursing home.** (The nursing home can typically give you an admission face sheet with the "qualifying hospital stay.")

6. **Health Insurance:** Verification of the amount of monthly health care insurance premium paid for each spouse. The premium stub is an ideal proof. If one premium is paid for both spouses, please ask the company to give you a specific breakdown of the premium that is attributable to the Medicaid applicant spouse. If you do not have a premium stub, please request a letter from the company. A notation on a bank statement is NOT sufficient. Please include premium information for Medicare Part D (prescription drug benefits). If your spouse has an advantage plan, Medicaid requires you to have a statement from the company showing which part of the premium is attributable to Part C and which is attributable to Part D.

7. **Proof of 2021 Social Security income for both spouses.** You will need the "Your New Monthly Benefits Amount" letter for 2021 showing the gross monthly benefit, deduction for the Medicare Part B premium, and the net deposit. **A notation on the bank statement is not sufficient proof.** *You can also get the proper form by setting up an online account by following the prompts under "Get your benefit verification letter online" section of the SSA website at www.ssa.gov.

8. **Proof of Veterans benefits**: the check or letter of notification (if within 12 months) or call 1-800-827-1000. If you receive a non-service connected pension from the VA, please request a letter which gives a breakdown of what part of the pension is for aid and attendance or is awarded due to unreimbursed medical expenses. Medicaid is now requiring this information. You can also contact the VA at 1-877-294-6380 which is the National VA Pension Line. Please call at a time when you can afford to be on hold for a half hour or more.

9. **Proof of Railroad Retirement benefits**: the check or letter of notification (if within 12 months) or call 1-877-772-5772.

10. **Proof of Pension Income for both spouses:** the check stub or a statement from the company showing gross and net income. **A notation on a bank statement is not sufficient proof.**

11. **Income from rental of property** along with the expenses of ownership (real estate tax, real estate insurance, utilities, routine maintenance, interest on mortgage payments). We will need a copy of your tax return showing income received from farming or rental properties in the past year.

12. **Fair Market Rental Value:** Medicaid will request proof that your real estate is earning a fair market income. You should not have to pay for an appraisal. Instead, please request that a realtor (or perhaps a farm bureau, if the property is agricultural) give you a free fair market analysis of the income your property should be receiving.

13. **Earnings**: name of employer, pay stubs covering the last 3 months, verification of work expenses.

14. **Proof of any other income received.**

15. **Proof of any long term care (nursing home) insurance.** We will need information regarding the policy term (length of coverage) and how much the policy will pay. The policy information face sheet typically provides this information. If the Medicaid applicant is already receiving payments for services, we will need copies of the last three check stubs and proof that the medical service provider (e.g., nursing home or home care agency) is receiving the payments. If the policy is an Indiana Partnership policy, we will need the service summary report showing the benefits paid out and the asset disregard.

16. **Prepaid funeral arrangement and deed to burial plot for both spouses.** In order for the funeral to be exempt, the amount paid must be linked to a statement of funeral goods and services. In other words, if you pay $10,000.00, you must have a statement from the funeral home that shows you have purchased $10,000.00 worth of goods and services. For prepaid funerals, we need the following:
    - A copy of the Statement of Goods and Services
    - Proof of the irrevocable nature of the agreement. If the funeral plan is being purchased within the month before our targeted date for Medicaid, the funeral paperwork should also contain a statement similar to the following: "IRREVOCABILITY: Indiana law requires that pre-need funeral agreements be made irrevocable after 30 days. By initialing here (_______) the pre-need funeral agreement will be made irrevocable immediately."
    - A statement within the funeral paperwork that indicates that if there are excess funds in the trust at the time of the individual's death, that the excess amount will be paid to the individual's estate or to Medicaid office (or State of Indiana or Division of Family Resources). **THIS IS A CRITICAL COMPONENT OF THE PROOF WE NEED TO SATISFY THE MEDICAID REQUIREMENTS.**

17. **Verification of both spouses' life insurance policies for the following dates:**

    - Written verification from the company of the cash surrender value of the policy.
    - Copy of the face sheet which shows the issue date of the policy and the face amount of the policy.
    - Since you are cash surrendering the policy, please copy the cash surrender check and accompanying paperwork
    - If you are keeping the policy owned by your spouse, you must change ownership of the policy to your name. Your spouse will still be the insured, and you will still be the beneficiary. We will proof of the ownership change, including date of change.
    - For policies that have only a death benefit, you will need a statement from the company indicating there is no cash surrender value for the policy.

18. **Bank statements showing the balance in any and all accounts owned - checking, savings, Certificates of Deposit (C.D.s), Christmas Club, etc.) - for the following two dates: ___________________________________.**

- If a date (the targeted date for Medicaid eligibility) has not yet occurred, then submit these verifications when they are available.
- We also need proof of closing of any account and proof of disposition of the proceeds (e.g., deposited into checking account, etc.) This applies to any account closed within the last five years.
- If you have written large checks or have large deposits in the material you provide to us, as requested above, please provide copies of those checks (if not included in the bank statement) and explanations of large deposits.
- We need all numbered pages of any bank statement, even if those pages are blank or contain only reconciliation information.

19. **Nursing home trust (personal needs or RFMS - Resident Funds Management Services) account** covering from opening through ____________. I recommend that you do ***not*** open a trust account if at all possible. These accounts are countable assets for purposes of Medicaid eligibility.

20. **Verification of ownership and value of any stocks or bonds (including U.S. Savings Bonds) for the following dates: ____.**
We also need proof of closing of any account and proof of disposition of the proceeds (e.g., deposited into checking account, etc.). This applies to any account closed within the last five years.

21. **Special Requirements for annuities, depending on date of purchase and activity on annuities:**
    a.) For any annuity purchased prior to November 1, 2009, Medicaid is requiring either a statement from the company that says there has been no activity on the annuity such as change of ownership, withdrawals, or deposits since on or after November 1, 2009 OR you will need to produce all statements of activity on the annuity from November 1, 2009 through the time of withdrawal of the annuity proceeds or the filing date of the Medicaid application, whichever is applicable.
    b.) If there *has* been activity on the annuity such as change of ownership, withdrawals, or deposits since on or after November 1, 2009, you will need to change the beneficiary to the state of Indiana as specifically detailed on page one of this checklist if you are keeping the annuity.
    c.) If the annuity was purchased on or after November 1, 2009, you will need to change the beneficiary to the state of Indiana as specifically detailed on page one of this checklist. If you are cashing in the annuity to prepare for Medicaid, this beneficiary change is not necessary.

22. **The registration or title** as well as verification of the current market value of any non-motorized recreational vehicle, camper trailer, boat, etc. owned jointly or individually by applicant or spouse.

23. **The registration or title** to all vehicles owned by the Medicaid applicant or spouse. We can assist you in getting values so long as we know the make, model, and approximate number of miles on the vehicle. If the vehicle is older than 1992, you will need to obtain a written statement of value from a licensed auto dealer.

24. **Property deeds for all real estate, including the home, owned by either spouse or by both jointly. Please also provide the real estate tax notice which shows the assessed value of the real estate.**

25. A **listing of the contents of any safety deposit box** rented by the resident.

26. **Copy of the last federal income tax return** filed on behalf of the Medicaid applicant.

27. **Shelter expenses:**
    - Proof of your rent OR your monthly mortgage payment.
    - If you live in an assisted living facility, the facility will need to provide us with a breakdown of the payment (e.g., which portion is for room & board, which portion for meals, etc.) Medicaid will factor only the room & board payment into your "shelter allowance" calculation.
    - Copy of your real estate taxes for your home
    - Copy of the premium bill for your homeowners or renters insurance
    - Condo or neighborhood association fees (if applicable)
    - One recent heating bill and electric bill.

28. **List and proof of gifts made in the last five years.** (Copies of checks are ideal proof.)

29. **Your most recent credit bureau report:** Go to: https://www.experian.com and you will be prompted on how to obtain your free credit report.

Eric Holcomb, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

May 19, 2020

Changes to Indiana health coverage application processing during public health emergency

Effective May 22, 2020, and for the duration of the public health emergency, the Office of Medicaid Policy and Planning will relax certain rules to support Hoosiers who qualify for health coverage benefits. Eligibility will be determined based on the answers given on the application (or at interview) and will not require supporting documentation. This change will allow us to approve coverage more quickly for people who are eligible. After the public health emergency declaration is lifted, we may reach out for documentation.

Please encourage applicants to answer every question on the application. For example: if they have no income, they should mark "No" and not leave it blank. Where the application asks for the amount of income, the applicant should enter "$0." If the person has a job but is not currently working, they should include the employer's name and indicate $0 income for all household members.

FSSA will continue to use electronic data sources to help verify income, citizenship status and other eligibility factors whenever possible. If this information conflicts with the information on the application, FSSA may ask for paper documentation.

If the applicant leaves any questions blank and, therefore, FSSA cannot determine eligibility, we will need to ask for additional documents and it will take longer to process the application.

If someone is applying on the basis of blindness or disability or due to being age 65 or older, an interview will be scheduled and the time and date communicated to the applicant via the mail. Except for certain legal agreements and trusts, FSSA will accept information given during these interviews and will and will not require supporting documentation until after the public health emergency ends.

Applicants should be advised that they are still required to provide complete and correct information to the best of their knowledge. A person who receives benefits by intentionally giving false information or by failing to report information may be criminally prosecuted under state and federal law.

EXHIBIT F

FEDERAL TRADE COMMISSION CONSUMER INFORMATION

How do I order my free annual credit reports?
The three national credit bureaus have a centralized website, toll-free telephone number, and mailing address so you can order your free annual reports in one place. Do not contact the three national credit bureaus individually. These are the only ways to order your free credit reports:

Visit AnnualCreditReport.com or call 1-877-322-8228. Complete the Annual Credit Report Request Form and mail it to:
Annual Credit Report Request Service
P.O. Box 105281
Atlanta, GA 30348-5281

Only one website — AnnualCreditReport.com — is authorized to fill orders for the free annual credit report you are entitled to under law.

How often can I get a free report?
Federal law gives you the right to get a free copy of your credit report every 12 months. Through the pandemic, everyone in the U.S. can get a free credit report each week from all three national credit bureaus (Equifax, Experian, and TransUnion) at AnnualCreditReport.com.

Also, everyone in the U.S. can get six free credit reports per year through 2026 by visiting the Equifax website or by calling 1-866-349-5191. That's in addition to the one free Equifax report (plus your Experian and TransUnion reports) you can get at AnnualCreditReport.com.

Are there other ways I can get a free report?
Under federal law, you're entitled to a free report if a company denies your application for credit, insurance, or employment. That's known as an adverse action. You must ask for your report within 60 days of getting notice of the action. The notice will give you the name, address, and phone number of the credit bureau, and you can request your free report from them.

- You're out of work and plan to look for a job within 60 days
- You're on public assistance, like welfare
- Your report is inaccurate because of identity theft or another fraud
- You have a fraud alert in your credit file

Outside of these free reports, a credit bureau may charge you a reasonable amount for another copy of your report within a 12-month period.

What to Expect When You Order Your Credit Report

What information do I have to give?

To keep your account and information secure, the credit bureaus have a process to verify your identity. Be prepared to give your name, address, Social Security number, and date of birth. If you've moved in the last two years, you may have to give your previous address. They'll ask you some questions that only you would know, like the amount of your monthly mortgage payment. You must answer these questions for each credit bureau, even if you're asking for your credit reports from each credit bureau at the same time. Each credit bureau may ask you for different information because the information each has in your file may come from different sources.

When will my report arrive?
Depending on how you ordered it, you can get it right away or within 15 days.

Online at AnnualCreditReport.com — you'll get access immediately.
By calling toll-free 1-877-322-8228 — it'll be processed and mailed to you within 15 days. By mail using the Annual Credit Report Request Form — it'll be processed and mailed to you within 15 days of receipt of your request. It may take longer to get your report if the credit bureau needs more information to verify your identity.

Can I get my report in Braille, large print, or audio format?
Yes, your free annual credit report are available in Braille, large print or audio format. It takes about three weeks to get your credit reports in these formats. If you are deaf or hard of hearing, access the AnnualCreditReport.com TDD service: call 7-1-1 and refer the Relay Operator to 1-800-821-7232. If you are visually impaired, you can ask for your free annual credit reports in Braille, large print, or audio formats.

Expedited Waiver Eligibility

Some home- and community-based services providers are currently able to complete an expedited Medicaid and Aged and Disabled waiver (https://www.in.gov/medicaid/members/212.htm) application for Hoosiers who fit certain criteria. Individuals or their representatives who contact one of the providers listed below, complete an application and meet eligibility requirements, will immediately be granted Medicaid and A&D waiver eligibility. The goal of this pilot program is for home-based services to start within 10 days of approval. Expediting the eligibility process is intended to help more Hoosiers receive the services they need in their homes instead of needing to move into a nursing facility.

Services provided

Many aging individuals want to live at home as long as they can and sometimes need extra support to remain at home. Some individuals want to return to home or to a community-based environment by leaving a nursing facility, especially during the COVID-19 pandemic. Medicaid-funded home- and community- based services and traditional health services include broad support services such as:

- **Attendant Care** can provide hands-on care to assist in activities such as bathing, dressing, eating, toileting, mobility, etc.
- **Care Management** is a collaborative process to assess, facilitate, plan, advocate, coordinate care, and evaluate the person's needs with service or community resource options.
- **Community Transition Service** can help pay for items that would be needed to allow someone to move out of a nursing facility and back home. This could include furniture, initial deposits, clothes, personal care items, etc.
- **Health Care Coordination** helps connect and coordinate both social and clinical services such as nutrition counseling and doctor visits.
- **Home and Community Assistance** can help with many daily tasks that do not require hands-on personal care such as cleaning, cooking, errands, help with paying bills, etc.
- **Home-delivered Meals** can deliver nutritious meals to the home.
- **Home Modifications** can provide accessibility updates to homes. This can include items such as ramps, bathroom remodels, and stair lifts.
- **Personal Emergency Response** is technology that monitors for falls and notifies authorities if one occurs.
- **Pest Control** this service can be utilized to make sure the home environment is free from insect infestation.

- **Prior Authorization Home Health** can provide needed skilled and unskilled home health needs through the prior authorization process.

- **Respite Care** pays for a person to come into the home to provide temporary relief to family members caring for a loved one at home.
- **Structured Family Caregiving** allows families to be paid for providing personal care services. The Area Agency on Aging may also provide training, education and technology resources.

Eligibility criteria and how to apply

Individuals wishing to apply for Expedited Waiver Eligibility must be eligible for Medicaid and the A&D waiver. Eligibility criteria includes:

- Age 65 or older
- Is not already receiving Medicaid benefits
- Has individual income of $2,349 or less
- Has countable assets under $2,000
- Requires assistance with at least three activities of daily living such as help with eating, dressing, toileting, etc.; or has a substantial skill need
- Meets functional criteria, also known as "nursing facility level of care" for the A&D Waiver. These conditions can be found here. (https://www.in.gov/medicaid/members/212.htm)
- Does not have complex financial assets that must be reviewed in detail to determine eligibility

To apply please call one of the providers listed below that serves your area and ask about applying for Expedited Waiver Eligibility.

Participating providers

The following providers are approved to administer the Expedited Waiver Eligibility application and provide real-time approval. Please contact the provider in your area and they will be able to assist you with application and answer questions about additional services that may be appropriate for you or your loved one.

Caregiver Homes of Indiana, Inc.
5975 Castle Creek Parkway N. Drive, Suite 435
Indianapolis, IN 46250
Counties served: Boone, Clark, Elkhart, Floyd, Gibson, Hamilton, Hancock, Harrison, Hendricks, Jasper, Johnson, Kosciusko, Lake, LaPorte, Marion, Marshall, Morgan, Newton, Perry, Porter, Posey, Pulaski, Scott, Shelby, Spencer, St. Joseph, Starke, Vanderburgh, Warrick
Website: https://info.seniorlink.com/indianacares4you (https://info.seniorlink.com/indianacares4you)

CICOA
8440 Woodfield Crossing B
Indianapolis, IN 46240
Counties served: Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Shelby
Phone: 317-254-5465
Email: mbough@cicoa.org (mailto:mbough@cicoa.org)

Independent Adult Day South
2225 Shelby Street
Indianapolis IN, 46203
Counties served: Marion
Phone: 317-360-0070
Email: info@adultday.com (mailto:info@adultday.com)

LifeSpan Resources
LifeSpan Resources, Inc.
PO Box 995
New Albany, IN 47151-0995
Counties served: Clark, Floyd, Harrison, Scott
Phone: 812-206-7912
Email: pdewees@LSR14.org (mailto:pdewees@LSR14.org)

Northwest Indiana Community Action
5240 Fountain Drive
Crown Point, IN 46307
Counties served: Jasper, Lake, Newton, Porter, Pulaski, Starke
Phone: 219-794-1829 ext. 2231
Email: expedwaivereligibility@NWI-CA.org (mailto:expedwaivereligibility@NWI-CA.org)

Oasis at 56th
4940 W 56th St.
Indianapolis, IN 46254
Counties served: Marion
Phone: 317- 297-3115
Email: nursing@oasis-56.com (mailto:nursing@oasis-56.com)

REAL Services
1151 S. Michigan Street
South Bend, IN 46601
Counties served: Elkhart, Kosciusko, LaPorte, Marshall, St. Joseph
Phone: 574-284-7107, 800-552-2916
Email: info@realservices.org (mailto:info@realservices.org)

Silver Birch Hammond
5620 Sohl Avenue
Hammond, IN 46320
Counties served: Lake
Phone: 219-228-5565
Email: nikisha.marshall@silverbirchliving.com (mailto:nikisha.marshall@silverbirchliving.com)

Silver Birch Evansville
475 South Governor Street
Evansville, IN 47713
Counties served: Vanderburgh
Phone: 812-962-8378
Email: makenzie.weintraut@silverbirchliving.com (mailto:makenzie.weintraut@silverbirchliving.com)

Southwest Indiana Regional Council on Aging
16 West Virginia Street, PO Box 3938
Evansville, IN 47737-3938
Counties served: Gibson, Perry, Posey, Spencer, Vanderburgh, Warrick
Phone: 912-464-7800
Email: adrc@swirca.org (mailto:adrc@swirca.org)

*If you are not able to be approved for expedited wavier eligibility, your application will still be processed as normal.

Online Services

- Find Child Care (http://www.in.gov/fssa/childcarefinder)
- Apply for Services (/fssa/dfr/ebt-hoosier-works-card/find-my-local-dfr-office)
- Forms.IN.gov (/fssa/forms.in.gov)
- IHCP Provider Healthcare Portal (https://portal.indianamedicaid.com/hcp/Default.aspx?alias=portal.indianamedicaid.com/hcp/provider)
- More IN.gov Online Services (http://www.in.gov/services.htm)
- IN.gov Subscriber Center (http://www.in.gov/subscriber_center.htm)

The Washington Post
Democracy Dies in Darkness

The Health 202: Medicaid boasts record enrollment, but a purge is coming

By Paige Winfield Cunningham

Reporter

June 22, 2021 at 8:03 a.m. EDT

with Alexandra Ellerbeck

Nearly 1 in 4 Americans are now on Medicaid — the largest population since the program was first created in 1965.

But millions, or even tens of millions, could get booted from the program next year, as states restart eligibility checks after a forced hiatus.

State Medicaid programs face a looming challenge.

Once the nation's public health emergency ends — likely at the end of the year — states will be responsible for going through their Medicaid rolls and determining who is and isn't eligible for the health insurance program for the low income.

It's normally a task states perform throughout the year, but they were banned from doing so during the pandemic, as a condition of extra federal dollars to help cover an expected surge in Medicaid enrollments. As we explained previously, states got extra money to help cover ballooning Medicaid costs, but in return they had to promise to not remove

anyone from their rolls until the federal government concludes the public health emergency.

All at once — probably starting in January 2022 — states will be under pressure to determine eligibility for their entire Medicaid population. Of course, some people will be appropriately removed from the rolls because they've

gotten a job, a raise or more work hours, making them no longer eligible.

But there will also be enrollment terminations because of out-of-date enrollee contact information or administrative error. **And that's what Medicaid advocates are worried about. It's not uncommon during eligibility determinations for states to lose up to 25 percent of their enrollees,** said Eliot Fishman, a Medicaid expert at the advocacy group Families USA.

"If this goes poorly you could see at least 20 million or maybe more people lose coverage because of administrative problems," Fishman told me.

"It's an eye-popping number so it's clearly going to be a huge priority for states and the Biden administration " he added.

It's a challenge to keep in mind even as the Biden administration celebrates the Medicaid enrollments.

Chiquita Brooks-LaSure, administrator of the Centers for Medicare and Medicaid Services, praised the safety-net program and the insurance it provided to Americans during the economic upheaval wrought by the pandemic and subsequent lockdowns.

Between February 2020 through this past January, enrollment climbed by 9.7 million to reach nearly 75 million nationwide, according to a report released yesterday by CMS. That's an aggressive growth curve, which now means Medicaid insures more Americans than any other health-care program or insurer.

Larry Levitt, senior vice president at the Kaiser Family Foundation:

"Taken together, the 15 percent spike means the size of the public insurance program for low-income Americans now significantly eclipses the nearly 63 million older Americans covered last year through Medicare," my colleague Amy Goldstein writes. "Both health insurance programs date to the mid-1960s and were pillars of Lyndon B. Johnson's 'Great Society' anti-poverty strategies."

"We've really seen how important Medicaid is to ensuring the overall health of our country and have seen this through the pandemic," Brooks-LaSure said.

"We are seeing what a lifeline the Medicaid program is to so, so many Americans," she told Amy.

The administration hinted it's thinking about the massive, upcoming eligibility determination process.

The process will be messy for states. By the time they restart eligibility checks, it will have been suspended for nearly two years. Many people on the rolls may have moved, making it hard to get in touch with them. And normally states check eligibility throughout the year; they're not equipped to check the whole population all at once.

Perhaps tellingly, the administration is working on new regulations around the process, according to a list of work-in-process agency rules posted yesterday by the White House Office of Management and Budget. One of the rules is related to "streamlining the Medicaid and CHIP application, eligibility determination, enrollment and renewal processes."

Fishman said the rule could beef up regulation for how much effort states must expend to get in touch with people, such as requiring them to use cellphone numbers instead of just hard-copy mail.

He said officials might be "realizing if they don't really get out in front of the end of the public health emergency, they are going to lose a ton of people."

Additionally, Brooks-LaSure said CMS is working to make sure states handle reviews properly.

"We are very focused on making sure we don't lose our gains in coverage through unnecessary hoops," she said yesterday.

She stressed the effort the administration is putting forth to ensure people eligible for government health insurance or subsidies get access to it — including the marketplace plans sold on Healthcare.gov. That coverage is popular among people who earn too much to be on Medicaid but little enough that they qualify for a range of subsidies to buy private coverage.

Brooks-LaSure said that in the past "a lot of people are lost between that transition" from the public insurance to Affordable Care Act health plans. "We should be getting whatever coverage they're eligible for," she said.

To: Leslie Huckleberry and Jessica Keyes
From: Dennis Frick and Claire Lewis
Re: NAELA's Response re Treatment of Community Spouse Retirement Accounts
Date: April 14, 2020

I. Rulemaking Is Required to Change FSSA's Policy.

FSSA asserts rulemaking is not required because FSSA's proposed change in policy mirrors federal law and is a correction of interpretation, not a change in policy.

As shown below, there is a split of opinion on the application of 42 U.S.C. § 1396r-5 to community spouse retirement accounts. Even if FSSA sincerely believes its new interpretation of the federal law is correct, that will result in a change in FSSA's policy which has been in effect for nearly six years. I.C. 4-22-2-3(b)(2) defines a rule as an agency statement designed to have the effect of law that "Implements, **interprets,** or prescribes" law or policy. So even if FSSA is correct that it is changing an interpretation, an interpretation of law or policy is still defined as a rule. Thus FSSA's change in interpretation needs to be promulgated.

The opportunity for public comment that comes with rulemaking would benefit FSSA. Even if FSSA is correct that it is not required to exempt community spouse retirement accounts, there are public policy reasons why they should be exempt, as can be seen by other states' decisions to exempt them. Even if FSSA is correct that it is not obligated to exempt community spouse retirement accounts, FSSA could choose an option under 42 U.S.C. § 1396a(r)(2) to choose a less restrictive methodology and exempt all or part of a community spouse's retirement account. Obtaining public input is valuable and should not be avoided.

II. Several States Do Not Count the Retirement Accounts of Community Spouses

At our meeting on March 27, FSSA expressed interest in any information on other states that do not count the retirement accounts of community spouses. This is not a complete list, but through some quick research these are some states we were able to identify who do not count community spouse retirement accounts in spousal impoverishment determinations.

Wisconsin

Wisconsin exempts community spouse retirement accounts per the decision in *Keip v. Wis. Dep't of Health & Family Servs.*, 232 Wis. 2d 380, 606 N.W.2d 543 (Wisc. Ct. App. 1999). We did not located Wisconsin's policy manual language, but an elder law attorney in Wisconsin confirmed that Wisconsin still follows the decision in *Keip*. *Keip* ruled that 42 U.S.C. § 1396r-5 requires that SSI rules on resources must be used in the spousal impoverishment calculations, and since non-eligible spouse retirement accounts are not counted under SSI, they are also not counted under spousal impoverishment. Because SSI does not count any assets of a spouse who is not living with an applicant spouse, *Keip* decided that the "living with" language in 20 C.F.R. § 416.1202(a)(1) does not show that it does not apply in the spousal impoverishment situation.

Alaska

Aged, Disabled and Long Term Care Medicaid Eligibility Manual
http://dpaweb.hss.state.ak.us/manuals/adltc/adltc.htm

520 N. INELIGIBLE SPOUSE RETIREMENT FUND

Retirement funds belonging to an ineligible community spouse is excluded as a resource per APA MS 460-4A. APA MS 431-2G provides a list of possible retirement funds that an ineligible spouse may have.

California

I did not locate an official citation, but the description by the California Advocates for Nursing Home Reform at http://www.canhr.org/factsheets/medi-cal_fs/html/fs_medcal_overview.htm states: "In spouse's name: The balance of the IRA or Pension fund is totally exempt from consideration and is not included in the community spouse resource allowance (CSRA)."

Georgia

Section 2502 of Georgia Medicaid Policy Manual, accessible at https://odis.dhs.ga.gov/General/Home/DhsManuals?id=813 by clicking on "MAN3480 - Medicaid"

Resources Excluded from Deeming
The following pension funds owned by an ineligible/community spouse or parent are not deemed to an A/R: (See Section 2332-2)

- IRAs
- Keoghs
- Private pension funds.

Kentucky

The State Plan at https://chfs.ky.gov/agencies/dms/Documents/StatePlanr1.pdf, Supplement 8b to attachment 2.6-A, Page 3 says retirement funds of both spouses are exempt until accessed. This is described as a more liberal resource methodology.

IRAs, Keogh Plan Funds, 401(k) retirement funds, and other deferred tax protected assets are considered as an unavailable resource until accessed by the owner. When accessed, the available amount is the amount actually withdrawn minus any penalty amounts resulting from the withdrawal.

Pennsylvania

This is from Pa. Long-Term Care Handbook
http://services.dpw.state.pa.us/oimpolicymanuals/ltc/index.htm#t=440_Resources%2F440_3_Personal_Property.htm&rhsearch=CS%20IRA&rhhlterm=CS%20IRA&rhsyns=%20

440.351 Qualified Annuities

...

The qualified annuity (IRA, 401K, etc) of the CS is not counted as an available resource. Count the payments as income if the CS is receiving payments from the annuity.

Florida

It does not count the community spouse's retirement account as a resource if the community spouse is drawing income off the account.

https://www.myflfamilies.com/programs/access/docs/esspolicymanual/1630.pdf

1640.0505.05 Retirement Funds of Spouses (MSSI, SFP)

...

The following policy applies to ICP, institutionalized MEDS-AD, institutionalized Hospice, HCBS and PACE Programs when the applicant has a community spouse (refer to Glossary, Chapter 4600, for definition):

1. At the time of application, if the community spouse receives payments from their retirement funds, the funds are not considered an asset when computing the couple's total countable assets. The payment is considered unearned income to the community spouse when computing the community spouse income allowance.

2. At the time of application, if the community spouse does not receive payments from a retirement fund he owns, but he has the option of withdrawing a lump sum, the total value of the funds must be considered an asset when computing the couple's total assets and the community spouse's asset eligibility. Early withdrawal penalties are excluded from the value of the funds, but any imposed taxes cannot be deducted.

III. Federal Law Does Not Mandate That the Community Spouse's Retirement Account Be Counted.

The case law is split on whether a community spouse's qualified retirement account can be counted in spousal impoverishment cases.

• A Wisconsin appeals court decided a community spouse's IRA cannot be counted, because it is not countable under SSI, and the state must apply the SSI rule. *Keip v. Wis. Dep't of Health & Family Servs.*, 232 Wis. 2d 380, 606 N.W.2d 543 (Wisc. Ct. App. 1999).

• The 10th Circuit Court of Appeals decided that 42 U.S.C. § 1396r-5 is ambiguous and that it is the state's decision whether or not to count a community spouse's retirement account. *Houghton v. Reinertson*, 382 F.3d 1162 (10th Cir. 2004). An Arkansas appeals court agreed and ruled likewise. *Ark. Dep't of Human Servs. v. Pierce*, 2014 Ark. 251, 435 S.W.3d 469 (Ark. 2014).

• Ohio and New Jersey appeals courts decided that 42 U.S.C. § 1396r-5 requires that the community spouse's retirement account be counted. *Mistrick v. Div. of Med. Assistance & Health Servs.*, 154 N.J. 158, 712 A.2d 188 (N.J. 1998); *Martin v. State Dep't of Human Servs.*, 130 Ohio App. 3d 512, 720 N.E.2d 576 (Ohio Ct. App. 1998).

Each of these cases seek to harmonize the language of 42 U.S.C. § 1396r-5. Although § 1396r-5 (a)(1) says the section supercedes other sections, § 1396r-5(a)(3) says the section does not affect the determination of what constitutes a resource. That is, SSI methodology and standards apply. § 1396r-5(c)(5) says that "resources" do not include resources excluded under 42 U.S.C. § 1382(a) or (d). While community spouse retirement accounts are not specifically listed there, NAELA in its memo asserted that the community spouse retirement accounts fall under § 1382b(a)(3)'s exemption of property essential for self support.

FSSA in its memo asserted that 20 CFR § 416.1202(a)(1), the SSI regulation which exempts a non-eligible spouse's qualified retirement account, does not apply in the spousal impoverishment context because it refers to a spouse "living with" a non-eligible spouse. The "living with" language is used because SSI rules do not count any resources of a spouse who is not living with the applicant spouse. When § 1396r-5 says to use SSI's resource methodology, it must be referring to the resource rules for spouses who live together; otherwise, none of the community spouse's resources would be counted. Thus, the phrase "living with" in 20 CFR § 416.1202(a)(1) does not show that it does not apply in the spousal impoverishment situation. *Keip* explained: "although it is true that the SSI rule which excludes an ineligible spouse's IRA as a countable asset applies only if the spouses are living together, that is because assets of the ineligible spouse are only deemed attributable to the eligible spouse if the couple is living together." 232 Wis. 2d at 395.

Further, § 1396r-5 requires that none of the community spouse's income be counted. A qualified retirement account consists of income that was deposited into the account while working plus earnings on the account. A retirement account consists solely of income, so it is consistent with § 1396r-5 that it be fully exempt.

IV. Conclusion

Although NAELA believes that *Keip* provides the best analysis of 42 U.S.C. § 1396r-5 and that community spouse retirement accounts must be disregarded in spousal impoverishment calculations, it recognizes that other courts have disagreed, with two state courts saying that they must be counted, and with one federal court of appeals and one state court saying it is up to the state to decide. This reinforces the need for FSSA to follow the rulemaking process to make a change, since the interpretation of 42 U.S.C. § 1396r-5 is not clear-cut, and since public input is needed.

Appendix B: Home and Community-Based Services Eligible for the ARP Section 9817 Temporary Increased FMAP

HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
State Plan Benefits		
Home Health Care	Home health services are mandatory services authorized at section 1905(a)(7) of the Act, and defined in regulations at 42 C.F.R. § 440.70. Home health services include nursing services, home health aide services, medical supplies, equipment, and appliances, and may include therapy services (physical therapy, occupational therapy, speech pathology and audiology).	Line 12-Home Health Services
Personal Care Services	Personal care services (PCS) are optional services authorized at section 1905(a)(24) and defined in regulations at 42 C.F.R. § 440.167. Personal care services can include a range of human assistance provided to persons who need assistance with daily activities. These services are provided to individuals who are not an inpatient or resident of a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), or institution for mental diseases (IMD), and may be provided in the individual's home and, at state option, in other locations.	Line 23A-Personal Care Services-Regular Payment
Self-Directed Personal Care Services	Section 1915(j) of the Act allows self-direction of state plan personal care services. Requirements are set forth in 42 CFR Part 441 Subpart J.	Line 23B-Personal Care Services-SDS 1915(j)
Case Management	Case management services, as defined under sections 1905(a)(19) and 1915(g) of the Act and 42 CFR § 440.169 and 42 CFR § 441.18, assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services.	Line 24A-Targeted Case Management Services-Community Case Management Line 24B-Case Management State Wide

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HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
School Based Services	These services include medical assistance for covered services under section 1905(a) that are furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan. Only school based services that meet the definition of one or more of the services listed in this appendix can be claimed at the increased FMAP under section 9817 of the ARP.	[This line is under development; further instructions will be issued.]
Rehabilitative Services	The rehabilitative services benefit is an optional Medicaid state plan benefit authorized at section 1905(a)(13) of the Act and codified in regulation at 42 CFR § 440.130(d) as "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level." All rehabilitative services, including mental health and substance use disorder services, authorized under this benefit can be claimed at the increased FMAP under section 9817 of the ARP.	[This line is under development; further instructions will be issued.]

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HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
Private Duty Nursing[9]	Private duty nursing is an optional Medicaid state plan benefit authorized at section 1905(a)(8) of the Act and codified in regulation at 42 CFR § 440.80 as "nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided: (a) by a registered nurse or a licensed practical nurse; (b) under the direction of the recipient's physician; and (c) to a recipient in one or more of the following locations at the option of the State: **(1) his or her own home;** (2) a hospital; or (3) a skilled nursing facility." The increased FMAP under section 9817 of the ARP is only applicable when the service is provided in a beneficiary's **own home**, and is being included here based on the authority at ARP section 9817(a)(2)(B)(vii) given to the Secretary to specify additional services eligible for enhanced funding.	[This line is under development; further instructions will be issued.]
Alternative Benefit Plans (Section 1937 of the Act)	Any of the Medicaid-covered services described under section 9817 of the ARP are eligible for the enhanced match when authorized under an approved Alternative Benefit Plan.	Follow CMS-64.9 Base Category of Service Definitions
HCBS Authorities		
Section 1915(c)	Waiver authority found at section 1915(c) of the Act gives states the option to offer long-term services and supports (LTSS) in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act. For example, services may include home accessibility modifications (e.g., installing a wheelchair ramp or grab bars in a shower) to improve individuals' ability to remain in their homes and prevent institutional admission.	Line 19A – Home and Community-Based Services – Regular Payment (Waiver)

[9] ARP section 9817(a)(2)(B) identifies certain services that are eligible for the HCBS increased FMAP. While private duty nursing is not explicitly identified as among the eligible services, CMS has determined that expenditures for private duty nursing services delivered in the home qualify under "such other services specified by the Secretary of Health and Human Services" in ARP section 9817(a)(2)(B)(vii) and are eligible for the HCBS increased FMAP.

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HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
Section 1915(i)	Section 1915(i) is an optional state plan benefit that allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target group criteria) as set forth in 42 CFR Part 441 Subpart M. States have broad latitude to determine the services to offer under the section 1915(i) state plan benefit option, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act.	Line 19B- Home and Community-Based Services - State Plan 1915(i) Only Payment
Section 1915(j) – Self-directed 1915(c) services.	Section 1915(j) of the Act allows self-direction of HCBS otherwise available under a section 1915(c) waiver program that are provided to an individual who has been determined eligible for the self-directed option. Requirements are set forth in 42 CFR Part 441 Subpart J.	Line 19C- Home and Community-Based Services - State Plan 1915(j) Only Payment
Section 1915(k)	The section 1915(k) Community First Choice (CFC) state plan benefit provides certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. States receive an extra six percentage points of federal match for CFC service expenditures. To the extent applicable, the increased FMAP under section 9817 of the ARP is additive to the increased FMAP specified in section 1915(k).	Line 19D- Home and Community Based Services State Plan 1915(k) Community First Choice
Program of All-Inclusive Care for the Elderly (PACE)	PACE provides comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. An interdisciplinary team of health professionals provides PACE participants with coordinated care.	Line 22- Programs Of All-Inclusive Care Elderly

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HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
Managed Long-Term Services and Supports	Managed long term services and supports (MLTSS) refers to the delivery of LTSS through capitated Medicaid managed care programs. Only the state plan and HCBS services defined in this appendix that are provided through a managed care delivery system are eligible for the enhanced FMAP referenced in this guidance. States can implement MLTSS using an array of managed care authorities, including a section 1915(a) voluntary program, a section 1932(a) state plan amendment, a section 1915(b) waiver, or a section 1115 demonstration. Any of those managed care authorities can be "paired" with other Medicaid authorities, such as section 1905(a), 1915(i), 1915(j), or 1915(k) or an HCBS waiver program under section 1915(c) to authorize HCBS benefits to be delivered through a managed care delivery system. See *Claiming the Increased FMAP for Managed Care Expenditures* in section 1.E of this letter for more information.	[This line is under development; further instructions will be issued.]
Demonstrations		
Section 1115	States can utilize section 1115(a) demonstration authority to test new strategies to promote the objectives of the Medicaid program that are not available under other authorities. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, including but not limited to statewideness and comparability, to the extent and for the period necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide FFP for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary. Any of the Medicaid-covered HCBS services described above are eligible for the enhanced match when authorized under an approved 1115 demonstration.	Follow CMS-64.9 Base Category of Service Definitions

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Appendix C: Examples of Section 9817 of the ARP Activities to Support State COVID-Related HCBS Needs

Under section 9817 of the ARP, states can implement a variety of activities to enhance, expand, or strengthen Medicaid HCBS. This appendix provides examples of activities that states can initiate as part of this opportunity to address COVID-related concerns during the period of the public health emergency.

Activity	Activity Description
Increased Access to HCBS	
New and/or Additional HCBS	Provide new or additional Medicaid HCBS services or increase the amount, duration, or scope of HCBS to reduce the risk of institutionalization during the COVID-19 PHE.
HCBS Provider Payment Rate and Benefit Enhancements	
Payment Rates	Increase rates for home health agencies, PACE organizations, and agencies or beneficiaries that employ direct support professionals (including independent providers in a self-directed or consumer-directed model) to provide HCBS under the state Medicaid program. CMS expects that the agency, organization, beneficiary, or other individuals that receive payment under such an increased rate will increase the compensation it pays its home health workers or direct support professionals. An increase to the PACE Medicaid capitation rate can be implemented as part of the state's regular annual rate update or on a temporary basis as an interim rate increase, but must comply with existing submission, review, and approval requirements. States are not permitted to provide supplemental funding to PACE organizations outside of the PACE Medicaid capitation payment due to regulatory requirements.
Leave Benefits	Provide paid sick leave, paid family leave, and paid medical leave for home health workers and direct support professionals that are not already included in the service rate/rate methodology.
Specialized Payments	Provide hazard pay, overtime pay, and shift differential pay for home health workers and direct support professionals that are not already included in the service rate/rate methodology. Provide adult day centers with funding to make physical, operational, or other changes to safely deliver services during the COVID-19 PHE.
Supplies and Equipment	
Purchase Personal Protective Equipment (PPE) and Testing Supplies	Purchase PPE and routine COVID testing for direct service workers and people receiving HCBS, to enhance access to services and to protect the health and well-being of home health workers and direct support professionals.
Work Force Support	
Workforce Recruitment	Conduct activities to recruit and retain home health workers and direct support professionals. Offer incentive payments to recruit and retain home health workers and direct support professionals.

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Activity	Activity Description
Workforce Training	Provide training for home health workers and direct support professionals that is specific to the COVID-19 PHE.
Caregiver Support	
Supports for Family Caregivers	Support family care providers of eligible individuals with needed supplies and equipment, which may include items not typically covered under the Medicaid program, such as PPE and payment as a service provider.
Support to Improve Functional Capabilities of Persons with Disabilities	
Assistive Technology and Other Supports for Persons with Disabilities	Provide assistive technologies (including internet activation costs necessary to support use of the assistive technologies), staffing, and other costs incurred during the COVID–19 PHE in order to mitigate isolation and ensure an individual's person-centered service plan continues to be fully implemented.
Transition Support	
One-Time Community Transition Costs	Facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a community-based living arrangement in a private residence where the person is directly responsible for his or her own living expenses. One-time community transition costs may include payment of necessary expenses to establish a beneficiary's basic living arrangement, such as security deposits, utility activation fees, and essential household furnishings, for example.[10]
Transition Coordination	Provide transition coordination services to eligible individuals who had to relocate to a nursing facility or institutional setting from their homes during the COVID–19 PHE, or moved into congregate non-institutional settings as a result of the COVID-19 PHE, as well as for temporary relocation of residents from various types of congregate settings to community-based settings to reduce the risk of COVID-19 infection during the COVID-19 PHE.
Mental Health and Substance Use Disorder Services	
Skill rehabilitation	Assist eligible individuals in receiving mental health services, substance use treatment and recovery services, and necessary rehabilitative services to regain skills lost during the COVID–19 PHE.
Expanding Capacity	Recruit additional behavioral health providers, implement new behavioral health services, increase pay rates for behavioral health providers, expand access to telehealth, or make other changes to address increases in overdose rates or other mental health and/or substance use disorder treatment and recovery service needs of Medicaid beneficiaries receiving HCBS during the COVID–19 PHE.

[10] See State Health Office Letter # 21-001, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), for more information on one-time community-transition costs.

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Activity	Activity Description
Outreach	
Educational Materials	Prepare information and public health and educational materials in accessible formats for individuals receiving HCBS (including formats accessible to people with low literacy or intellectual disabilities) about prevention, treatment, recovery and other aspects of COVID–19 for eligible individuals, their families, and the general community. States could leverage relationships with community partners, such as Area Agencies on Aging, Centers for Independent Living, non-profit home and community-based services providers, and other entities providing HCBS for these activities.
Language Assistance	Pay for American sign language and other language interpreters to assist in providing HCBS to eligible individuals and to inform them about COVID–19.
Access to COVID-19 Vaccines	
Support for Individuals with HCBS Needs and Their Caregivers	Assist with scheduling vaccine appointments. Provide transportation to vaccine sites. Provide direct support services for vaccine appointments. Develop and implement in-home vaccination options. Education and outreach about the COVID-19 vaccine.

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Appendix D: Examples of Section 9817 of the ARP Activities to Support State HCBS Capacity Building and LTSS Rebalancing Reform

Under section 9817 of the ARP, states can implement a variety of activities to enhance, expand, or strengthen Medicaid HCBS. This appendix provides examples of activities that states can initiate as part of this opportunity to support state HCBS capacity building and LTSS rebalancing.

Activity Function	Activity Description
New and/or Additional HCBS	Provide new or additional Medicaid HCBS services or increase the amount, duration, or scope of HCBS; funding must be used to supplement not supplant existing services.
Building No Wrong Door Systems (NWD)	Improve access to HCBS through non-administrative NWD activities such as establishing toll free phone lines, developing informational websites and automating screening and assessment tools, and conducting marketing and outreach campaigns.
Strengthening Assessment and Person-Centered Planning Practices	Adopting standardized functional assessments. Enhancing person-centered planning practices. Providing person-centered planning training.
Quality Improvement Activities	Upgrading critical incident management reporting systems. Adopting new HCBS quality measures. Implementing improvements to quality measurement, oversight, and improvement activities. Implementing the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) or another experience of care survey.
Developing Cross-System Partnerships	Creating incentives for managed care plans or providers to develop partnerships with community-based organizations, social service agencies, counties, housing agencies, and public health agencies. Promoting provider collaborations by requiring the formation of and participation in regional/local provider networks. Building Medicaid-housing partnerships. Building social determinants of health (SDOH) network partnerships.
Training and Respite	Providing caregiver training and education. Providing in-person or virtual training to beneficiaries, caregivers, and/or providers to support community integration (e.g., to support beneficiaries with seeking employment, to train providers or caregivers to support individuals with behavioral challenges that can make it difficult to access community resources). Providing respite services to support family caregivers.
Eligibility Systems	Implementing new eligibility policies and/or procedures, such as to implement expedited eligibility for HCBS (subject to CMS approval), or streamline application and enrollment processes
Reducing or Eliminating HCBS Waiting Lists	Increasing the number of HCBS waiver slots in order to reduce or eliminate waiver waiting lists.

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Activity Function	Activity Description
Institutional Diversion	Embedding options counselors into hospital discharge programs. Strengthening/improving Preadmission Screening and Resident Review (PASRR) processes to prevent unnecessary institutionalization.
Community Transition	Expanding a community transition program to additional populations or institutional settings. Improving the use and availability of data (e.g., Minimum Data Set, Medicare and Medicaid claims and encounter data) to support community transition programs. Providing additional one-time community transition services or other HCBS that can help to support the transition from institutional settings.
Expanding Provider Capacity	Expanding self-directed programs. Creating financial incentives to expand the number, retention rates, and expertise/skills of the direct care workforce. Providing nursing facilities or other institutional settings with funding to convert to assisted living facilities or to provide adult day services, respite care, or other HCBS.
Addressing Social Determinants of Health and Health Disparities	Assessing health disparities among older adults and people with disabilities. Testing alternative payment methodologies or the delivery of new services that are designed to address SDOH that may include housing-related supports such as one-time transition costs, employment supports, and community integration, among others. Providing more intensive care coordination for individuals with significant socioeconomic needs based on risk-stratification modeling.
Employing Cross-system Data Integration Efforts	Establishing data sharing and governance agreements that enumerate standards and practices for data sharing among state and county agencies, providers, and community-based organizations such as with the National Adult Maltreatment Reporting System. Providing training and technical assistance to build providers' performance measurement and predictive analytics capabilities. Building a stronger health and welfare system by integrating claims and encounter data with the state's incident management system.
Expanding Use of Technology and Telehealth	Making investments in infrastructure to facilitate incorporation of HCBS into interoperable electronic health records (EHRs). Covering individual tele-communications start-up costs (e.g., equipment, internet connectivity activation costs). Testing the impact of assistive technologies on the need for in-person supports. Providing smartphones, computers, and/or internet activation fees to address functional needs, promote independence, and/or support community integration.
Providing Access to Additional Equipment or Devices	Providing eyeglasses, wheelchair transfer boards, and adaptive cooking equipment to address functional needs, promote independence, and/or support community integration.

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Activity Function	Activity Description
Adopting Enhanced care Coordination	Implementing health information technology care coordination enhancements such as notification systems and capabilities (e.g., hospital admission, discharge, and transfer notifications) to share information across different health care settings. Integrating Medicare and Medicaid data and/or improving Medicaid managed care plan access to Medicare data to improve care coordination for individuals receiving HCBS who are dually eligible for Medicare and Medicaid. Implementing integrated care models that can more effectively address the needs of complex populations.

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State of Indiana

Indiana Family and Social Services Administration

Proposed Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817

State of Indiana

Submitted to The Centers for Medicare and Medicaid Services

July 9, 2021

Eric Holcomb, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Transmittal Letter

July 9, 2021

The Indiana Family and Social Services Administration (FSSA) is submitting the following Spending Plan to CMS pursuant to the guidance issued via SMD #21-003. FSSA is grateful to CMS for granting our request for a 30-day extension for plan submission and submits this plan timely in advance of the extended deadline of July 11, 2021. FSSA's designated point of contact for the quarterly spending plan and narrative submissions will be Allison Taylor, the State Medicaid Director.

As part of our Spending Plan submission, FSSA attests to the following assurances:

- The state is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;
- The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021

FSSA looks forward to CMS' review of our Spending Plan. We believe we will be able to use the enhanced FMAP funding to improve the continuum of HCBS, and enable improved health and well-being outcomes for Hoosiers.

Sincerely,

Allison Taylor

Allison Taylor
Medicaid Director, Office of Medicaid Policy and Planning
Indiana Family and Social Services Administration

Spending Plan Narrative

Background

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP), of which Section 9817 provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). In accordance with ARP and the additional Centers for Medicare and Medicaid (CMS) guidance issued, the Indiana Family and Social Services Administration (FSSA) plans to use the federal funds attributable to the increased FMAP and state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement the strategies outlined in this Spending Plan to enhance and expand access to, quality of, and capacity of HCBS under the Medicaid program.

In response to the COVID-19 Public Health Emergency (PHE), Indiana's FSSA will use this enhanced FMAP funds to increase community living options for qualifying Medicaid beneficiaries, stabilize and support the HCBS workforce and HCBS provider network, build up the necessary health information technology infrastructure, and accelerate long-term services and supports (LTSS) reform in accordance with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131–12134, as interpreted by the Supreme Court in Olmstead v. L.C., 527 U.S. 581 (1999) and with Title XIX of ARP.

Executive Summary

States are in a unique position to accelerate the expansion of HCBS which offer older adults and individuals with disabilities greater choice and control in regards to services that help them achieve greater quality of life. Indiana is in the midst of implementing an array of HCBS strategies that promote community living and services in support of this goal. This module describes Indiana's plan to utilize the HCBS enhanced FMAP funds to improve delivery of services that are sustainable across communities, equitable in their approach and access, data-driven, and invested in continuous improvement of quality and outcomes.

Our plan initially focuses on a stabilization phase in response to the COVID-19 public health emergency. In a concurrent phase over the three-year enhanced FMAP period through March 2024, FSSA proposes to utilize an outcomes-orientation approach in determining how to effectively advance HCBS in the State of Indiana. Our four (4) priority areas, as outlined in this plan, and echoed and validated by our stakeholder partners, are:

1. Workforce
2. Enhance HCBS
3. Build Provider Capacity
4. Caregiver Training and Support

The proposals detailed in this spending plan are preliminary ideas put forth by the state of Indiana and are subject to change as the project evolves.

Plan Details

Phase I: Stabilize Community Provider Networks

As we emerge from the public health emergency, it is critical that we stabilize Indiana's workforce and community-based provider network. This first, immediate phase will focus on meeting urgent needs in the HCBS landscape and will supplement the relief funds that the State has already distributed.

FSSA plans to do so through the establishment and administration of targeted stabilization grant programs. We will apply an equity lens to this effort, and a key driver of program design will be to prioritize HCBS provider groups and communities that have been underrepresented in the relief funds paid out to date.

To that end, FSSA will work with stakeholders to determine eligibility criteria, which may differ for various phases of these stabilization grant programs in order to target underrepresented provider groups and employees. Factors that may be considered when determining eligibility include geography, race, gender, and regional income level.

➢ Provider Stabilization Grant Program

In order to support providers affected by the public health emergency, FSSA will work with stakeholders to develop a stabilization grant program.

Purpose: To address COVID-19 related expenses including costs related to compensation and benefits (including incentives related to the COVID-19 vaccine), COVID-19 testing, personal protective equipment, and other COVID-19 related expenses especially costs for administering vaccine to homebound individuals.

Cost Allowance: FSSA will determine allowable expenses for the provider stabilization grant program.

Application Process and Determination: In order to distribute these funds, FSSA will develop an application process for providers with accessibility and simplicity in mind. To apply, providers will be asked to supply information to FSSA regarding their operational costs. Grant amounts will be determined based on the total amount of allowable COVID-19 related expenses claimed by the provider for the grant period.

➢ Workforce Stabilization Grant Program

To recognize the extraordinary efforts of the direct support workforce, FSSA will distribute a grant specifically to support frontline staff who worked to support their communities through the COVID-19 pandemic.

Purpose: To provide bonuses for current frontline staff who remained active through COVID-19.

Cost Allowance: Prior to soliciting applications, FSSA will determine a set number of categories that individuals could fall into depending on their duration of tenure as an active frontline employee during the COVID-19 public health emergency. Tied to each category will be a corresponding set bonus amount per employee. These bonus amounts will be tiered accordingly, with the largest bonus amount correlated to the longest tenure period category, and so on.

Application Process and Determination: FSSA will develop an easy and accessible application process where providers are invited to submit the necessary qualifying information for their employees. We will require that this full amount be passed on to each staff member represented in the calculation and will provide a small percentage fee for their administration of the pass through.

➢ Caregiver Support Grant Program

To recognize and validate the often uncompensated yet vital work of caregivers, FSSA will establish a dedicated caregiver support grant to promote access to valuable technology resources that help facilitate human connection and reduce loneliness as caregivers and loved ones transition out of the COVID-19 pandemic and beyond.

Purpose: To provide access to technology, such as tablet devices, image sharing applications or animatronic pets to combat social isolation and loneliness exacerbated by the COVID-19 public health emergency.

Cost Allowance: FSSA has determined a preliminary estimate of electronic devices needed for individuals in the HCBS continuum to support and combat the negative expressions of those experiencing social isolation and loneliness. FSSA plans to make technical assistance available for anyone who receives an electronic device through this process in order to ensure recipients of these devices can experience the full benefits these options can offer.

Application Process and Determination: FSSA will develop an equitable and easily accessible application process, differentiated between caregivers and providers, to ensure the appropriate technology reaches the appropriate recipients. A longer-term solution will also be articulated during this process, and further detail can be found in Section IV.

Phase II: Effectively Advance HCBS in the State of Indiana

1. Workforce

Support the Provider Workforce

One of our key priorities is to support and expand the HCBS provider workforce, especially front-line workers, which will ultimately support the provision of quality HCBS. In this transitional post-COVID-19 time, it is critical that we build Indiana's community-based provider workforce and translate lessons learned from the public health emergency into sustainable, long-term strategies.

➢ Recruitment and Retention of Workforce

On a broad level, FSSA is centering our plans around a data and outcomes-driven approach to enhance HCBS services in line with community needs. A core requirement is thus to expand the existing HCBS workforce.

FSSA plans to develop a comprehensive direct service workforce strategy. Included in this will be a research review of evidence-based or best practices used by other states and organizations that led to increased recruitment, retention, and career satisfaction among direct service workforce. This research will be conducted in collaboration with our State University Partners to develop actionable and sustainable recommendations for growing and sustaining the direct service workforce in Indiana. In conjunction with this work, FSSA will hold a Workforce Summit with Providers, Direct Support Workers, the Department of Workforce Development (DWD), Educational Institutions, Individuals Served, Families and Others to share the results of the research review and to hear from direct support workforce subject matter experts which will help to inform our long-term plan.

As part of the implementation of this comprehensive strategy, FSSA plans to explore how to use a pay-for-outcomes strategy in regards to provider recruitment and retention strategies. One example of a potential pay for performance measure is the percentage of staff hired with a certain level of training.

To support individuals in the workforce, including paid family caregivers which can be any family member who is paid through the Medicaid waiver to provide services to a waiver participant, FSSA plans to build up training and resources for both individuals interested in pursuing a career as a direct service worker and current direct service workers. These efforts may include the following:

- Developing a common curriculum for direct service workers providing HCBS
- Creating career ladders for direct service roles

- Developing a clear and feasible path for individuals to become high quality direct service providers
- Developing financial supports for individuals in the form of scholarships, subsidized childcare, paid internships, and loan forgiveness opportunities
- Coordinating and developing peer-learning networks to support direct service providers
- Implementing a statewide recruitment campaign to highlight the importance of direct service work and connect candidates with direct service opportunities in their community. This would include a one-stop website for providers and employees to post and find direct service work

As many states are also focusing on expanding the direct service provider workforce, we will continue to work closely with our peers across the country to build upon and implement other innovative ideas. We will also work to promote direct support work as a career path and to establish apprenticeship pathways that increase the workforce.

Looking at long-term stability, FSSA plans to take this opportunity to develop structural strategies for sustainable provider and workforce growth. Concurrent with the strategies outlined above, FSSA will research and develop pathways to use Medicaid as a funding source for sustainable workforce initiatives. This includes researching payment strategies and regulatory requirements and their potential as barriers to access. Based on these findings, FSSA will identify payment and legislative strategies that address these barriers in order to promote and expand workforce competency and capacity.

➢ Private Duty Nursing

As part of a broader effort to transition away from institutional care to HCBS, FSSA hopes to expand HCBS provider capacity, including increasing Private Duty Nursing. Private Duty Nursing enables individuals that need in-home monitoring, require adjustments in treatment regimens, or have medical conditions that require frequent assessments and care plan changes to receive the care they need in the comfort of their own home. Currently, the Indiana State Plan Home Health rate structure is designed to incentivize short-term stays with the daily overhead fee, creating a disincentive for providers to deliver extended visits. Many Medicaid members need extended services, and in combination with overall nursing shortages, there is a statewide challenge finding nursing care for extended hours. While the shortage in care is especially acute in rural areas, the gap exists statewide. In order to incentivize delivering extended services to promote enhanced health and well-being for our Medicaid members requiring longer term care, we hope to leverage this funding to establish the rate for Private Duty Nurses.

2. Enhance HCBS

To Ensure All Individuals have Easy and Equitable Access to HCBS

The State of Indiana is committed to enhancing the delivery of HCBS in order to provide easy and equitable access to necessary services. It is our top priority to center the individuals served as we build upon our existing infrastructure and implement targeted strategies that empower all individuals to thrive in their communities. Our efforts will include ensuring equitable access to HCBS, expanding wraparound services to address systemic barriers to quality home and community-based care, and integrating our systems to provide a cohesive HCBS environment.

➢ Address Social Needs of Members Receiving HCBS

In order to expand access to home and community-based service options, Indiana is taking a holistic approach to tackling systemic barriers that currently prevent individuals from being supported in their home and community.

A key component of home and community-based services is supporting individuals receiving services through using integrated supports to address their social needs. These needs can be as unique as the individuals supported, but generally focus on issues related to housing, employment, access to food, transportation, etc. With this in mind, FSSA will invest in efforts specifically targeted at increasing access to housing, transportation, employment, and wealth management education.

To address housing, we will work with the Indiana Housing and Community Development Authority along with the Corporation for Supportive Housing to build on current efforts to build the pool of accessible, affordable housing across the State. For individuals with intellectual and developmental disabilities, this includes building on the community integration set-aside, as well as the Moving Forward project. For older adults, we will create a grant for the purpose of developing a Community Aging in Place – Advancing Better Living for Elders (CAPABLE) pilot program, pursuing an innovative approach to building home modification capacity, and developing housing support services. The CAPABLE pilot program is an evidence-based client-directed home-based intervention to increase mobility, functionality, and capacity to "age in place" for older adults, provided by a team of an occupational therapist, a nurse, and a handy worker to address both the home environment and use the strengths of the older adult to improve safety and independence. FSSA will evaluate the potential positive outcomes and cost savings this pilot program could achieve, which will inform the program design of a long-term approach.

For employment, FSSA will work with self-advocates, families, and providers to use recommendations advanced by the Task Force for Assessment of Services and Supports for People with Intellectual and Developmental Disabilities and the recently adopted Indiana Employment First Plan to develop a comprehensive approach to increasing competitive, community-based employment opportunities. This approach will include strategies that emphasize enhanced benefits planning support and the use of quality-driven payment mechanisms, such as pay for performance.

To address other areas of social need, FSSA will work with individuals, families, and other stakeholders to identify strategies to address challenges and barriers.

From a workforce perspective, FSSA plans to address non-clinical barriers by building a sustainable workforce that increases capacity and access to care at the least restrictive setting. This will include strategies to increase workforce that reflects the demographics of the members who receive HCBS services. This will allow individuals to remain at home and to avoid unwanted and unnecessary institutional stays.

➢ Address Health Inequities

Indiana is committed to providing quality care for all individuals, which requires a targeted approach when considering health inequities. This commitment will require the integration of health equity considerations into policy and programs, collaborating with other agencies, measuring and tracking outcomes data, ensuring equal access and intentionally engaging minority communities. Initially, FSSA will explore opportunities to assess the current barriers individuals may face in accessing healthcare and HCBS services, depending on a variety of factors such as race, geography, disability, and income level.

FSSA will work with local entities such as the local Indiana Minority Health Coalitions (IMHC) to provide community supports, assist in identifying disparities, create collaborative strategies, improve communication channels, and provide education.

Aside from ensuring that workforce strategies are inclusive and accessible, FSSA will develop a comprehensive plan to measure, analyze, and respond to identified inequities in health and social programs across race and geography. To do so, we will connect with local communities that understand their own needs best in order to inform and support our recruitment and training efforts.

Additionally, FSSA will engage outside technical assistance and advisory support to review and provide guidance on identifying and addressing health inequities in Indiana's LTSS system. One specific initiative that FSSA will pursue is developing and implementing an in-home vaccination program to ensure equitable access to COVID-19 vaccines and other vaccines in the long term. Another key component of this work will be to grow our data capacity to better analyze the data by race, location, disability, poverty rates, and other factors in order to better understand the health landscape.

➢ Policy and Regulatory Review

FSSA plans to provide technical assistance to ensure that the home health and personal care needs of our members are being met both efficiently and effectively. This will be accomplished by reviewing the regulatory and policy infrastructure and subsequently developing and implementing a plan to make the appropriate and necessary changes to

both State Plan and waiver services, including the interplay between their separate and distinct processes. Our overriding goal is to maximize available resources by incentivizing the right care at the right time. The hope is to allow for more effective utilization of both waiver and State Plan services, as well as to encourage potential additional services to meet the needs of our members.

➢ Expedited Eligibility

FSSA is committed to developing an expedited eligibility model for Indiana to decrease the waiting time for HCBS delivery to likely Medicaid beneficiaries. The agency plans to utilize a combination of State process changes, information technology (IT) system improvements, communications, and training to implement the model.

- State Process Changes

  State process changes will build upon our pilot expedited eligibility program to offer expedited application processing statewide for the HCBS population. FSSA also plans to create a specialized LTC Eligibility unit that will focus on applications for members needing LTSS. The unit will have expertise in assisting HCBS applicants and be specially trained in the special income limit (SIL) and budgeting processes for HCBS members.

- System Changes

  IT system changes will support the ability to establish eligibility quickly. The specialized unit and their expedited process will be marketed to stakeholders statewide to assure understanding and uptake for their services.

- Communications/Marketing

  To ensure utilization of the expedited eligibility model once in place, FSSA will pursue a comprehensive marketing campaign that employs differing methods based on targeted populations and their caregivers. Additionally, FSSA will develop expanded informational web pages on the EWE program as well as informational, easy-to-understand video modules that describe LTC options focused on HCBS waivers and how to effectively serve as an Authorized Representative and assist an LTC applicant.

- Training

  FSSA will invest in additional technical assistance and training options to support implementation and onboarding of the expedited eligibility model. Trainings may include:
  - LTC expertise training to develop a deeper bench of LTC experts
  - On-demand training for local Area Agencies on Aging (AAA) and providers
  - Extra training for Navigators on LTC applications

➢ Legal Aid

Under the Older Americans Act, FSSA is required to have a Legal Assistance Developer (LAD) to facilitate legal assistance services across Indiana for older individuals with the greatest social and economic needs. While legal assistance is currently provided across the state through legal assistance providers who contract with the individual AAAs, the services are ad hoc; the identification and delivery of the services is inefficient; and services are not necessarily tailored to the needs of the community. There is very little available data on legal services and no consistent strategy driving the services. This lack of coordination indicates that the legal assistance services are likely not meeting the true needs of our clients.

The legal assistance program needs an assessment by experts to better understand the legal needs of older individuals in Indiana and to form a strategic plan with recommendations on how to best deliver legal services through the AAAs and other innovative ideas around identifying potential clients, training, and other program needs. Additionally, this assessment would help further Indiana's goal of respecting an individual's rights by analyzing the current use of supported decision-making by legal assistance providers and their understanding of that concept. The assessment would make recommendations to ensure supported decision-making is an integral part of legal service delivery in appropriate situations. We plan to engage a university with subject-matter expertise to create this assessment to understand and meet the legal needs of older Hoosiers. The university will be responsible for completing a comprehensive assessment studying the history, strengths, and weaknesses of the current legal services system; studying and identifying the legal assistance needs of older Hoosiers across the state; and creating workable recommendations for the legal assistance program.

➢ Telehealth Expansion for Individuals with Intellectual and Developmental Disabilities (I/DD)

A central pillar of the State's plans for HCBS is improving access to holistic health services for individuals who face disproportionate roadblocks in accessing treatment or care through evidence-based mechanisms. While telehealth utilization increased dramatically due to the COVID-19 pandemic, telehealth remains inaccessible for many. To bridge the gap, we plan to pilot telehealth expansion for individuals with I/DD who face disproportionate accessibility barriers (i.e., access to public transportation, paratransit services, caregiver assistance, etc.), which are exacerbated for individuals living in rural or underserved areas across Indiana. Telehealth expansion will provide immediate access to doctors and telehealth experts focusing on populations with complex support needs, with services tailored to meet individual needs of each individual. Doctors will perform telemedicine exams through sophisticated diagnostic tools and implement individualized treatment plans by working closely with staff, family, and patients. The State plans to potentially make this telehealth service available to

individuals with I/DD in residential facilities and the family home. It is anticipated that the implementation of the service would reduce emergency room visits and medical costs as well as result in improved health outcomes and patient satisfaction with care due to enhanced speed of diagnosis and treatment in comparison with traditional emergency room visits.

➢ Building Indiana's Self-Advocacy Leadership Network

Home and community-based services are rooted in the principles of person-centeredness and self-direction. For many individuals with intellectual and developmental disabilities, they have not had life experiences and opportunities that have enabled them to build skills around decision-making, advocacy (and self-advocacy), and the engagement needed to direct their own life. Self-Advocates of Indiana – a group of Hoosier citizens who speak out, advocate, and educate for equal rights, respect, and inclusion for all in the community – recommend that the best way to support individuals with I/DD in developing their skills and experience with self-advocacy and self-direction is through training and peer-to-peer support.

With this in mind, Indiana proposes working with self-advocates, families, and other system stakeholders to develop a statewide, comprehensive approach to building a self-advocacy leadership network. To help promote self-advocacy in daily life and in public policy, we will develop training and curriculum based on the Charting the LifeCourse (CtLC) Framework, developed through the National Supporting Families Community of Practice, which Indiana has been a part since 2016. In addition to trainings, the approach will include strategies to build a peer mentoring network to enable self-advocates with lived decision-making and advocacy experience to connect with and support other self-advocates in navigating systems and supports that lead to their good life.

Additionally, FSSA is interested in providing access to mobile applications that support individuals with their person-centered planning, remaining connected and in communication with their support team, and understanding and navigating supports and issues important to them. To do so, FSSA would pursue a pilot program to implement these solutions. Learnings from this pilot would be investigated, and similar solutions could be pursued or adapted to include other HCBS populations. Eventually, these solutions could be transitioned to an existing Medicaid waiver as necessary.

➢ Social Isolation Support through Technology

FSSA hopes to increase HCBS sustainability by decreasing older adult loneliness and social isolation within Indiana communities. Social isolation occurs when an individual does not have adequate opportunities to interact with others, whereas loneliness is a subjective experience stemming from the perception of not having enough social relationships or contact with other people. Recent studies show that millions of

Americans, both young and old, are socially isolated, lonely, or both, which negatively impacts quality of life and health outcomes. To combat this epidemic, FSSA plans to reduce institutional admissions by promoting communities of sustainable wellbeing and independence for Hoosiers. These efforts will expand upon the Caregiver Supports Grant Program initiated in Phase I.

Informed by research studies, a number of innovative social connectedness interventions have been identified to reduce loneliness and isolation in older adults, and as a result, enhance health outcomes and independent living. These interventions include:

- Interactive app-based technology solutions
- Tablet devices and technical assistance
- Accessible and secure digital communication platforms
- Animatronic pets

FSSA hopes to implement these solutions as programs in service of our HCBS population. We will also explore expansion of the program to individuals with I/DD and other HCBS consumers as learnings develop.

➢ Aging and Disability Resource Center (ADRC) Support

The State of Indiana is currently embarking on a comprehensive reform of Medicaid-funded LTSS, with a focus on improving health and wellness outcomes and increasing equitable access to outcomes-focused care and community-based services. In Indiana, ADRCs provide streamlined access to information and resources, care options, short-term case management, and benefits enrollment across the spectrum of LTSS as part of Indiana's efforts to improve holistic, front-door access to needed supports for individuals with existing or anticipated long-term care needs. Across the State, HCBS Aged and Disabled (A/D) Medicaid Waiver growth has eclipsed the amount of funding available to perform enrollment intake activities, such as Level of Care (LOC) assessments and initial person-centered service planning. This is a temporary concern as the intake function is currently performed by Area Agencies on Aging; however, as Indiana transitions to a managed LTSS (mLTSS) model, the enrollment intake process may transform as well.

Indiana also plans to leverage funding to conduct the Community Assessment Survey for Older Adults (CASOA), an ADRC-related survey administered by the National Research Center, Inc. that has historically been performed every four years. The CASOA provides a statistically valid survey of the strengths and needs of older adults as reported by older adults in communities across the state to improve our understanding and ability to predict the services and resources required to serve the aging population in Indiana. The results of this survey will be leveraged to improve ADRC-related services and more broadly, LTSS services.

Additionally, while institutional providers express a desire to transition their provision of care, there has historically been a lack of funding support. As a result, the State has identified a need to fund direct assistance for the transfer from institutions to home-based services. This funding would provide direct assistance to providers to promote transitioning from institutional care into HCBS to enhance capacity and build a more holistic continuum of care.

➢ Dementia Strategic Plan and Implementation Report

As the State builds out our continuum of care to holistically support Hoosiers, we plan to leverage funds to enhance access and quality of care for individuals with dementia. Under Indiana Code, the State is required to produce a Dementia Strategic Plan and Implementation report by December 1, 2021. The Dementia Strategic Plan and Implementation Report are required to be submitted annually to the Indiana Legislature. In order to meet legislative requirements, the State has identified a funding need for enhanced capacity.

The Dementia Strategic Plan directly seeks to enhance and sustain HCBS for individuals with dementia as well as individuals with I/DD as they may have unique and specific needs. The Dementia Strategic Plan will start with an evaluation phase that considers the services, resources, and care available to address the needs of individuals with dementia, and their families and caregivers. Following evaluation, we will work to identify methods to reduce the financial costs of dementia, as well as strategies to enhance Indiana's dementia-based workforce, to increase access to HCBS for individuals with dementia, and to enhance the quality of care. Informed by these findings, we will also recommend strategies to decrease health disparities concerning dementia in ethnic and racial populations in Indiana.

The Dementia Strategic Plan and Implementation Report is imperative not only to fulfill legislative requirements, but also to improve the continuum of care equitably for individuals who face disproportionate barriers to care.

➢ HCBS and mLTSS Value-Based Purchasing (VBP)

As part of the ongoing, statewide LTSS reform effort, FSSA is implementing processes to explore and support evidence-based VBP work. The State's long-term goal is to align cost and quality of services to enhance sustainable health and well-being outcomes. FSSA is currently in an early stage of this effort and will continue to evaluate which providers to move to VBP. Following this determination, we hope to engage a vendor to perform the following services for the appropriate providers:

- Recommend performance measures
- Design performance measures for the State measures if no national measure exists

- Evaluate and identify data needed for measurement and how to obtain data the State does not have access to already
- Design and implement learning collaboratives for measurement reporting and project plans

The aforementioned vendor outputs will support the State in finalizing a list of candidate HCBS and mLTSS performance measures for identified providers.

➢ Supportive Housing Partnership Consultant

As the State builds out our continuum of health and well-being supports, it is imperative to consider new, collaborative partnerships to address root causes across all social determinants of health. Supportive housing interventions improve outcomes for families and individuals across the board, including improving housing stability, and further improving health outcomes and lowering public costs by reducing the use of publicly-funded crisis services. Specifically for the elderly or individuals with I/DD, supportive housing programs improve health outcomes, quality of life, and enable maximum independence. As such, FSSA plans to hire a Supportive Housing Partnership Consultant to advise us on how we can build a stronger relationship across State divisions, specifically with the Indiana Housing and Community Development Authority (IHCDA). The Consultant would help move the needle for the State's strategic partnerships by leveraging an existing IHCDA assessment and recommendations report, which provides a starting point for our learning and discussions around what we want to implement and partner on. The Consultant would also provide assistance in writing the required Residential Care Assistance Program waiver.

➢ Integrate HCBS Data Systems to Improve Quality and Reduce Inequities

In order to streamline real-time information sharing in support of the other strategic outcomes described in this spending plan, FSSA will make immediate improvements to its HCBS data systems. Establishing a comprehensive and integrated HCBS data environment will lead to an improved understanding of differences in health outcomes as well as increased efficiency, which is pivotal from a quality and equity perspective. FSSA will accomplish this through system upgrades, updated data management resources, expanded data partners, and enhanced development capacity.

- Data Integration Efforts

FSSA plans to pursue improvements to data warehousing for data integration with HCBS claims data and other data sources from source transactional systems. Ancillary HCBS systems will be a part of this effort, including but not limited to HCBS case management, incident reporting, eligibility, health information exchange, and Medicare encounters systems. FSSA also plans to work with Indiana Health Information Exchange (IHIE) to leverage the Fast Healthcare Interoperability

Resources (FHIR) standard and to build a provider-friendly application for ease of exchange and access of member demographics, social needs, care plans, and medical histories.

- Dual Eligible Special Needs Plans (D-SNPs) and Medicare Data Integration

Indiana plans to pursue activities around D-SNP and Medicare data integration. A primary activity will be the planning and operationalization of processes to bring in Medicare encounter data from state D-SNPs and integrating with the State's enterprise data warehouse. Further, the State plans to bring in Consumer Assessment of Healthcare Providers and Systems (CAHPS) data received from state D-SNPs in alignment with the requirements in the 2022 SMAC. The State also plans to incorporate D-SNP data from the Indiana Health Information Exchange (IHIE).

- Data Products

In order to achieve better HCBS outcomes, FSSA will pursue a data products and applications managed services partner to support the development and deployment of necessary data products and applications. This includes but is not limited to record linkage services, automation services, business intelligence, data science, advanced analytics, and project management. It also includes the development of data dashboards to monitor outcomes, support internal decision-making and disseminate key information to public stakeholders.

- Project Management and Data Governance

FSSA plans to enhance its HCBS data governance to assure improved management of education and literacy, data quality, privacy and security, strategic alignment, and metadata management. FSSA will build up our Research and Evaluation capacity to support project management, business and partner engagement, data management, requirements gathering, analysis & visualization, and co-authoring for state programs and state-university partnership research, evaluation, data briefs, and task orders.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

FSSA will complete a CAHPS Survey for HCBS consumers to learn valuable information regarding beneficiaries' perception of quality of care. This would allow us to gain feedback regarding available HCBS programs in Indiana, learn where there are gaps in programming, and hear about the end user experience as it relates to provider service delivery. The results of the CAHPS survey will be integrated with our data systems and used to inform our value-based purchasing activities.

- Care Management for Social Services (CaMSS) Support

In order to enable an enhanced continuum of care, FSSA hopes to enhance IT systems that enable care management. By implementing improvements to Indiana's current care management IT system, CaMSS, we hope to provide more holistic insights into individual needs, align care across programs, and move towards a more integrated and outcomes-based approach.

- Implementation of and Enhancements to the BDDS Portal

FSSA is continuing to enhance the Bureau of Developmental Disability and Rehabilitative Services (BDDS) Portal to consolidate legacy data systems, and build appropriate system functionality to effectively meet the State's business needs in supporting individuals with I/DD in waiver services as well as in our intermediate care facilities. These critical enhancements and changes will ensure necessary data elements and reporting requirements are captured to support monitoring and management of outcomes, person-centered planning processes, and compliance monitoring for the HCBS Settings Rule.

3. Build Provider Capacity

To Meet the Growing HCBS Needs of the Medicaid Population

FSSA is committed to improving the HCBS system to enable all Hoosiers to access the care they need and thrive in the settings they choose. As demand for HCBS increases among older individuals or individuals with I/DD, we must adjust to reflect the needs of and strategically help improve health outcomes for some of our most vulnerable Hoosiers. As part of our existing mLTSS reform efforts, the State plans to increase the number of Hoosiers who qualify for HCBS under Medicaid in conjunction with increasing the availability of HCBS, and as such, we plan to bridge the gaps in our existing HCBS infrastructure by supporting provider capacity building efforts across the state. We will accomplish this by supporting providers to build out additional capacity, right-sizing institutional networks, and developing a crisis system for older adults and individuals with I/DD.

➢ Build Capacity to Deliver

Concurrently to the stabilization plans described in Phase I, Indiana must build additional capacity within our provider network to deliver HCBS.

Some potential supports that FSSA will pursue in partnership with providers include increasing the availability of structured family caregiving and shared living. These service models often result in better quality of life for the individuals supported, while at the same time create new, non-traditional opportunities for direct service workers. In addition, FSSA will work with individuals, families, and providers to increase access to adult day centers (particularly in rural areas), community employment supports, and will

promote self-direction as a core determinant of an individual's health plan and peer-to-peer support approaches.

FSSA will also address workforce capacity by increasing the workforce through non-agency caregiver support strategies, as further detailed in Section II.

➢ Update Institutional Networks

As part of the effort to rebalance the provision of Long Term Supports and Services (LTSS), FSSA intends to partner with the nursing facility industry to improve alignment of available facilities with projected future institutional needs. Potential changes include the reduction of multiple occupancy rooms, managed closure of facilities in regions with low nursing facility occupancy levels, and assistance for maintaining or opening facilities in regions projected to have future bed capacity challenges.

A key area of focus will be providing support to all residents of nursing facilities that close for any reason (e.g., changing market dynamics or a State supported closure program). The closure of an existing nursing facility provides an opportunity to re-evaluate each resident's needs and to determine options for meeting those needs in a community setting. Revisiting care options is a key step in the journey to build a person-centered and financially sustainable system for the future.

FSSA is currently evaluating financial approaches that can be used to support nursing facilities in areas with limited bed capacity and to encourage closures in geographies where bed capacity significantly exceeds current and projected needs. In both instances, FSSA will leverage available quality metrics to make sure that any capacity re-sizing results in aggregate quality improvements.

To support providers in this transition and address underutilized capacity, FSSA plans to create a number of grant opportunities that incentivize institutional and RCAP settings to convert to HCBS settings and 14(c) programs to transition to community employment programs. In support of this shift, FSSA will also facilitate a Learning Collaborative and technical assistance programs for providers to leverage. Once these strategies are in motion and HCBS capacity is increasing, FSSA will facilitate the appropriate bed closure in institutional settings.

➢ Develop a Crisis System and Support Implementation of 9-8-8

The State of Indiana is looking to invest in expanding the capability and capacity of the Indiana Crisis System as part of its HCBS investment plan. The State will leverage Medicaid funding to support service capacity infrastructure, including the capacity to be responsive to the needs of all HCBS recipients experiencing crisis. Indiana is interested in developing a robust crisis system predicated on the Crisis Now model as delineated in the SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, which includes four core elements:

- High-tech crisis call centers with real time coordination
- Centrally deployed, 24/7 mobile crisis
- Crisis receiving and stabilization programs
- Essential crisis care principles and practices

As such, our efforts will include the support for a call center or multiple call center organizations to develop the infrastructure necessary to provide 24x7 call coverage capacity while meeting the expectations laid out in the SAMHSA toolkit. Part of this effort will also address the rules the FCC adopted in July 2020, designating 988 as the phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors. Switching to an easy-to-remember 988 as the '911' for suicide prevention and mental health crisis services will make it easier for Hoosiers in crisis to access the help they need and decrease the stigma surrounding suicide and mental health issues. FSSA plans to implement this new resource by July 2022.

The State will also be allocating funding to community behavioral health providers to expand mobile response team capacity and crisis stabilization capacity, which are a critical component of the Crisis Now model.

These services will be sustained in future years by leveraging other existing funding mechanisms.

➢ HCBS Rating Methodology

FSSA has begun work on an HCBS reimbursement approach that will provide several benefits to HCBS providers. One objective of the revised reimbursement is to move away from reliance on provider cost reports which will reduce the administrative burden that they impose on HCBS providers. Additionally, a primary goal of the methodology work is to improve the alignment and continuity of the rate setting across FSSA's divisions to provide HCBS reimbursement that is consistent and predictable. Our intent is to implement rating methodologies that are easily understood by HCBS providers and that offer greater stability for their business planning purposes. To that end, rate methodology updates will also reflect labor and expense changes driven by the COVID-19 public health emergency.

Another key goal of the rating methodology work is to deliver rates that support the sustainability of the HCBS programs with a specific focus on how rates impact the provider's ability to hire and retain adequate staff to deliver the services needed by HCBS eligible Medicaid members.

Finally, the updated rating methodology should promote person-centeredness and Value-Based Purchasing. The person-centered rating aspects will support community

integration for HCBS participants, and the Value-Based Purchasing focus will help to drive health outcomes.

4. Caregiver Training and Support

To Support Families and Caregivers of Individuals Receiving HCBS

FSSA is committed to improving the system of supports for families and caregivers. According to the AARP's 2020 LTSS Scorecard, Indiana ranked 51st overall for support of caregivers. Caregivers play an essential role in supporting Hoosiers receiving HCBS, and women of color represent a majority of paid and unpaid caregivers. In order to equitably enhance the system of supports for families and caregivers, Indiana is prioritizing an array of services and supports to help HCBS recipients and their families support their overall mental, physical, and emotional well-being as detailed throughout this section. Indiana will center these initiatives on addressing inequities across a variety of factors including gender, race, geography, income level, and disability.

➢ Caregiver Training for HCBS Waiver Participants

In order to equip caregivers to help individuals receiving HCBS meet their needs, FSSA will provide training for caregivers. The Caregiver Training service will be provided to HCBS Aged & Disabled (A/D) Medicaid Waiver, Family Supports Waiver (FSW), Community, Integration, and Habilitation (CIH) Waiver, as well as Traumatic Brain Injury (TBI) Waiver participants. This service would reach families who are not otherwise eligible for the existing Structured Family Caregiving service. Family caregivers will be provided with the resources they need through ongoing support from a professional caregiver coach who is experienced in working with lay caregivers and navigating the HCBS landscape, using family-centered coaching protocols that conform to best practices and are informed by the needs of lay caregivers, and promoting the use of telephony and other accessible technology to meet family caregivers where they are and enable access to caregivers across the state. Training mentors will also support caregivers in uplifting the individual's voice and fostering self-determination.

➢ Caregiver Survey

FSSA will also leverage funding to gather crucial feedback from the diverse caregiver community to better understand existing gaps in the continuum of supports and create a strategic plan to address the identified gaps. Contractual support is needed in order to implement the Caregiver survey, gap analysis, and strategic planning to implement recommended changes in accordance with the results of the survey and gap analysis.

➢ Caregiver Mental Health Supports

FSSA is excited to commit funding to providing critical mental health supports for caregivers, a priority that was echoed by our stakeholders and partners. As a first step, FSSA will conduct research and connect with peer states and stakeholder partners to determine effective mental health support strategies. A necessary part of this effort will include increasing Indiana's capacity to assess the needs, including the personal physical and mental health, of family caregivers. FSSA would like to explore potential innovative and accessible avenues; such as, training and resources in trauma-informed care specific to the elderly or individuals with I/DD, self-care practices, processing emotions associated with diagnoses, caregiver support groups, and caregiver counseling.

Specifically, FSSA plans to address caregiver isolation and loneliness, which have serious implications on mental and physical health. These feelings can jump-start thoughts and behaviors that exacerbate the emotional toll of caregiving.

In order to maintain good caregiver health, the following areas of support have been identified in the past five years and heavily validated through stakeholder feedback as critical to improving caregiver mental health and health outcomes: Connection and Training.

In order to improve caregiver mental and physical health based on the needs identified above, FSSA is interested in exploring partnerships to support implementation of an innovative model to address the unmet needs of family caregivers (FCs). One potential idea is the Caregiver Village, a digital interactive community, which would provide 24/7 access to pertinent resources and support sustained engagement of volunteer advocates (Vas) and FCs and provide resources to them.

➢ Caregiver Assessment Technology

In order to enhance Indiana's care continuum, FSSA will consider what assessment technology may be beneficial to implement. Initially, FSSA plans to engage consulting support to assess how other states with mLTSS recommend the use of caregiver assessment platforms as well as how data integration and HCBS measurement work would flow if we decide to implement an assessment platform. The results from the initial assessment would include recommendations to support FSSA's decision-making process around purchasing and implementing a dedicated platform. If the State determines that AAAs should utilize a caregiver platform for non-mLTSS members, funds could be used to release an RFP and purchase one statewide system. If so, FSSA will pursue additional research to inform the RFP.

Stakeholder Feedback

As the State of Indiana strategically approached our plan development, we have intentionally engaged stakeholders to gather integral recommendations and insights from the community. It is FSSA's goal to partner with the provider and member communities to ensure that the services delivered are in line with community and individual needs and that funds are most effectively leveraged to improve HCBS for Hoosiers. Our goal is to enhance the HCBS delivery system through building equitable, effective, efficient, and sustainable supports to improve health outcomes, fill unmet social needs, and support all Hoosiers to achieve their full emotional, mental and physical well-being potential.

As previously described, FSSA is in the collaborative process of reforming the LTSS system across Indiana, and has gathered intentional feedback through 50+ various stakeholder engagement opportunities and the goals of ARP funding align well with the LTSS reform project's goals. FSSA leveraged the lessons learned and input from stakeholders throughout the LTSS project thus far to define key spending priorities.

FSSA sought input from the community through various mechanisms, including individual communications and discussions, written correspondence, as well as a survey designed to support FSSA in determining spending priorities for the enhanced funding. The survey was distributed broadly to our stakeholder community and FSSA received over 660 responses from recipients or potential recipients of HCBS, family caregivers, direct service professionals, HCBS industry providers, HCBS industry/association representatives, and other stakeholders in the current HCBS system.

Respondent Type	%	Count
Consumer (recipient or potential recipient of HCBS)	10.44%	69
Family Caregiver	16.79%	111
Consumer advocate representative	5.60%	37
Direct service professional (DSP, e.g., personal care worker, attendant care)	8.93%	59

HCBS industry provider	35.10%	232
HCBS industry / association representative	3.48%	23
Other - please specify	19.67%	130
Total	100%	661

Survey respondents were asked to identify their top priorities for inclusion in Indiana's spending plan from the list published in CMS' guidance around allowable expenses. Workforce Recruitment was universally identified as the top priority across each of the Respondent types shown above, with nearly 50% of Respondents identifying it as a top priority. More broadly, feedback coalesced across the survey and written and verbal stakeholder feedback reinforced the State's strategic spending priorities to invest in workforce recruitment and retention, expand HCBS provider capacity, provide family and caregiver supports including training and respite, provide stabilization grants in the wake of the COVID-19 crisis, decrease HCBS delivery time, invest in eligibility systems, and broadly build out the HCBS continuum of care to support Hoosiers in all social determinants of health to realize improved health outcomes and thrive with their families and communities.

The top 10 priorities identified by survey respondents are shown in the table below and align well with Indiana's spending priorities detailed in the preceding sections.

HCBS Funding Priority	%	Count
Workforce Recruitment	48.57%	322
Expanding HCBS Provider Capacity	44.80%	297
Reducing or Eliminating HCBS Waiting List / Increasing Number of HCBS Waiver Slots	32.28%	214
Caregiver Training and Respite	27.90%	185

Leave Benefits	24.28%	161
Eligibility Systems	23.38%	155
Expanding Behavioral Health and Substance Use Services Capacity	21.57%	143
Expanding Use of Technology and Telehealth	18.55%	123
Assistive Technology and Other Supports for Persons with Disabilities	16.89%	112
Supplies/Equipment Supports for Family Caregivers	16.59%	110

Further, Indiana also reviewed 85 comments submitted by survey respondents detailing their ideas for how the state should allocate its funding. Comments covered a range of subjects including the scope of HCBS services and potential expansion opportunities, reimbursement rates and compensation, transportation options, and the benefits and challenges of technology. FSSA has considered these comments in the development of this plan.

Indiana is grateful to have the opportunity to engage with various stakeholders and incorporate critical insights from the community. Realizing alignment in the State's strategic priorities with priorities expressed by the diverse coalition of HCBS stakeholders is imperative to transforming the continuum of care to improve the health and well-being of Hoosiers.

Spending Plan Budget

In order to estimate the additional funds available to the state as a result of the enhanced FMAP, the State established as a first step the qualifying baseline total costs for HCBS Services for the April 1, 2021 to March 31, 2022 time period, which is approximately 2.26 billion dollars in expenditures. Applying the ten percent (10%) enhanced FMAP to this baseline yielded an estimation of the state funds ($226 million) equivalent to the amount of federal funds attributable to the increased FMAP. These state funds then become available to be used through March 31, 2024, and the estimated total funds available are calculated by applying the matching FMAP share to the state funds estimate. For the purposes of distribution of the spending over time, the State assumes an even distribution with an equal share of the total funding being used in each year of the eligible three-year period.

FSSA has developed the following budget estimate in alignment with the overarching goals and priorities detailed in the preceding sections. The estimated total funds available of $877,558,287 has been calculated based on the above. The table below shows the percentage of the total budget FSSA plans to allocate to each of the five major plan components, and the equivalent dollar amount based on the estimated total funds available.

Plan Component	Percent of Total	Total Estimated Funds
Stabilization	20.00%	$175,511,657.40
Workforce	25.00%	$219,389,571.75
Enhance HCBS	20.00%	$175,511,657.40
Build Provider Capacity	30.00%	$263,267,486.10
Caregiver Training and Support	5.00%	$43,877,914.35
TOTAL	100.00%	$877,558,287.00

Section Two

Estate Planning for the Family Farm

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Section Two

Estate Planning for the Family Farm……………………. Anna M. Howard

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Sample – JB Smith Irrevocable Income Only Trust

Estate Planning for the Family Farm

Agriculture is a huge part of Indiana's heritage. According to the Indiana State Department of Agriculture, more than $4.6 billion of Indiana's agricultural products are exported throughout the world. In fact, Indiana's agriculture brings in approximately $31.2 billion a year to Indiana's economy. Even more impressive, as of 2019, 96% of Indiana farms are still family-owned or operated. [1] This is where we, as elder law attorneys and estate planners, can assist and support our local farmers. Just like our clients who come in and want to protect the family home that their parents or grandparents built, our farmers want to be able to protect the family farm that has been passed down from one generation to another.

I. Estate Planning Questions and Concerns

A. Power of Attorney Authority

As with all clients, it is important that a good Durable Power of Attorney is created in order for the designated agents to have all necessary authorities in order to continue the management of the farm, other business actions and sale or gift the property. Indiana Code §30-5-5 provides a list of powers a principal can grant to an agent. We typically grant and spell out all of the authority granted under the Indiana Code to assure that the agent has the authority needed.

Sometimes clients come in with an already existing power of attorney and want to know if the document has all the authority needed. Some key provisions, outside of the basics of having banking authority, that we want to make sure that are authorized under the power of attorney are as follows:

[1] See Indiana State Department of Agriculture website https://www.in.gov/isda/about/about-indiana-agriculture/

I.C. §30-5-5-2 grants the agent authority over real property transactions which includes the authority to sell, quitclaim, or mortgage the property.

I.C. § 30-5-5-6 grants the agent authority over business operations and transactions

I.C. 30-5-5-9 grants the agent authority to gift. However, this authority is limited in that the agent can only gift up to the federal gift taxing limit to the agent or someone the agent is responsible for. This is for the protection of the principal to protect against an agent from misappropriating the principal's funds. However, when planning for long term care needs, it may be important for the agent to gift assets to themself, especially, if the agent is the only heir or beneficiary.

In order to provide the agent with additional authority over and beyond the authority granted under I.C. §30-5-5 an attorney can create an Addendum to the Power of Attorney (also referred to as a Medicaid addendum). An Addendum to the Power of Attorney, grants the agent very broad authority in conducting estate planning and asset preservation strategies in the event the client requires long-term care.

The addendum can grant additional authority to gift over and beyond what I.C. §30-5-5-9 allows. Some example language is:

> "To make a gift or gifts at any time or times of any or all of my assets, cash, property or interests in property, including any right to change the beneficiary on any policy of life insurance I may own, and without regard to any restrictions on aggregate yearly value of a gift to an individual as set forth in I.C. 30-5-5-9."

This additional authority would allow the agent to gift in essence all of the principal's funds in a way that would allow the principal to qualify for a government benefit program such a Medicaid or the VA Aid and Attendance Pension.

An increment part of gifting to allow for asset protection is the ability to create and fund an irrevocable trust. I.C. §30-5-5 does not grant an agent the authority to create an irrevocable trust. However, this authority can be granted under the addendum to the power of attorney. Today, each financial institution has their own legal department that will scrutinize all documents provided. Therefore, it is important to be clear in the language used in the addendum and to spell out all of the authority granted to the agent. Some sample language for the addendum is:

> "To create and fund any trust or trusts on my behalf, including authority to designate beneficiaries to take effect after my death. My Agent may amend, modify, revoke, or terminate any trust created by me or on my behalf. Furthermore, my Agent may withdraw or add property to an existing trust created by me or on my behalf."

B. Distribution of Estate

Some important questions to consider when working with the farmer client on their distributive documents.

- What is the client's overall distribution plan goals? Does the client want all of his or her children to receive an equal share of the estate? Does the client want to make any specific bequest to certain individuals or charities?
- What other assets beside the farm does the client own? It is important to get a good picture of all assets owned by the client, including accounts which have beneficiary designations such as retirement accounts, life insurance policies and annuities. Sometimes the largest asset the client owns is the farm yet the client comes in with a list of monetary specific bequests to charities or other individuals and our job is to determine the best way to accomplish the client's goals without breaking up the family farm.

- What is the client's specific goal with the farm? Is it important that the farm be divided equally between all children? Is there one particular child that manages the farm business and the client really wants that child to continue to manage the farm?
- What if no child or beneficiary desires to keep or maintain the farm?

Granting one beneficiary the right of first refusal.

It is not uncommon to have a client that has one child or family member who manages the farm or business while the other children have started their own careers and have no desire to participate in the family farm business. The client's distribution goal is to have all children equally receive under the estate but also allow for the one child to continue to run the family farm business and keep it in the family. Depending on the total available assets in the estate, the client may be able to direct that the one child can receive the farm property as their part of the estate. If the total estate value does allow for the direct distribution, the other option is to provide the child a right of first refusal to purchase the farm business from the estate using their respective share as a part of the purchase price.

No matter what the client's estate plan directs, when distributing the farm business to one child as part of their respective share or providing that child with the right of first refusal on the sale of the farm business, it is important the document provides clear instructions to the Trustee or Personal Representative. The document should direct the fiduciary how to value the property/business, provide a time limit for the child to respond to the offer and a time limit for them to be able to obtain financing, if necessary. The document should also provide instructions on what is considered part of the right of first refusal, if the business is in a corporation or LLC then the agent is directed to offer the shares or interest for sale. However, if the farm is not

owned by any other entity, then the document should define, if only the farmland is considered part of the right of first refusal or if the that right also includes farm machinery, structures, etc.

Example: Corporation

If the Trust owns stock of ABC Farm Inc, Inc, (hereinafter "Business Stock") which corporation is incorporated in the State of Indiana, then Johnny Appleseed shall have the right of first refusal to enter into an agreement with the Trustee to purchase the Business Stock, at an agreed upon value based on the fair market value as determined by an independent appraisal as of the date of death of the Grantor. Johnny Appleseed may use his share of the trust estate toward the purchase of the business.

If Johnny Appleseed waives his right of first refusal, fails to enter into an agreement and/or obtain financing to purchase the Business Stock within one (1) year after the death of the Grantor, then the Trustee is directed to sell such shares or to sell or liquidate the business operated by such corporation, as the Trustee deems advisable. The price to be received for such shares or business shall be their fair market value as determined by independent appraisal.

Until such shares or business have been sold, the Trustee shall continue to hold and operate the business of such corporation as part of the trust estate. The Trustee shall have all powers with respect to such business which the Grantor could exercise if present and acting.

Example: Farm Business not owned by LLC or Corporation

Upon the death of the Grantor, the Trustee is directed to provide Ray Kinsella the right of first refusal to purchase the farmland with structures, plus any farm machinery and vehicles used solely for the farm business at its appraised value as determined by an independent appraisal. If Ray Kinsella waives his right of first refusal or fails to obtain financing within six (6) months

from the date of the death of the Grantor, then the Trustee is directed to sale the farmland either through private sale or public auction, and distribute the farm proceeds in accordance with Section 5.3 herein.

C. Reviewing the farm lease agreement

It amazes me how many times I have been told that there is a not a written farm lease agreement between the owner of the land and the farmer who is farming the land. Typically, it is when I am working with the child or power of attorney for the land owner who is now in need of long term care. If we are doing Medicaid, I will ask for a copy of the farm lease agreement and am told "Well dad and Joe Smith the farmer had a gentlemen's agreement." The reasonings can be anywhere from that 'Dad and Joe Smith the farmer go back years', or 'that is just the way it has always been'. On the other hand, there is a farm lease agreement in place but it hasn't been reviewed or renewed in several years.

1. Key Elements of Farm Lease:

A farm lease doesn't have to be as long and extensive to be valid, but you do want to make sure there are some important key components of the agreement spelled out.

- The names and addresses of the party
- A good legal description of the land. Make sure to include the number of tillable and untillable acres.
- The period or crop years covered. If the lease is for a time period of longer than 3 years than pursuant to IC 32-31-2-1, the lease must be recorded with the Recorder's Office in the County in which the land is located.
- If a cash rent agreement, then the amount and terms of the payment.
- If a crop share agreement, then shares of costs and crops should be detailed
- Resource contributions of landlord and tenant.

2. Additional terms of a Farm Lease

Other terms or provisions one can put into a farm lease are listed below.

- Provisions on how to amend the lease: note that any amendments should be in writing.
- Responsibility for repairs, can be divided between minor repairs and major repairs
- Responsibility for liability insurance
- Use of farm structures such as the barns and bins
- If the lease is a long-term lease, then you may want to include who is responsible for more long-term projects such as the payment for lime or the inclusion of a water drainage ditch.

II. Medicaid Treatment of Farms/ Businesses

A. Treatment of Farm/Business for Medicaid Eligibility

Under Indiana Medicaid law, income-producing property is considered an exempt resource as long it produces income greater than the expense of ownership and is rented at fair market value.

IHCPPM 2615.35.15 Income-Producing Personal Property (MED 1, 4)

Items of personal property utilized in the production of income are exempt resources.26 Examples of such are farm machinery, livestock, tools, equipment, a vehicle used in a business inventory, furnishings, and appliances included with a rental unit. This exemption does not, however, include income-producing financial assets such as certificates of deposit, other interest-bearing bank accounts, stocks, bonds, IRA's and so forth.

If the client is leasing the farmland, then the income is considered rental income for Medicaid purposes.

IHCPPM 3420.00.00 RENTAL INCOME

Rental income is payment for the use of real or personal property. Rental payments may be received for the use of land (including farmland), for land and buildings, for a room, apartment, or house, or for machinery and equipment.

FSSA uses the net rental income in determining eligibility and allows for most deductions of expenses that are allowed by the Internal Revenue Service.

IHCPPM 3420.05.05 Allowable Rental Expenses

Allowable rental expenses include costs allowed by the Internal Revenue Service.5 Please, refer to Chapter 2810.30.00 and Section 3460.05.00. Examples of rental expenses allowed under all categories are: Property taxes. Interest payments. Repairs. Advertising expenses. Lawn care. Insurance premium for property only. Trash removal expenses. Snow removal expenses. Water. Utilities; and Other necessary expenses.

Since farm income is paid typically only once or twice a year, FSSA will calculate the net monthly income by totaling all gross payments received and deducting the allowable annual expenses and dividing by 12. If the client files a Schedule F to IRS Form 1040 “Profit or Loss From Farming”, I submit this form to the State as verification of the net income earned for the previous year. This is particular helpful when the farm lease agreement is a crop-share agreement in which the farmer and owner share expenses and profit.

B. Medicaid Estate Recovery

Though the farmland may be exempt for purposes of applying and maintaining eligibility for Medicaid benefits, Medicaid has a right to estate recovery which could include the farm property.

4705.00.00 CLAIMS AGAINST THE ESTATE

Under the provisions of the Social Security Act (42 USC 1396p) the state is required to recover certain Medicaid benefits correctly paid on behalf of an individual from the individual's estate. The circumstances under which a recovery claim must be filed are explained in this and the following sections. Upon the death of a Medicaid recipient, the total amount paid for medical

coverage, except as explained in Section 4710.00.00 and Section 4725.10.00, is allowed as a preferred claim against the estate of such person in favor of the state. All assets owned by the deceased individual at the time of death, including both real and personal property, become a part of the estate, even if no probate proceedings are initiated in court. The estate does not include property held jointly with rights of survivorship, property held in trust, or life insurance proceeds paid to the deceased's survivors or other beneficiaries. The claim provision is applicable to all categories of MA, including the categories providing limited coverage, except for SLMB (MA J) and QI (MA I). This exception applies to recipients who die on and after May 1, 1999 and is applicable to the state's payment of the Medicare premiums. Amounts paid for Medicare premiums under any MA Category will not be recovered from the recipient's estate. For recipients whose death occurred before October 1, 1993, the claim includes benefits paid for services provided after the recipient became 65 years of age. For recipients whose death occurs after October 1, 1993, the claim includes benefits paid for services provided. After the recipient became age 55 if the services were provided after October 1, 1993, and After the recipient became age 65, if the services were provided before October 1, 1993. In addition, a claim against the estate can be filed for Medicaid benefits "incorrectly paid" on behalf of a recipient regardless of age.

If the client owns the farm in his or her sole name, then the farm would be subject to estate recovery. The State can also go after the farm land if it is owned by the Medicaid recipient's living trust. FSSA has the right to recover Medicaid benefits paid out on behalf of the Medicaid recipient after age 55.

The State's Use of Liens

FSSA also has a right to place a lien on property in order to secure their right of recovery when the property is sold. The State does have limitations and rules to follow if the State intends to place a lien on a Medicaid recipient's real property. The Medicaid recipient must be in a medical institution as defined under IC 12-15-8.5-1 and cannot be reasonably expected to return home. (IC 12-15-8.5- 2). The Medicaid recipient and the Medicaid recipient's authorized representative must receive written notice of the State's intention to file the lien. Once the lien is established, the lien continues until either the house is sold or upon the death of the Medicaid recipient. However, the State has two (2) years after the Medicaid recipient's death to file the foreclosure action under the lien. (IC 12-5-8.5-7).

Currently, the State is not utilizing the use of liens against Medicaid recipient's real property but as time goes on, especially after the pandemic ends, the State may decide to start utilizing liens to help recover costs paid out on behalf of Medicaid recipients.

III. Protecting the Farm/Business

A. Irrevocable income Only Trust

One option to protect the family farm and still allow the client to receive the farm income is to create an Irrevocable Income Only Trust. An Irrevocable Income Only Trust allows for the Grantor to transfer the farm and other assets into the trust and start the five-year look back period for purposes of Medicaid planning. The Grantor is entitled to receive the income generated from the assets owned by the trust, which would include the net farm income paid each year. However, the Grantor is not allowed to revoke the trust, switch assets or to reacquire the assets transferred to the trusts. Since the trust principal is not available to the Grantor, then those assets are protected from Medicaid eligibility and not subject to a transfer penalty after the five-year look back expires.

The Irrevocable Income Only Trust also has some great tax advantages. This trust is treated as a Grantor trust for tax purposes. Since the income is paid out to the Grantor, the income is reported on the Grantor's tax return. Typically, the Grantor will be in a lower tax bracket than a Trust and this will allow for a savings on taxes. Another tax benefit is that the Grantor retains the Section 121 personal residence exclusion which can exempt $250,000 ($500,000 for a couple) of gain on the sale of the Grantor's primary residence. Finally, since the trust is a Grantor trust for tax purposes, upon the death of the Grantor, the trust assets receive the step-up basis in value for the beneficiaries. This could mean a huge savings in capital gains taxes if the beneficiaries sold the farm after the Grantor's death.

Upon the death of the Grantor, the trust assets are not subject to estate recovery and therefore will pass directly to the Grantor's beneficiaries. By utilizing an irrevocable Income only trust, the client is able to qualify for Medicaid, use the farm income to help cover care costs, protect the farm from estate recovery and keep the tax benefits as if the Client owned the farm in their sole name.

It is important to note that an Irrevocable Income Only Trust does not protect assets for purposes of Veteran's Affairs benefits. The Department of Veteran's Affairs consider assets owned in an irrevocable income only trust as an asset for the Grantor. The rational is that if the Grantor is entitled to the income from the trust, then the entire trust corpus is counted as an asset. So it is important that if part of your asset protection planning considers the use of VA benefits for a Veteran or their Surviving Spouse, then the use of an Irrevocable Income Only Trust may not be the best option.

JB SMITH IRREVOCABLE INCOME ONLY TRUST

JB SMITH IRREVOCABLE INCOME ONLY TRUST

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SCHEDULE A 9

JB SMITH IRREVOCABLE INCOME ONLY TRUST

THIS AGREEMENT, entered into this 6th day of July, 2021, by and among JB Smith, of Marion County, Indiana ("Grantor"), and Daughter Smith, of Rush County, Indiana ("Trustee"). Whenever the term "Trustee" is used in this document, it shall apply equally to any "Successor-Trustee". Whenever used herein, the term "Grantor" will have the same meaning as the term "Settlor" as defined in the Indiana Code section 30-4-1-2, or its successor section.

WITNESSETH THAT;

WHEREAS, the Grantor wishes to deliver to the Trustee certain property to be held in trust for the use and purposes and upon the terms and conditions hereinafter set forth and;

WHEREAS, the Trustee has agreed to hold and administer such property as may be received hereunder, upon the terms and conditions hereinafter set forth;

NOW THEREFORE, in consideration of the promise and mutual covenants herein contained and other valuable consideration, the parties do hereby agree as follows:

ARTICLE I.

Trust Funding

The Grantor has delivered to the Trustee the property described in Schedule A. Such property and any other property that may be received by the Trustee as additions to this Trust shall be held and disposed of by the Trustee on the terms stated in this Agreement.

ARTICLE II.

Irrevocability of Trust

The Grantor has carefully considered the advisability of reserving the right to amend, alter or revoke this Agreement and has determined not to reserve that right and now declares that this Agreement shall not be subject to amendment, alteration, or revocation in whole or in part of as to any of its terms by the Grantor or any person acting at the direction of the Grantor.

ARTICLE III.

Trust Purpose

The primary purpose of the trust is to hold assets that may now or in the future generate income for the Grantor while preserving the principal value of the trust for the beneficiaries named herein and to qualify as a "Grantor Trust" within the meaning of IRC §671.

ARTICLE IV.

Right of Occupancy of Real Estate

As long as the Grantor is living, the Grantor shall retain the right of occupancy to any homestead real estate owned by the Trust.

ARTICLE V.

Distribution of Income and Principal During the Life of the Grantor

Section 5.01 Distribution of Income.

During the lifetime of the Grantor, any net income of the trust shall be distributed in periodic installments to the Grantor. The entire net income of the trust shall be distributed to Grantor.

Section 5.02 Distribution of Principal.

The Trustee shall not distribute principal of this trust to the Grantor. The Grantor shall not have the right to compel the Trustee to distribute principal to the Grantor. The Trustee may, in the Trustee's sole and unfettered discretion, distribute principal to the Grantor's children, Daughter Smith and Son Smith. Any distribution to a child of the Grantor while the Grantor is living shall not be considered an advancement in determining that child's respective share as a beneficiary under Article VI.

ARTICLE VI.

Distribution Upon Death of the Grantor

Upon the death of the Grantor, the Trustee shall distribute the trust assets equally among Daughter Smith and Son Smith. If any beneficiary should predecease the Grantor with issue surviving, then such beneficiary's share shall be distributed to his or her children, per stirpes. If any beneficiary should predecease the Grantor with no issue surviving, then his or her share shall be distributed to the remaining beneficiary, per stirpes.

After dividing the trust assets, the Trustee shall, as soon as practicable, terminate the trust and distribute the shares to the beneficiaries

ARTICLE VII.

Spendthrift Clause

No interest under this instrument shall be transferable or assignable by any beneficiary, or be subject during their life to the claims of their creditors, including alimony claims. If any attempt should be made by any creditor of a beneficiary to reach any rights, benefits, or interests of a beneficiary, the Trustee may apply the income or principal to which the beneficiary would

otherwise be entitled, for their support and maintenance, or the support and maintenance of those dependent upon the beneficiary in such manner as the Trustee, in the Trustee's sole discretion, shall determine.

ARTICLE VIII.

General Administrative Provisions

Section 8.01 Governing Law.

This instrument and the dispositions hereunder shall be construed and regulated and their validity and effect shall be determined by the laws of Indiana.

Section 8.02 Method of Payment.

The Trustee may pay, transfer, or assign income or principal in any one or more of the following ways: (1) directly to a beneficiary; (2) to the guardian of the person or of the property of a beneficiary during the incapacity of a beneficiary; or, (3) by expending such income or principal directly to a provider of goods or services, or (4) to a suitable custodian under the Uniform Transfers to Minors Act.

Section 8.03 Waiver of Bond.

To the extent that any such requirements can be legally waived, no Trustee shall ever be required to give any bond as Trustee, to qualify before, or be appointed by any Court, or to obtain the order of approval of any Court in the exercise of any power of discretion hereunder, although the Trustee may do so at that Trustee's discretion. The Trustee is relieved from any requirements as to routine Court accounting that may now or hereafter be required by the statutes in force in any jurisdiction, although the Trustee is not precluded from obtaining judicial approval of its accounting.

Section 8.04 Trustee's Accounting.

The Trustee is relieved from any requirements as to routine Court accountings that may now or hereafter be required by the statutes in force in any jurisdiction, although it is not precluded from obtaining judicial approval of its accountings. The Trustee shall render an annual accounting and statement of accounts to the income beneficiary. In the event that the income beneficiary is incapacitated, such accounting shall be delivered to beneficiary's agent or guardian.

Section 8.05 Compensation.

Any Trustee, or Successor Trustee, shall be entitled to reasonable compensation for services in administering and distributing this Trust and to reimbursement for expenses.

Section 8.06 Income Tax.

The Trustee shall be responsible for the timely filing of all income tax returns required to be filed by the Trust and shall make estimated tax payments if such payments are due. If, in good faith, the Trustee incorrectly estimates such payments and as a result the Trust incurs added interest or penalties, the Trustee shall be exonerated.

ARTICLE IX.

Trustee Powers

The Trustee, shall have all powers enumerated under the Indiana Code and any other power that may be granted by law, to be exercised without the necessity of Court approval, as the Trustee, in the Trustee's sole discretion, determines to be in the best interests of the beneficiaries. No person who deals with the Trustee shall be required to inquire into the propriety of any of the Trustee's actions, nor shall any person, except as provided herein, who transfers money or other property to the Trustee be required to see to the application of such money or property. The powers granted herein are to be construed in the broadest possible manner and shall include the following, and shall pertain to both principal and income, but shall in no way be limited thereto:

Section 9.01 Power to Retain Property.

To retain any property received from the Grantor without liability for loss due to lack of diversification or non-productivity.

Section 9.02 Power to Invest.

To invest and reinvest the trust estate in any kind of real or personal property without regard to any law restricting investment by a Trustee and without regard to current income.

Section 9.03 Power to Sell.

To sell any trust property, for cash or on credit, at public or private sales; to exchange any trust property for other property; and to determine the prices and terms of sales and exchanges.

Section 9.04 Power to Conserve Trust Estate.

To take any action with respect to conserving or realizing upon the value of any trust property, and with respect to foreclosures, reorganizations, or other changes affecting the trust property; to collect, pay, contest, compromise, or abandon demands or claims belonging to or

held against the trust estate, wherever situated; and to execute contracts, notes, conveyances, and other instruments, including instruments containing covenants and warranties binding upon and creating a charge against the trust estate.

Section 9.05 Power to Continue Business.

To continue the operation or management of any business or other enterprise.

Section 9.06 Power to Insure and Pay Taxes.

To insure property against damage or loss, and the fiduciary against liability with regard to third persons; and to pay taxes, assessments and expenses incurred in the acquisition, retention and maintenance of property, and in the administration of the estate.

Section 9.07 Power to Access Electronic Communication

The power to access the content of an electronic communication, a catalogue of electronic communications or any other digital assets that is carried, maintained, processed, received, or stored in the account of the Trust.

ARTICLE X.

Succession of Trustees

Section 10.01 Successor Trustee.

If Daughter Smith resigns, dies, becomes incapacitated or otherwise not able to serve as Trustee, then Son Smith is designated as Successor Trustee.

Section 10.02 Accounts Rendered and Accepted.

Any Successor Trustee may accept, without examination or review, the accounts rendered and the property delivered by or for a predecessor Trustee, without incurring any liability or responsibility for so doing.

IN WITNESS WHEREOF, the parties have executed this Trust Agreement on the day and year first written above.

______________________________	______________________________
JB Smith Grantor	Daughter Smith Trustee
	______________________________
	Son Smith Successor Trustee

JB SMITH IRREVOCABLE INCOME ONLY TRUST

SCHEDULE A

DATE	**DESCRIPTION**	**VALUE**
July 6, 2021	1234 Smith Homestead Avenue, Indianapolis, IN 46250	$350,000

Section Three

Public Law 50-2021: Indiana's New Health Care Advance Directives Law

Kristin Steckbeck Bilinski
Dale, Huffman & Babcock
Bluffton, Indiana

Keith P. Huffman
Dale, Huffman & Babcock
Bluffton, Indiana

Section Three

Public Law 50-2021: Indiana's New Health Care Advance Directives Law……….. Kristin Steckbeck Bilinski Keith P. Huffman

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SEA No. 204 39

Advanced Elder Law 2021
<u>Proposed Advance Directives Discussion Topics</u>

1. **Delegation: pros and cons?** Does the ability to identify a class or list of permissible/impermissible delegees make it less problematic?

2. **Compensation of the health care representative: pros and cons?** Permit payment for time, or just reimbursement of expenses?

3. **Oversight by heath care proxies: pros and cons?** Does this muddy the waters with unenforceable "authority", or provide a necessary check-and-balance?

4. **Authority of third party to revoke AHCR: pros and cons?** Does this increase the risk of conflict and indecision amongst members of the family?

5. Possible mechanisms to identify the declarant when audio-only technology is being used in a witness situation?

6. How to handle client meetings/discussions in light of all these changes . . . use of questionnaire to have client answer some questions in advance? Will our meetings necessarily get 3x as long?

7. Interplay of attorney-drafted form and third party forms such as Five Wishes or Prepare for your Care . . . can/should a client use both?

NEW Indiana Advance Directive Law
Educational Sheet for Health Care Professionals

What is an advance directive?

- **An advance directive (AD) is a legal document a patient can use to:**
  - Appoint a health care representative (HCR) to speak on his/her behalf in the event of a loss of decisional capacity; and
  - Express healthcare decisions and/or treatment preferences for future care.

What is in the new Indiana advance directive statute (SEA 204)?

- **Flexibility in how future health care decisions and/or treatment preferences are documented.**
  - There is no required language that must be included and there is no longer an official or mandatory state form.
- **Updated signing requirements for advance directive forms.**
  - Signature of the Patient: The patient must sign the form. The patient can also direct someone else to sign it in his/her direct presence (e.g., if unable to sign).[1]
  - Signature of Two Adult Witnesses or Notary: The form must also be signed by either (2) adult witnesses or a notarial officer (such a notary public).
  - Electronic signature: An AD can be signed on paper or electronically.
- **New remote signing options when people are not in the same physical location:**
  - Sign electronically during a video call that includes the patient and two adult witnesses or a notary public.
  - Sign paper copies of the form during a video call that includes the patient and two adult witnesses or a notary ("signed in counterparts"). The signed copies must be assembled into one document within 10 business days of receipt.
  - Sign during a phone call that includes the patient and two witnesses. The witnesses must be able to confirm it is the patient and confirm capacity.
- **The new Health Care Representative (HCR) combines the roles of the HCR and power of attorney for health care under prior Indiana law.**
  - The new HCR requires a patient signature + 2 witnesses or a notary public.
  - The HCR must defer to the patient when the patient has capacity. If the patient loses capacity, the HCR must take the patient's known or implied preferences into account when making decisions and if unknown, the HCR must act in the patient's best interests.
  - The HCR can act on behalf of a patient without capacity including accessing patient medical records, signing POST, and applying for public benefits among other responsibilities.

[1] The person who signs at the patient's direction cannot be one of the witnesses, the notarial officer, or one of the named health care representatives.

Were there any other changes that are important to know about?

- **Advanced practice registered nurses and physician assistants may now sign the Indiana Out-of-Hospital Do Not Resuscitate order form.**
    - This change is consistent with a 2018 change that allows advance practice providers to sign the POST (Physician Orders for Scope of Treatment).

Why were these changes needed?

- **This is the first comprehensive update to Indiana's advance directive statute in almost 30 years.**
    - The old advance directive laws were spread out across three statutes. These statutes included vague and conflicting language.
    - The old statutes required use of outdated living will language that was unhelpful in the clinical setting and framed options as all or nothing.
    - There were two ways for someone to appoint a legal representative for health care decisions. The differences were poorly understood and created confusion.
    - COVID-19 made requirements for "in the direct presence" signing impossible for many.
    - Indiana's requirements were increasingly out of step with the rest of the country.

When do these changes take effect?

- This legislation takes effect on July 1, 2021, meaning a person with decisional capacity can sign a new AD. Starting January 1, 2023, everyone must follow the new law.
- Advance directives completed before January 1, 2023 under the old laws will remain legally valid and do not need to be updated unless by the patient.
- A later-signed advance directive is presumed to revoke and replace all earlier ones signed by the same patient, unless the later AD specifically says otherwise.
- The advance directive that is most recently signed by the patient is the one that controls.

Where can I get more information?

- The Indiana State Department of Health Advance Directives Resource Center contains links to forms that meet the state requirements as well as a sample health care representative appointment form.
- Indianapost.org has sample advance directives that can be used in addition to links to national forms that meet state requirements.

Compiled by Susan Hickman, PhD, and Jeffrey S. Dible, JD, on behalf of the Indiana Patient Preferences Coalition (www.indianapost.org). This information may be reproduced and distributed for educational purposes.

NOTE: These materials refer both to the current text of Indiana Engrossed House Bill 1317 as shown on http://iga.in.gov/legislative/2020/bills/house/1317 (referred to as "HB 1317 Engrossed 2020") and to that same legislation as revised in 2020 by the Probate Code Study Commission and circulated by attorney Jeffrey Dible of Frost Brown Todd in Indianapolis (referred to as "Revisions"). All cites within the proposed draft language are to the revised version of the statutes, which was the version enacted as Public Law 50-2021.

Springing Powers
IC § 16-36-7-25(1) (HB 1317 Engrossed 2020); IC § 16-36-7-29(1) (Revisions)

The authority of [] pursuant to this instrument shall only be effective upon [date].

AND/OR

The authority of [] pursuant to this instrument shall only be effective upon []'s attaining the age of [] years.

AND/OR

The authority of [] pursuant to this instrument shall only be effective upon []'s residing within fifty (50) miles of my residence at [].

AND/OR

The authority of [] pursuant to this instrument shall only be effective upon the establishment of my incapacity. For purposes of this paragraph [], my incapacity shall be established pursuant to IC § 16-36-1-4 by the good faith opinion of my attending physician or by order of a probate court.

Determination of Incapacity
IC § 16-36-7-25(2) (HB 1317 Engrossed 2020); IC §16-36-7-29(2) (Revisions)

In determining whether or not I am incapacitated as set forth in IC § 16-36-1-4 by a physician, psychologist, or other health care professional, the following individuals shall be authorized to participate in that determination process: [], [], and []. However, under no circumstances shall the nonmedical opinion of any of the individuals listed herein supersede or be permitted to veto the decision of a physician, psychologist, or other health care professional.

AND/OR

In determining whether or not I am incapacitated as set forth in IC 16-36-1-4 by a physician, psychologist, or other health care professional, the following evidence shall be considered, as reported to my health care providers by my spouse, family members, and/or friends:

1. Changes in my personal hygiene and my motivation to care for myself;

2. Changes in the degree to which I care for and order my living space and surroundings;

3. Changes in my personal affect, mood, and interactions with others;

4. Changes in my ability or willingness to interact with health care providers and direct my own health care; and

5. Changes in my enthusiasm for recreational activities that previously interested me.

Termination of Access to Medical Records
IC § 16-36-7-25(3) (HB 1317 Engrossed 2020); IC § 16-36-7-29(3) (Revisions)

[]'s access to my medical records shall terminate upon the establishment of my incapacity. For purposes of this paragraph [], my incapacity shall be established pursuant to IC §16-36-1-4 by the good faith opinion of my attending physician or by order of a probate court.

Appointment of More Than One Representative
IC § 16-36-7-25(4) (HB 1317 Engrossed 2020); IC § 16-36-7-29(4) (Revisions)
IC § 16-36-7-25(5) (HB 1317 Engrossed 2020); IC § 16-36-7-29(5) (Revisions)

I hereby appoint [] as my health care representative. If [] fails or ceases to serve as my health care representative or during any periods of time in which [] is not reasonably available (as determined by my attending physician) to exercise the authority granted by this instrument, I appoint [] as my first successor health care representative.

OR

I hereby appoint [] and [], either one of whom may act alone, as my health care representative.

OR

I hereby appoint [], [], and [], acting by majority action, as my health care representative. In the event that any one of [], [], and [] is not reasonably available (as determined by my attending physician) to serve as my health care representative, then the remaining two individuals shall act together as my health care representative. In the event that two of [], [], and [] are not reasonably available (as determined by my attending physician) to serve as my health care representative, then the remaining individual shall act alone as my health care representative.

Compensation of Health Care Representative
IC § 16-36-7-25(6) (HB 1317 Engrossed 2020); IC § 16-36-7-29(6) (Revisions)
IC § 16-36-7-25(7) (HB 1317 Engrossed 2020); IC §16-36-7-29(7) Revisions)

My health care representative shall be entitled to a fee of $___ per hour for services rendered as my health care representative, including: caregiving services in my place of residence; transporting me or traveling with me to medical appointments; communicating with a medical care provider on my behalf in person, electronically, or telephonically; and attendance to my medical needs at a hospital, rehabilitation or nursing facility or doctor's office. My health care representative shall also be entitled to reimbursement for reasonable expenses incurred on my behalf and reasonable travel costs in connection with attending to my medical needs.

OR

My health care representative shall not be entitled to a fee for services under this instrument. However, my health care representative shall be entitled to reimbursement for reasonable expenses incurred on my behalf and reasonable travel costs in connection with attending to my medical needs.

OR

My health care representative shall not be entitled to a fee for services under this instrument, or for reimbursement for reasonable expenses incurred on my behalf and reasonable travel costs in connection with attending to my medical needs.

Oral Revocation
IC § 16-36-7-25(8) (HB 1317 Engrossed 2020); IC § 16-36-7-29(8) (Revisions)

Any oral revocation or amendment of this instrument by me pursuant to IC § 16-36-1-7 shall only be valid if witnessed and approved by my attending physician.

OR

Any oral revocation or amendment of this instrument by me pursuant to IC §16-36-1-7 shall only be valid if witnessed and approved by my attending physician together with a disinterested third party who is not related to me by blood or marriage.

Restriction on Access to Mental Health Records
IC § 16-36-7-25(9) (HB 1317 Engrossed 2020); IC §16-36-7-29(9) (Revisions)

My health care representative named on page [] of instrument shall not have authority to consent to mental health treatment on my behalf and shall not have access to my mental health records. Instead, I nominate [] as my health care representative with respect to all matters concerning my mental health treatment, including access to my mental health records.

Oversight & Audit of Health Care Representative
IC § 16-36-7-25(10) (HB 1317 Engrossed 2020); IC §16-36-7-29(10) (Revisions)

[] shall be permitted to oversee the actions of my health care representative pursuant to IC § 16-36-7-29(10). In connection therewith, [] shall be permitted and entitled to the following:

(1) To receive my health information and medical records from the health care representative and/or any physician, hospital, or other medical provider;

(2) To monitor, audit, and evaluate the actions of my health care representative; and

(3) To take remedial action to protect my best interests, including but not limited to revoking this instrument in part or in full, and filing a petition with a court for appropriate relief.

OR

[] shall be permitted to oversee the actions of my health care representative pursuant to IC § 16-36-7-29(10). In connection therewith, [] shall be permitted and entitled to the following:

(1) To receive my health information and medical records from the health care representative and/or any physician, hospital, or other medical provider;

(2) To monitor, audit, and evaluate the actions of my health care representative; and

(3) To take remedial action to protect my best interests, including but not limited to filing a petition with a court for appropriate relief. However, no person shall be deemed to have authority to revoke this instrument, in part or in full, pursuant to this paragraph.

Written Revocation
IC §16-36-7-28 (HB 1317 Engrossed 2020); IC §16-36-7-32 (Revisions)
IC § 16-36-7- 30(4) (HB 1317 Engrossed 2020); IC §16-36-7-34(4) (Revisions)

My execution of this instrument shall not be deemed to revoke any and all prior appointments of health care representative executed by me.

OR

My execution of this instrument shall be deemed to revoke any and all prior appointments of health care representative executed by me.

AND/OR

This instrument may only be revoked by a written statement executed by me in a writing that complies with IC § 16-36-7-28, and may not be revoked orally as provided in IC §16-36-7-32(a)(3).

Delegation
IC 16-36-7-29 (HB 1317 Engrossed 2020); IC 16-36-7-33 (Revisions)

My health care representative shall not be permitted to delegate any authority pursuant to this instrument.

OR

My health care representative shall be permitted to delegate authority pursuant to this instrument and IC § 16-36-7-33, but only to the following person(s) or class of persons:

1.) An adult descendant of mine;

2.) An adult sibling of mine; and

3.) The adult child or adult descendant of a sibling of mine.

AND/OR

My health care representative shall be permitted to delegate authority pursuant to this instrument and IC 16-36-7-33, but delegation shall not be permitted to the following person(s) or class of persons:

1.) A descendant of my spouse who is not also a descendant of mine;

2.) A sibling of mine; and

3.) A descendant of a sibling of mine.

Conflicting Authority of Health Care Representatives
IC § 16-36-7-30(3) (HB 1317 Engrossed 2020); IC § 16-36-7-34(3) (Revisions)

If more than one health care representative is named in this instrument, or if more than one health care representative is deemed to have authority pursuant to this instrument and a prior appointment of health care representative instrument that has not been revoked, and such appointments are not subject to an order of priority, then each named health care representative has concurrent authority to act individually.

OR

If more than one health care representative is named in this instrument, or if more than one health care representative is deemed to have authority pursuant to this instrument and a prior appointment of health care representative instrument that has not been revoked, and such appointments are not subject to an order of priority, then such health care representatives must act jointly (if two are named) or by majority vote (if more than two are named).

Authority of Proxy
IC §16-36-7-30(13) (HB 1317 Engrossed 2020); IC § 16-36-7-34(13) (Revisions)

No person who would otherwise act as a proxy for my health care decisions pursuant to IC §16-36-7-42 and IC §16-36-7-43 (if an advance directive did not otherwise exist) may make written demand for a narrative description or other accounting of the actions taken and decisions made by my health care representative pursuant to this instrument.

OR

Each person who would otherwise act as a proxy for my health care decisions pursuant to IC §16-36-7-42 and IC §16-36-7-43 (if an advance directive did not otherwise exist) may make written demand for a narrative description or other accounting of the actions taken and decisions made by my health care representative pursuant to this instrument.

Authority to Apply for Public Benefits
IC §16-36-7-32(6) (HB 1317 Engrossed 2020); IC §16-36-7-36(6) (Revisions)

My health care representative shall not have the authority to apply for public benefits on my behalf pursuant to IC §16-36-7-36(6), and shall not have access to information regarding my income, assets, and banking and financial records for any purposes pursuant to this instrument.

OR

My health care representative shall have authority to apply for public benefits on my behalf pursuant to IC § 16-36-7-36(6), and shall have access to information regarding my income, assets, and banking and financial records for any purposes, and such authority shall continue following my death for purposes of applying for public benefits posthumously.

NOTICE: **This Appointment of Health Care Representative is an adaptation of a form copyrighted by the firm with which the Grantor's legal counsel is associated. It has been prepared in a manner which specifically addresses the Grantor's circumstances and wishes. Its provisions may not be suitable for anyone else.**

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

OF

JANE DOE
("Grantor")

1. Single Attorney-In-Fact

I hereby appoint my spouse, **JOHN DOE**, as my health care representative (hereinafter referred to as my "Representative").

2. Substitute Representative [Single Successor(s) in Order]

If my Representative named in Paragraph 1 of this instrument fails or ceases to serve as my Representative, or during any periods of time in which my Representative named in Paragraph 1 is not reasonably available (as determined by my attending physician) to exercise the authority granted by this instrument, I appoint my [], [], as my Representative. If [] is not reasonably available (as determined by my attending physician) to exercise the authority granted by this instrument, I appoint my [], [], as my Representative.

2. Substitute Representative [Multiple Concurrent Successors]

If my Representative named in Paragraph 1 of this instrument fails or ceases to serve as my Representative, or during any periods of time in which my Representative named in Paragraph 1 is not reasonably available (as determined by my attending physician) to exercise the authority granted by this instrument, I hereby appoint [] and [], either one of whom may act alone, as my Representative.

2. Substitute Representative [Successors By Majority]

If my Representative named in Paragraph 1 of this instrument fails or ceases to serve as my Representative, or during any periods of time in which my Representative named in Paragraph 1 is not reasonably available (as determined by my attending physician) to exercise the authority granted by this instrument, I hereby appoint [], [], and [], acting by

majority action, as my health care representative. In the event that any one of [], [], and [] is not reasonably available (as determined by my attending physician) to serve as my health care representative, then the remaining two individuals shall act together as my health care representative. In the event that two of [], [], and [] are not reasonably available (as determined by my attending physician) to serve as my health care representative, then the remaining individual shall act alone as my health care representative.

3. <u>Effective Immediately</u>

This instrument shall take effect at the time it is signed by me, and at all times thereafter my Representative shall have authority to communicate with my health care providers and participate in my medical decision making. However, at any time that my health care providers believe that I am not mentally incapacitated, and in the event of a disagreement between me and my Representative as to the course and scope of my medical care, my health care providers shall follow only my direction and instruction and not that of my Representative.

3. <u>Effective Only Upon Incapacity</u>

The authority of my Representative pursuant to this instrument shall only be effective upon the establishment of my incapacity. For purposes of this paragraph 3, my incapacity shall be established pursuant to IC § 16-36-1-4 by the good faith opinion of my physician or by order of a probate court.

4. <u>Determination of Incapacity</u>

In determining whether or not I am incapacitated as set forth in IC § 16-36-1-4 by a physician, psychologist, or other health care professional, the following individuals shall be authorized to participate in that determination process: [], [], and []. In connection therewith, the physician, psychologist, or other health care professional may disclose any necessary medical information with such persons in order to aid in such determination. However, under no circumstances shall the nonmedical opinion of any of the individuals listed herein supersede or be permitted to veto the decision of a physician, psychologist, or other health care professional.

In determining whether or not I am incapacitated as set forth in IC 16-36-1-4 by a physician, psychologist, or other health care professional, the following evidence shall be considered, as reported to my health care providers by my spouse, family members, and/or friends:

1. Changes in my personal hygiene and my motivation to care for myself;

2. Changes in the degree to which I care for and order my living space and surroundings;

3. Changes in my personal affect, mood, and interactions with others;

4. Changes in my ability or willingness to interact with health care providers and direct my own health care; and

5. Changes in my enthusiasm for recreational activities that previously interested me.

5. <u>Powers Granted</u>

Except as limited by the provisions of this instrument, I empower my Representative to act as my health care representative under Chapter 16-36-7 of the Indiana Code, as amended (or replaced) from time to time. I intend for the authority hereby granted to my Representative to include authority to do for me and in my name the following:

(1) employ or contract with companions, caregivers, and health care providers to care for me;

(2) consent to or refuse health care for me in accordance with IC 16-36-7, as amended (or replaced) from time to time;

(3) admit me to or release me from any hospital or other health care facility;

(4) have access to records, including medical records, concerning my condition;

(5) make anatomical gifts on my behalf;

(6) request an autopsy of my body; and

(7) make plans for the disposition of my body, including (but not necessarily limited to) the making of funeral and burial or cremation arrangements, both before and after my death, which are in keeping

with my station in life and any wishes of mine known to my Representative.

(8) I may set forth additional instructions or details regarding my health care wishes in an Exhibit A attached hereto, and hereby incorporate such Exhibit A herein. If attached, I direct my Representative to respect and honor such instructions to every extent practicable under the circumstances.

6. Specific Authority to Withdraw or Withhold Health Care

In furtherance of the authority granted to my Representative to consent to or refuse health care for me (item (2) of Paragraph 5), I empower my Representative to ask, in my name, for health care to be withdrawn or withheld when it is not beneficial or, even if my death may result, when any benefit is outweighed by the demands of the treatment.

I authorize my Representative to make decisions in my best interests concerning withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis and prognosis made by my health care providers, my 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 Representative may express my will that such health care be withdrawn or withheld and may consent on my behalf that such health care be discontinued or not instituted, even if my death may result.

My Representative must try to discuss any such decision with me. However, if I am unable to communicate, my Representative may make such a decision for me after consulting with my physicians and my other health care providers. To the extent appropriate, my Representative shall also discuss any such decision with my family and other interested individuals.

7. Medical Information Access

In furtherance of the authority granted to my Representative to have access to all records concerning my condition (item (4) of Paragraph 5), I intend for my Representative to be treated as I would be treated with respect to my rights regarding the use and disclosure of my medical records and my other individually identifiable health information. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, other covered health care provider, or insurance company, to give, disclose, and release to my Representative, without restriction, all of my medical records and my other individually identifiable health information regarding any past, present, or future medical or mental health condition.

The authority given to my Representative under this Paragraph shall supersede all prior agreements that I may have made with, and all prior instructions that I may have given to, my health care providers to restrict access to or disclosure of my medical records and my other individually identifiable health information.

OPTIONAL: The authority as granted to my Representative by this paragraph 7 shall be limited to times that I am incapacitated as set forth in paragraph 3, above.

8. Liability Limited

My Representative is **NOT** required to exercise any power granted by this instrument, even though I become incapable of consenting to my own health care. However, if at any time (while I am incapable of consenting to my own health care) my Representative is reasonably available but unwilling to make timely decisions with respect to the authority granted by this instrument, they shall be deemed to have resigned as my Representative. My Representative shall be liable only for acts performed in bad faith.

9. Delegation of Authority Prohibited

My Representative may **NOT** delegate any authority granted by this instrument.

9. Delegation of Authority Permitted [to certain people]

My Representative shall be permitted to delegate authority pursuant to this instrument and IC § 16-36-7-33, but only to the following person(s) or class of persons:

1.) An adult descendant of mine;

2.) An adult sibling of mine; and

3.) The adult child or adult descendant of a sibling of mine.

9. Delegation of Authority Permitted [excluding certain people]

My Representative shall be permitted to delegate authority pursuant to this instrument and IC 16-36-7-33, but delegation shall not be permitted to the following person(s) or class of persons:

1.) A descendant of my spouse who is not also a descendant of mine;

2.) A sibling of mine; and

3.) A descendant of a sibling of mine.

10. <u>No Compensation; Reimbursement Permitted</u>

My Representative shall not be entitled to a fee for services under this instrument. However, my Representative shall be entitled to reimbursement for reasonable expenses incurred on my behalf and reasonable travel costs in connection with attending to my medical needs.

10. <u>No Compensation or Reimbursement</u>

My Representative shall not be entitled to a fee for services under this instrument, or for reimbursement for expenses incurred on my behalf or travel costs in connection with attending to my medical needs.

10. <u>Compensation and Reimbursement Permitted</u>

My Representative shall be entitled to [a fee of $___ per hour] [reasonable compensation] for services rendered as my health care representative, including: caregiving services in my place of residence; transporting me or traveling with me to medical appointments; communicating with a medical care provider on my behalf in person, electronically, or telephonically; and attendance to my medical needs at a hospital, rehabilitation or nursing facility or doctor's office. My Representative shall also be entitled to reimbursement for reasonable expenses incurred on my behalf and reasonable travel costs in connection with attending to my medical needs.

11. <u>Use of Copies in Lieu of an Original</u>

Any photographic or facsimile copy of this instrument shall be of the same force and effect as an original, IF my Representative certifies in writing under the penalties for perjury that the copy is a true and correct copy.

12. <u>Revocation</u> [written only]

This instrument may only be revoked by a written statement executed by me in a writing that complies with IC § 16-36-7-28, and may not be revoked orally as provided in IC §16-36-7-32(a)(3).

12. Revocation [oral, witnessed by physician only]

Any oral revocation or amendment of this instrument by me pursuant to IC § 16-36-7-32(a)(3) shall only be valid if witnessed and approved by my attending physician.

12. Revocation [oral, witnessed by physician and third party]

Any oral revocation or amendment of this instrument by me pursuant to IC § 16-36-7-32(a)(3) shall only be valid if witnessed and approved by my attending physician together with a disinterested third party who is not related to me by blood or marriage.

13. Prior Instruments Revoked

My execution of this instrument shall be deemed to revoke any and all prior appointments of health care representative executed by me.

13. Prior Instruments Not Revoked

My execution of this instrument shall not be deemed to revoke any and all prior appointments of health care representative executed by me.

If more than one Representative is deemed to have authority pursuant to this instrument and a prior appointment of health care representative instrument that has not been revoked, and such appointments are not subject to an order of priority, then each named Representative has concurrent authority to act individually.

14. No Oversight by Health Care Proxies

No person who would otherwise act as a proxy for my health care decisions pursuant to IC §16-36-7-42 and IC §16-36-7-43 (if an advance directive did not otherwise exist) may make written demand for a narrative description or other accounting of the actions taken and decisions made by my Representative pursuant to this instrument.

14. Oversight by Health Care Proxies

Each person who would otherwise act as a proxy for my health care decisions pursuant to IC §16-36-7-42 and IC §16-36-7-43 (if an advance directive did not otherwise exist) may make written demand for a narrative description or other accounting of the actions taken and decisions made by my Representative pursuant to this instrument.

15. Oversight of My Representative; Authority to Revoke this Instrument

[] shall be permitted to oversee the actions of my Representative pursuant to IC § 16-36-7-29(10). In connection therewith, [] shall be permitted and entitled to the following:

(1) To receive my health information and medical records from the health care representative and/or any physician, hospital, or other medical provider;

(2) To monitor, audit, and evaluate the actions of my health care representative; and

(3) To take remedial action to protect my best interests, including but not limited to revoking this instrument in part or in full, and filing a petition with a court for appropriate relief.

15. Oversight of My Representative; No Authority to Revoke this Instrument

[] shall be permitted to oversee the actions of my Representative pursuant to IC § 16-36-7-29(10). In connection therewith, [] shall be permitted and entitled to the following:

(1) To receive my health information and medical records from the health care representative and/or any physician, hospital, or other medical provider;

(2) To monitor, audit, and evaluate the actions of my health care representative; and

(3) To take remedial action to protect my best interests, including but not limited to filing a petition with a court for appropriate relief. However, no person shall be deemed to have authority to revoke this instrument, in part or in full, pursuant to this paragraph.

16. No Authority to Access Financial Records or Apply for Public Benefits

My Representative shall not have the authority to apply for public benefits on my behalf pursuant to IC §16-36-7-36(6), and shall not have access to information regarding my income, assets, and banking and financial records for any purposes pursuant to this instrument.

17. Indiana Law

This instrument is being signed and delivered in contemplation of Indiana law, and it shall be interpreted and governed in accordance with Indiana law.

18. Different Representative for Mental Health Care and Records [OPTIONAL]

My Representative named on page 1 of this instrument shall not have authority to consent to mental health treatment on my behalf and shall not have access to my mental health records. Instead, I nominate my [], [], as my Representative with respect to all matters concerning my mental health treatment, including access to my mental health records. If [] is not reasonably available (as determined by my attending physician) to exercise the authority granted by this paragraph, I appoint my [], [], as my Representative with respect to all matters concerning my mental health treatment, including access to my mental health records.

[The balance of this page intentionally left blank]

FIRST ALTERNATE SIGNING PAGE - Notarization

Signed in the presence of the undersigned Notary Public this _____ day of ________________, 2021.

____
Jane Doe
123 Main Street
Anywhere, USA 00000

STATE OF INDIANA)
)
COUNTY OF ________________)

Before me, a Notary Public in and for the State of Indiana, this _____ day of ________________, 2021, personally appeared **JANE DOE**, who signed the foregoing power of attorney in my presence, or in my presence authorized and directed another individual to sign the foregoing power of attorney, and acknowledged the execution of it to be a voluntary act and deed for the uses and purposes therein expressed.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal.

A resident of _________________ County

____
Notary Public (Signature)

My commission expires:
____

____
Notary Public (printed name)

This instrument was prepared by **Kristin Steckbeck Bilinski**, Attorney at Law, Indiana Bar No. 27029-02, Dale, Huffman & Babcock, 1127 North Main Street, Bluffton, Indiana 46714.

SECOND ALTERNATE SIGNING PAGE – Two witnesses in person

Signed in the direct, physical presence of the two undersigned witnesses this _____ day of _______________, 2021.

____
Jane Doe
123 Main Street
Anywhere, USA 00000

____
, Witness

____
, Witness

This instrument was prepared by **Kristin Steckbeck Bilinski**, Attorney at Law, Indiana Bar No. 27029-02, Dale, Huffman & Babcock, 1127 North Main Street, Bluffton, Indiana 46714.

THIRD ALTERNATE SIGNING PAGE – Two witnesses remote with audio-visual technology

Signed in the presence of the two undersigned witnesses this _____ day of ________________, 2021.

____
Jane Doe
123 Main Street
Anywhere, USA 00000

____
, Witness

____
, Witness

Description of technology used to ensure that Declarant and Witnesses satisfied the requirement of "presence" as set forth in Indiana Code §§ 16-36-7-19 and 16-36-7-28:

This instrument was prepared by **Kristin Steckbeck Bilinski**, Attorney at Law, Indiana Bar No. 27029-02, Dale, Huffman & Babcock, 1127 North Main Street, Bluffton, Indiana 46714.

FOURTH ALTERNATE SIGNING PAGE – Two witnesses remote with audio-only technology

Signed in the presence of the two undersigned witnesses this _____ day of ________________, 2021.

____
Jane Doe
123 Main Street
Anywhere, USA 00000

____
, Witness

____
, Witness

Description of technology used to ensure that Declarant and Witnesses satisfied the requirement of "presence" as set forth in Indiana Code §§ 16-36-7-19 and 16-36-7-28:

Description of method by which the Witnesses positively identified the Declarant:

This instrument was prepared by **Kristin Steckbeck Bilinski**, Attorney at Law, Indiana Bar No. 27029-02, Dale, Huffman & Babcock, 1127 North Main Street, Bluffton, Indiana 46714.

EXHIBIT A

I hereby specifically instruct my Representative(s) as follows concerning my health care, medical treatment, and end-of-life care:

Quick Reference Guide to the Indiana Advance Directive for Health Care (2021)

Source: Indiana Code, Title 16, Article 36, Chapter 7 (Part of Public Law 50-2021)

Basic elements of the new Indiana advance directive (AD)

(1) No official or mandatory form for the AD

(2) Basic permitted and typical contents:

- (a) Name 1 or more health care representatives (HCRs)
- (b) State specific health care decisions and/or treatment preferences, including preferences for life-prolonging procedures or palliative care [*The statute contains no limitations on the expression of treatment preferences]*
- (c) [*Optional*] Disqualify named individual(s) from receiving delegated authority or serving as a HCR

(3) Signing requirements:

- (a) Declarant (patient or signer) signs on paper or electronically ***OR*** directs some adult (not a health care representative and not a witness) to sign declarant's name in declarant's direct presence
- (b) Declarant signs in the "presence" of 2 adult witnesses ***OR*** signs in the "presence" of a notary public or other notarial officer [*see back page for ways to satisfy "presence' requirement*]
- (c) The 2 witnesses ***OR*** the notarial officer also sign the AD electronically or on paper

Basic presumptions and rules IF the advance directive (AD) does NOT explicitly say otherwise:

A. The AD and the authority of each named HCR is effective upon signing and remains in effect until the AD is revoked in writing

B. A later-signed AD supersedes and revokes an earlier-signed AD by the same Declarant

C. Unless HCRs are listed in order of priority (primary & backup, etc.), 2 or more HCRs named in the same AD have concurrent, equal, and independently exercisable authority and are not required to act jointly

D. If Declarant still has capacity to consent to health care, orders and instructions by Declarant will control over any decisions by a HCR and any specific instructions stated in in the AD

E. Any health care representative (HCR) can delegate authority under the AD in writing to any competent adult(s) or other persons (a delegation should be signed in the same manner as an AD)

F. The HCR has authority to compete anatomical gifts, to authorize an autopsy, and to arrange for burial or cremation of the Declarant's remains after Declarant's death

G. The HCR can access Declarant's medical records & health information under HIPAA and state law

H. The HCR has authority to consent to mental health treatment for the Declarant

I. Each HCR has authority to sign a POST / POLST or an out-of-hospital DNR declaration for Declarant if Declarant is found to be a qualified [eligible] person

J. The HCR has authority to apply for public benefits (including Medicaid and CHOICE) for Declarant and to access Declarant's financial and asset records for that purpose

K. Each HCR is entitled to collect reasonable compensation and expense reimbursement for actions taken and services performed for or on behalf of Declarant

Compiled by Jeffrey S. Dible, J.D. and Susan E. Hickman, Ph.D. Health care providers, patient advocacy organizations, bar associations, and social service agencies may reproduce and distribute this guide.

Standard of conduct for each health care representative:

- Defer to Declarant's personal decisions and judgment at all times when Declarant has capacity to consent to health care and is able to communicate instructions, wishes, and treatment preferences
- Take into account Declarant's explicit or implied intentions and preferences and make only the health care decisions that Declarant would have made
- Act in good faith and in Declarant's best interests if Declarant's specific preferences are not known
- Remain reasonably available to consult with Declarant's health care providers and to provide informed consent for Declarant if Declarant does not have capacity

Optional provisions that CAN be included in an advance directive (AD) [*see I.C. §§ 16-36-7-29 and 16-36-7-34; not a complete list*]:

1. State a delayed effective date or triggering event (*e.g.*, future incapacity) and/or a specific ending date for the AD or for any HCR's authority
2. Keep an earlier-signed AD or an earlier-appointed HCR's authority in effect after a new AD is signed
3. Prohibit or restrict the delegation of authority by the HCR to other specific persons
4. Require another person to witness or approve a revocation of or amendment to the AD
5. Name 2 or more HCRs in a stated order of priority or confirm that they are authorized to act alone and independently
6. Require multiple HCRs to act jointly or on a majority vote basis to exercise some or all health care powers
7. Prohibit an HCR from collecting compensation or state an hourly rate or other standard for determining HCR's reasonable compensation
8. Designate some person other than a HCR to serve as an advocate or monitor
9. Authorize any person (proxy) who is listed in I.C. §16-36-7-42 and -43 to make a written demand that any HCR provide a written accounting or report of the HCRs actions on behalf of Declarant

Methods for signing that satisfy the "presence" requirement between Declarant and the 2 witnesses or between the Declarant and the notarial officer [*see* I.C. §§ 16-36-7-19 and -28]:

In-Person Options		**Virtual Options**		
Declarant and 2 witnesses or Declarant and the notarial officer sign on paper in direct physical presence of each other	Declarant and 2 witnesses or Declarant and the notarial officer sign electronically in direct physical presence of each other	Sign identical counterparts on paper; Declarant & witnesses or notary interact using 2-way audiovisual technology; assemble signed counterparts within 10 business days	Declarant and 2 witnesses or Declarant and notary sign electronically while interacting using 2-way audiovisual technology	Declarant and 2 witnesses sign with audio-only interaction by telephone during signing [*Witnesses must be able to positively identify Declarant & confirm capacity*]

NOTE: An Indiana notary public must comply with Indiana law and regulations, including regulations for "remote notarial acts," if Declarant and notary interact at a distance using audiovisual technology.

Compiled by Jeffrey S. Dible, J.D. and Susan E. Hickman, Ph.D. Health care providers, patient advocacy organizations, bar associations, and social service agencies may reproduce and distribute this guide.

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.

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 Immediately

This Advance Directive and my Health Care Representative(s)' power and authority under it are effective immediately and 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) in decreasing order of priority, but subject to the conditions stated in the next section ("My Continuing Right to Act and Decide Personally") below.

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

At all times, my Health Care Representative who has the highest priority and who is reasonably available to act has the full authority to make and communicate health care decisions and give informed consent on my behalf, but subject to my right to act personally.

My Continuing Right to Act and Decide Personally

Although 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, 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.

My Wishes and Preferences About Life-Prolonging Procedures [*illustrative sample only*]

If I am competent to give my own consents and instructions for my health care, my orally-stated instructions will always supersede and control over the instructions I have stated below.

I 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 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.

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.

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

Complete ONE of the two following blocks

Signatures of 2 Adult Witnesses

____
Signature of Adult Witness 1

____
Printed Name of Adult Witness 1

____
Signature of Adult Witness 2

____
Printed Name of Adult Witness 2

Notarization

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

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 Immediately

This Advance Directive and my Health Care Representative(s)' power and authority under it are effective immediately and 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

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

Although 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, 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.

My Wishes and Preferences About Life-Prolonging Procedures [*illustrative sample only*]

If I am competent to give my own consents and instructions for my health care, my orally-stated instructions will always supersede and control over the instructions I have stated below.

I 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.

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.

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

____
Signature of Adult Witness 1

____
Printed Name of Adult Witness 1

____
Signature of Adult Witness 2

____
Printed Name of Adult Witness 2

Notarization

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

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

____
Signature of Adult Witness 1

____
Printed Name of Adult Witness 1

____
Signature of Adult Witness 2

____
Printed Name of Adult Witness 2

Notarization

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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PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2020 Regular Session of the General Assembly.

SENATE ENROLLED ACT No. 204

AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-10-7-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 8. (a) The division shall contract in writing for the provision of the guardianship services required in each region with a nonprofit corporation that is:

(1) qualified to receive tax deductible contributions under Section 170 of the Internal Revenue Code; and

(2) located in the region.

(b) The division shall establish qualifications to determine eligible providers in each region.

(c) Each contract between the division and a provider must specify a method for the following:

(1) The establishment of a guardianship committee within the provider, serving under the provider's board of directors.

(2) The provision of money and services by the provider in an amount equal to at least twenty-five percent (25%) of the total amount of the contract and the provision by the division of the remaining amount of the contract. The division shall establish guidelines to determine the value of services provided under this subdivision.

(3) The establishment of procedures to avoid a conflict of interest for the provider in providing necessary services to each

incapacitated individual.

(4) The identification and evaluation of indigent adults in need of guardianship services.

(5) The adoption of individualized service plans to provide the least restrictive type of guardianship or related services for each incapacitated individual, including the following:

(A) Designation as a representative payee by:

(i) the Social Security Administration;

(ii) the United States Office of Personnel Management;

(iii) the United States Department of Veterans Affairs; or

(iv) the United States Railroad Retirement Board.

(B) Limited guardianship under IC 29-3.

(C) Guardianship of the person or estate under IC 29-3.

(D) The appointment of:

(i) a health care representative under IC 16-36-1-7 **or IC 16-36-7;** or

(ii) a power of attorney under IC 30-5.

(6) The periodic reassessment of each incapacitated individual.

(7) The provision of legal services necessary for the guardianship.

(8) The training and supervision of paid and volunteer staff.

(9) The establishment of other procedures and programs required by the division.

SECTION 2. IC 12-10-13-3.3, AS AMENDED BY P.L.168-2018, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 3.3. As used in this chapter, "legal representative" means:

(1) a guardian;

(2) a health care representative acting under IC 16-36-1 **or IC 16-36-7;**

(3) an attorney-in-fact for health care appointed under IC 30-5-5-16;

(4) an attorney-in-fact appointed under IC 30-5-5 who does not hold health care powers; or

(5) the personal representative of the estate;

of a resident of a long term care facility.

SECTION 3. IC 12-10-18-1, AS ADDED BY P.L.140-2005, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 1. (a) A law enforcement agency that receives a notification concerning a missing endangered adult from:

(1) the missing endangered adult's:

(A) guardian;

(B) custodian; or

(C) guardian ad litem; or

(2) an individual who:

(A) provides the missing endangered adult with home health aid services;

(B) possesses a health care power of attorney **that was executed under IC 30-5-5-16** for the missing endangered adult; or

(C) has evidence that the missing endangered adult has a condition that may prevent the missing endangered adult from returning home without assistance;

shall prepare an investigative report on the missing endangered adult, if based on the notification, the law enforcement agency has reason to believe that an endangered adult is missing.

(b) The investigative report described in subsection (a) may include the following:

(1) Relevant information obtained from the notification concerning the missing endangered adult, including the following:

(A) A physical description of the missing endangered adult.

(B) The date, time, and place that the missing endangered adult was last seen.

(C) The missing endangered adult's address.

(2) Information gathered by a preliminary investigation, if one was made.

(3) A statement by the law enforcement officer in charge setting forth that officer's assessment of the case based upon the evidence and information received.

SECTION 4. IC 16-18-2-1.5, AS AMENDED BY P.L.205-2018, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 1.5. (a) "Abortion clinic", for purposes of IC 16-21-2, IC 16-34-2-4.7, IC 16-34-3, and IC 16-41-16, means a health care provider (as defined in section ~~163(d)(1)~~ **163(e)(1)** of this chapter) that:

(1) performs surgical abortion procedures; or

(2) beginning January 1, 2014, provides an abortion inducing drug for the purpose of inducing an abortion.

(b) The term does not include the following:

(1) A hospital that is licensed as a hospital under IC 16-21-2.

(2) An ambulatory outpatient surgical center that is licensed as an ambulatory outpatient surgical center under IC 16-21-2.

(3) A health care provider that provides, prescribes, administers, or dispenses an abortion inducing drug to fewer than five (5) patients per year for the purposes of inducing an abortion.

SECTION 5. IC 16-18-2-6.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 6.1. "Advance directive", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-2.**

SECTION 6. IC 16-18-2-28.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 28.8. "Attending", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-1.1.**

SECTION 7. IC 16-18-2-29 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 29. "Attending physician" means the licensed physician who has the primary responsibility for the treatment and care of the patient. ~~For purposes of IC 16-36-5, the term includes a physician licensed in another state.~~

SECTION 8. IC 16-18-2-35.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 35.5. "Best interests", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-3.**

SECTION 9. IC 16-18-2-92.4, AS AMENDED BY P.L.164-2013, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 92.4. (a) "Declarant", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-3.

(b) "Declarant", for purposes of IC 16-36-6, has the meaning set forth in IC 16-36-6-2.

(c) "Declarant", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-4.

SECTION 10. IC 16-18-2-92.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 92.5. "Declaration", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-5.**

SECTION 11. IC 16-18-2-105.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 105.8. "Electronic", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-6.**

SECTION 12. IC 16-18-2-106.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 106.2. "Electronic record", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-7.**

SECTION 13. IC 16-18-2-106.3, AS ADDED BY P.L.204-2005, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 106.3. **(a) "Electronic signature", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-8.**

(b) For purposes of IC 16-42-3 and IC 16-42-22, "electronic

signature" means an electronic sound, symbol, or process:

(1) attached to or logically associated with an electronically transmitted prescription or order; and

(2) executed or adopted by a person;

with the intent to sign the electronically transmitted prescription or order.

SECTION 14. IC 16-18-2-160 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 160. **(a)** "Health care", for purposes of IC 16-36-1, has the meaning set forth in IC 16-36-1-1.

(b) "Health care", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-9.

SECTION 15. IC 16-18-2-160.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 160.3. "Health care decision", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-10.**

SECTION 16. IC 16-18-2-161, AS AMENDED BY P.L.113-2015, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 161. (a) "Health care facility" includes:

(1) hospitals licensed under IC 16-21-2, private mental health institutions licensed under IC 12-25, and tuberculosis hospitals established under IC 16-11-1 (before its repeal);

(2) health facilities licensed under IC 16-28; and

(3) rehabilitation facilities and kidney disease treatment centers.

(b) "Health care facility", for purposes of IC 16-21-11 and IC 16-34-3, has the meaning set forth in IC 16-21-11-1.

(c) "Health care facility", for purposes of IC 16-28-13, has the meaning set forth in IC 16-28-13-0.5.

(d) "Health care facility", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-11.

SECTION 17. IC 16-18-2-163, AS AMENDED BY P.L.112-2020, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 163. (a) Except as provided in subsection (c), "health care provider", for purposes of IC 16-21 and IC 16-41, means any of the following:

(1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or legally authorized by this state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), a dentist, a registered or licensed practical nurse, a midwife, an optometrist, a pharmacist, a podiatrist, a chiropractor, a physical therapist, a respiratory care practitioner, an occupational therapist,

a psychologist, a paramedic, an emergency medical technician, an advanced emergency medical technician, an athletic trainer, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.

(2) A college, university, or junior college that provides health care to a student, a faculty member, or an employee, and the governing board or a person who is an officer, employee, or agent of the college, university, or junior college acting in the course and scope of the person's employment.

(3) A blood bank, community mental health center, community intellectual disability center, community health center, or migrant health center.

(4) A home health agency (as defined in IC 16-27-1-2).

(5) A health maintenance organization (as defined in IC 27-13-1-19).

(6) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).

(7) A corporation, partnership, or professional corporation not otherwise qualified under this subsection that:

(A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;

(B) is organized or registered under state law; and

(C) is determined to be eligible for coverage as a health care provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function.

Coverage for a health care provider qualified under this subdivision is limited to the health care provider's health care functions and does not extend to other causes of action.

(b) "Health care provider", for purposes of IC 16-35, has the meaning set forth in subsection (a). However, for purposes of IC 16-35, the term also includes a health facility (as defined in section 167 of this chapter).

(c) "Health care provider", for purposes of IC 16-32-5, IC 16-36-5, IC 16-36-6, and IC 16-41-10 means an individual licensed or authorized by this state to provide health care or professional services as:

(1) a licensed physician;

(2) a registered nurse;

(3) a licensed practical nurse;

(4) an advanced practice registered nurse;

(5) a certified nurse midwife;
(6) a paramedic;
(7) an emergency medical technician;
(8) an advanced emergency medical technician;
(9) an emergency medical responder, as defined by section 109.8 of this chapter;
(10) a licensed dentist;
(11) a home health aide, as defined by section 174 of this chapter; or
(12) a licensed physician assistant.

The term includes an individual who is an employee or agent of a health care provider acting in the course and scope of the individual's employment.

(d) "Health care provider", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-12.

~~(d)~~ **(e)** "Health care provider", for purposes of section 1.5 of this chapter and IC 16-40-4, means any of the following:

(1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or authorized by the state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), an ambulatory outpatient surgical center, a dentist, an optometrist, a pharmacist, a podiatrist, a chiropractor, a psychologist, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.
(2) A blood bank, laboratory, community mental health center, community intellectual disability center, community health center, or migrant health center.
(3) A home health agency (as defined in IC 16-27-1-2).
(4) A health maintenance organization (as defined in IC 27-13-1-19).
(5) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).
(6) A corporation, partnership, or professional corporation not otherwise specified in this subsection that:
(A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;
(B) is organized or registered under state law; and
(C) is determined to be eligible for coverage as a health care

provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function.

(7) A person that is designated to maintain the records of a person described in subdivisions (1) through (6).

~~(e)~~ **(f)** "Health care provider", for purposes of IC 16-45-4, has the meaning set forth in 47 CFR 54.601(a).

SECTION 18. IC 16-18-2-163.4, AS ADDED BY P.L.137-2015, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 163.4. **(a)** "Health care representative", for purposes of IC 16-21-12, has the meaning set forth in IC 16-21-12-4.

(b) "Health care representative", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-13.

SECTION 19. IC 16-18-2-167.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 167.5. "Health information", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-14.**

SECTION 20. IC 16-18-2-186.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 186.5. "Incapacity" and "incapacitated", for purposes of IC 16-36-7, have the meaning set forth in IC 16-36-7-15.**

SECTION 21. IC 16-18-2-190 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 190. **(a) "Informed consent", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-16.**

(b) "Informed consent", for purposes of IC 16-41-6, has the meaning set forth in IC 16-41-6-2.

SECTION 22. IC 16-18-2-203, AS AMENDED BY P.L.164-2013, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 203. (a) "Life prolonging procedure", for purposes of ~~IC 16-36-4, has the meaning set forth in IC 16-36-4-1.~~

~~(b) "Life prolonging procedure", for purposes of IC 16-36-6, has the meaning set forth in IC 16-36-6-3.~~ **IC 16-36, means 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.

(b) The term does not include the performance or provision of any medical procedure or medication necessary to provide comfort care or to alleviate pain.

SECTION 23. IC 16-18-2-253.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2021]: **Sec. 253.8. "Notarial officer", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-17.**

SECTION 24. IC 16-18-2-254.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 254.3. "Observe", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-18.**

SECTION 25. IC 16-18-2-293.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 293.3. "Presence", "present", or "to be present", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-19.**

SECTION 26. IC 16-18-2-296.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 296.2. "Proxy", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-20.**

SECTION 27. IC 16-18-2-308.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 308.2. "Reasonably available", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-21.**

SECTION 28. IC 16-18-2-331.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 331.4. "Sign", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-22.**

SECTION 29. IC 16-18-2-331.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 331.5. "Signature", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-23.**

SECTION 30. IC 16-18-2-348.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 348.7. "Telephonic interaction", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-24.**

SECTION 31. IC 16-18-2-354.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 354.8. "Treating physician", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-25.**

SECTION 32. IC 16-18-2-378.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 378.5. "Written" and "writing", for purposes of IC 16-36-7, have the meaning set forth in IC 16-36-7-26.**

SECTION 33. IC 16-21-12-4, AS ADDED BY P.L.137-2015, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 4. As used in this chapter, "health care representative" means an individual:

(1) appointed as the patient's health care representative under IC 16-36-1-7;

(2) appointed as the patient's health care representative under IC 16-36-7; or ~~an individual~~

(3) holding the patient's health care power of attorney under IC 30-5-5-16.

However, if the patient has not appointed a health care representative under IC 16-36-1-7 **or IC 16-36-7** or granted a health care power of attorney to an individual under IC 30-5-5-16, the term means an individual authorized to consent to health care for the patient under ~~IC 16-36-1-5.~~ **IC 16-36-7-42.**

SECTION 34. IC 16-21-12-15, AS ADDED BY P.L.137-2015, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 15. (a) This chapter may not be construed to interfere with the rights of a health care representative appointed under IC 16-36-1 **or a health care representative appointed under IC 16-36-7.**

(b) This chapter may not be construed to create a private right of action against a hospital, a hospital employee, or an individual with whom a hospital has a contractual relationship.

(c) No cause of action of any type arises against a hospital, a hospital employee, a staff member, or an individual with whom a hospital has a contractual relationship based upon an act or omission of a lay caregiver.

SECTION 35. IC 16-36-1-3, AS AMENDED BY P.L.139-2019, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 3. (a) Except as provided in subsections (b) through (d), unless incapable of consenting under section 4 of this chapter, an individual may consent to the individual's own health care if the individual is:

(1) an adult; or

(2) a minor and:

(A) is emancipated;

(B) is:

(i) at least fourteen (14) years of age;

(ii) not dependent on a parent **or guardian** for support;

(iii) living apart from the minor's parents or from an individual in loco parentis; and

(iv) managing the minor's own affairs;
(C) is or has been married;
(D) is in the military service of the United States;
(E) meets the requirements of section 3.5 of this chapter; or
(F) is authorized to consent to the health care by any other statute.

(b) A person at least seventeen (17) years of age is eligible to donate blood in a voluntary and noncompensatory blood program without obtaining ~~parental~~ permission **from a parent or guardian.**

(c) A person who is sixteen (16) years of age is eligible to donate blood in a voluntary and noncompensatory blood program if the person has obtained written permission from the person's parent **or guardian.**

(d) An individual who has, suspects that the individual has, or has been exposed to a venereal disease is competent to give consent for medical or hospital care or treatment of the individual.

SECTION 36. IC 16-36-1-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 4. (a) An individual described in section 3 of this chapter may consent to health care unless, in the good faith opinion of the attending physician, the individual is incapable of making a decision regarding the proposed health care.

(b) A consent to health care under section 5, 6, or 7 of this chapter is not valid if:
(1) the health care provider has knowledge that the individual has indicated contrary instructions in regard to the proposed health care; ~~even if the individual is believed to be incapable of making a decision regarding the proposed health care at the time the individual indicates contrary instructions.~~ **and**
(2) the individual has not been determined to be incapable of consenting to health care by:
(A) an order of a probate court under section 8 of this chapter; or
(B) the individual's attending physician under subsection (a).

SECTION 37. IC 16-36-1-7, AS AMENDED BY P.L.81-2015, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 7. (a) An individual who may consent to health care under section 3 of this chapter may appoint another representative to act for the appointor in matters affecting the appointor's health care.

(b) An appointment and any amendment must meet the following conditions:
(1) Be in writing.
(2) Be signed by the appointor or by a designee in the appointor's

presence **before January 1, 2023.**

(3) Be witnessed by an adult other than the representative.

(c) The appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.

(d) The authority granted becomes effective according to the terms of the appointment.

(e) The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the appointor regains the capacity to consent.

(f) Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the appointor, except when the appointor is capable of consenting.

(g) In making all decisions regarding the appointor's health care, a representative appointed under this section shall act as follows:

(1) In the best interest of the appointor consistent with the purpose expressed in the appointment.

(2) In good faith.

(h) A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:

(1) The appointor.

(2) The appointor's legal representative if one is known.

(3) The health care provider if the representative knows there is one.

(i) An individual who is capable of consenting to health care may revoke:

(1) the appointment at any time by notifying the representative orally or in writing; or

(2) the authority granted to the representative by notifying the health care provider orally or in writing.

SECTION 38. IC 16-36-1.5-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 5. (a) This section applies to a patient who:

(1) receives mental health services; and

(2) is mentally incompetent.

(b) A patient described in subsection (a) shall provide consent for mental health treatment through the informed consent of one (1) of the following:

(1) The patient's legal guardian or other court appointed

representative.

(2) The patient's health care representative under IC 16-36-1.

(3) An attorney in fact for health care appointed under IC 30-5-5-16.

(4) The patient's health care representative acting in accordance with the patient's psychiatric advance directive as expressed in a psychiatric advance directive executed under IC 16-36-1.7.

(5) The patient's health care representative conferred under IC 16-36-7.

SECTION 39. IC 16-36-4-1 IS REPEALED [EFFECTIVE JULY 1, 2021]. ~~Sec. 1. (a) As used in this chapter, "life prolonging procedure" means 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.~~

~~(b) The term does not include the performance or provision of any medical procedure or medication necessary to provide comfort care or to alleviate pain.~~

SECTION 40. IC 16-36-4-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 10. The following is the living will declaration form:

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~~ **initialing** 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 **appointed** under ~~IC 30-5-5.~~ **IC 30-5-5-16.**

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 ___________

SECTION 41. IC 16-36-5-1.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 1.1. As used in this chapter, "attending" means the physician, advanced practice registered nurse, or physician assistant who has the primary responsibility for the treatment and care of the patient.**

SECTION 42. IC 16-36-5-4.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 4.3. As used in this chapter, and with respect to a declarant, witness, or other person who signs or participates in the signing of an out of hospital DNR declaration under this chapter, "in the presence of" has the meaning set forth in section 7.7 of this chapter.**

SECTION 43. IC 16-36-5-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 4.5. As used in this chapter, and with respect to a declarant and witness, "observe" means to**

perceive another's actions or expression of intent through the senses of eyesight, hearing, or both. The term includes perceptions perceived through the use of technology or learned skills to:

(1) assist a person's capability for eyesight, hearing, or both; or

(2) compensate for an impairment of a person's capability for eyesight, hearing, or both.

SECTION 44. IC 16-36-5-7.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 7.7 As used in this chapter, and with respect to a declarant, witness, or other person who signs or participates in the signing of an out of hospital DNR declaration under this chapter, "presence" means a process of signing and witnessing a DNR declaration in which:**

(1) the declarant and witness are:

(A) directly present with each other in the same physical space;

(B) able to interact with each other in real time through use of any audiovisual communications technology now known or later developed; or

(C) are able to speak to and hear each other in real time through telephonic interaction;

(2) the:

(A) identity of the declarant is personally known to all witnesses;

(B) witnesses are able to view a government issued, photographic identification of the declarant; or

(C) witnesses are able to ask any question of the declarant that:

(i) authenticates the identity of the declarant; and

(ii) establishes the capacity and sound mind of the declarant to the satisfaction of the witnesses; and

(3) each witness is able to interact with the declarant and each other when observing or hearing in real time, as applicable:

(A) the declarant's expression of intent to execute an out of hospital DNR declaration under this chapter;

(B) the declarant's actions in executing or directing the execution of the out of hospital DNR declaration under this chapter; and

(C) the actions of the declarant and all other witnesses when signing the out of hospital DNR declaration.

The term includes the use of technology or learned skills for the

purpose of assisting with hearing, eyesight, and speech or for the purpose of compensating for a hearing, eyesight, or speech impairment.

SECTION 45. IC 16-36-5-7.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 7.9. As used in this chapter, and with respect to a declarant, witness, or other person who signs or participates in the signing of an out of hospital DNR declaration under this chapter, "present" has the meaning set forth in section 7.7 of this chapter.**

SECTION 46. IC 16-36-5-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 9. As used in this chapter, "representative" means a person's:

(1) legal guardian or other court appointed representative responsible for making health care decisions for the person;

(2) health care representative **appointed** under ~~IC 16-36-1; or~~ **IC 16-36-1-7;**

(3) health care representative appointed under IC 16-36-7; or

~~(3)~~ **(4)** attorney in fact for health care appointed under IC 30-5-5-16.

SECTION 47. IC 16-36-5-9.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 9.5 As used in this chapter, "telephonic interaction" means interaction through the use of any technology, now known or later developed, that enables two (2) or more people to speak to and hear each other in real time even if one (1) or more of the persons cannot see each other.**

SECTION 48. IC 16-36-5-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 10. An attending physician, **advanced practice registered nurse, or physician assistant** may certify that a patient is a qualified person if the attending physician, **advanced practice registered nurse, or physician assistant** determines, in accordance with reasonable medical standards, that one (1) of the following conditions is met:

(1) The person has a terminal condition (as defined in IC 16-36-4-5).

(2) The person has a medical condition such that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

SECTION 49. IC 16-36-5-11 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 11. (a) A person who is of sound mind and at least eighteen (18) years of age may execute an out of hospital DNR declaration.

(b) A person's representative may execute an out of hospital DNR declaration for the person under this chapter only if the person is:

(1) at least eighteen (18) years of age; and

(2) incompetent.

(c) An out of hospital DNR declaration must meet the following conditions:

(1) Be voluntary.

(2) Be in writing.

(3) Be signed by the person making the declaration or by another person in the declarant's presence and at the declarant's express direction.

(4) Be dated.

(5) Be signed in the presence of at least two (2) competent witnesses.

(d) If the requirements concerning presence are met, a competent declarant and all necessary witnesses may complete and sign an out of hospital DNR declaration in two (2) or more tangible, paper counterparts with the declarant's signature placed on one (1) original counterpart and the signatures of the witnesses placed on one (1) or more different tangible, paper counterparts if the text of the out of hospital DNR declaration states that the declaration is being signed in separate counterparts. If an out of hospital DNR declaration is signed in counterparts under this subsection, one (1) or more of the following persons must combine each of the separately signed tangible, paper counterparts into a single composite document that contains all of the text of the declarant, the signature of the declarant, and the signature of each witness:

(1) The declarant.

(2) A health care representative who has been appointed by the declarant.

(3) A person who supervised the signing of the out of hospital DNR declaration in the person's presence.

(4) Any other person who was present during the signing of the out of hospital DNR declaration.

The person who combines the separately signed counterparts into a single composite document must do so not later than ten (10) business days after the person receives all of the separately signed tangible, paper counterparts. Any scanned, photocopied, or other

accurate copy of the single, composite document shall be treated as validly signed under this subsection if the single, composite document contains the complete text of the out of hospital DNR declaration and all required signatures.

(e) If physical impairment, physical isolation, or other factors make it impossible or impractical for a declarant to use audiovisual technology to interact with witnesses or to otherwise comply with the requirements concerning presence as defined in section 7.7 of this chapter, the declarant and the witnesses may use telephonic interaction to witness and sign an out of hospital DNR declaration. A potential witness may not, however, be compelled to only use telephonic interaction when participating in the signing or witnessing of an out of hospital DNR declaration under this subsection. If an out of hospital DNR declaration is signed using telephonic interaction under this subsection:

(1) the:

(A) identity of the declarant must be personally known to the witness;

(B) witness must be able to view a government issued, photographic identification of the declarant; or

(C) witness must be able to ask any question of the declarant that:

(i) authenticates the identity of the declarant; and

(ii) establishes the capacity and sound mind of the declarant to the satisfaction of the witness;

(2) the text of the declaration must specify that the declarant and witnesses used telephonic interaction throughout the witnessing and signing process of the out of hospital DNR declaration; and

(3) the out of hospital DNR declaration is presumed valid if it specifies that the declarant and the witnesses witnessed and signed the declaration in compliance with Indiana law.

A health care provider or person who disputes the validity of an out of hospital DNR declaration described under this subsection has the burden of proving the invalidity of the declaration or noncompliance with this subsection, as applicable, by a preponderance of the evidence.

~~(d)~~ **(f)** An out of hospital DNR declaration must be issued on the form specified in section 15 of this chapter.

SECTION 50. IC 16-36-5-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 12. An out of hospital DNR order:

(1) may be issued only by the declarant's attending physician, **advanced practice registered nurse, or physician assistant;** and

(2) may be issued only if both of the following apply:

(A) The attending physician, **advanced practice registered nurse, or physician assistant** has determined the patient is a qualified person.

(B) The patient has executed an out of hospital DNR declaration under section 11 of this chapter.

SECTION 51. IC 16-36-5-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 13. (a) An attending physician, **advanced practice registered nurse, or physician assistant** who does not issue an out of hospital DNR order for a patient who is a qualified person may transfer the patient to another physician, who may issue an out of hospital DNR order, unless:

(1) the attending physician, **advanced practice registered nurse, or physician assistant** has reason to believe the patient's declaration was not validly executed, or there is evidence the patient no longer intends the declaration to be enforced; and

(2) the patient is unable to validate the declaration.

(b) Notwithstanding section 10 of this chapter, if an attending physician, **advanced practice registered nurse, or physician assistant,** after reasonable investigation, does not find any other physician willing to honor the patient's out of hospital DNR declaration and issue an out of hospital DNR order, the attending physician, **advanced practice registered nurse, or physician assistant** may refuse to issue an out of hospital DNR order.

(c) If the attending physician, **advanced practice registered nurse, or physician assistant** does not transfer a patient under subsection (a), the attending physician, **advanced practice registered nurse, or physician assistant** may attempt to ascertain the patient's intent and attempt to determine the validity of the declaration by consulting with any of the following individuals who are reasonably available, willing, and competent to act:

(1) A court appointed guardian of the patient, if one has been appointed. This subdivision does not require the appointment of a guardian so that a treatment decision may be made under this section.

(2) A person designated by the patient in writing to make a treatment decision.

(3) The patient's spouse.

(4) An adult child of the patient or a majority of any adult

children of the patient who are reasonably available for consultation.

(5) An adult sibling of the patient or a majority of any adult siblings of the patient who are reasonably available for consultation.

(6) The patient's clergy.

(7) Another person who has firsthand knowledge of the patient's intent.

(d) The individuals described in subsection (c)(1) through (c)(7) shall act in the best interest of the patient and shall follow the patient's express or implied intent, if known.

(e) The attending physician, **advanced practice registered nurse, or physician assistant** acting under subsection (c) shall list the names of the individuals described in subsection (c) who were consulted and include the information received in the patient's medical file.

(f) If the attending physician, **advanced practice registered nurse, or physician assistant** determines from the information received under subsection (c) that the patient intended to execute a valid out of hospital DNR declaration, the attending physician, **advanced practice registered nurse, or physician assistant** may:

(1) issue an out of hospital DNR order, with the concurrence of at least one (1) physician documented in the patient's medical file; or

(2) request a court to appoint a guardian for the patient to make the consent decision on behalf of the patient.

(g) An out of hospital DNR order must be issued on the form specified in section 15 of this chapter.

SECTION 52. IC 16-36-5-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 15. An out of hospital DNR declaration and order must be in substantially the following form:

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this ____ day of __________. I, _____________, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below. I declare:

My attending physician, **advanced practice registered nurse, or physician assistant** has certified that I am a qualified person, meaning

that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital or a health facility, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this out of hospital DNR declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

This declaration was signed by me and by the witnesses in compliance with Indiana law and by: [Initial or check only one (1) of the following spaces]

__ Signing on paper or electronically in each other's direct physical presence.

__ Signing in separate counterparts on paper using two (2) way, real time audiovisual technology.

__ Signing electronically using two (2) way, real time audiovisual technology or telephonic interaction.

__ Signing in separate counterparts on paper using telephonic interaction between the me (declarant) and all witnesses.

I understand the full import of this declaration.

Signed___________________________________

Printed name______________________________

____

City and State of Residence___________________

The declarant is personally known to me, and I believe the declarant 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_____________Printed name____________Date___________

Witness_____________Printed name____________Date___________

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I,____________________, the attending physician, **advanced practice registered nurse, or physician assistant** of __________________, have certified the declarant as a qualified person

to make an out of hospital DNR declaration, and I order health care providers having actual notice of this out of hospital DNR declaration and order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the out of hospital DNR declaration is revoked.

Signed ____________________Date__________
Printed name______________________________
Medical license number _____________________

SECTION 53. IC 16-36-5-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 16. Copies of the out of hospital DNR declaration and order must be kept:

(1) by the declarant's attending physician, **advanced practice registered nurse, or physician assistant** in the declarant's medical file; and
(2) by the declarant or the declarant's representative.

SECTION 54. IC 16-36-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 17. (a) The emergency medical services commission shall develop an out of hospital DNR identification device that must be:

(1) a necklace or bracelet; and
(2) inscribed with:
(A) the declarant's name;
(B) the declarant's date of birth; and
(C) the words "Do Not Resuscitate".

(b) An out of hospital DNR identification device may be created for a declarant only after an out of hospital DNR declaration and order has been executed by a declarant and an attending physician, **advanced practice registered nurse, or physician assistant.**

(c) The device developed under subsection (a) is not a substitute for the out of hospital DNR declaration and order.

SECTION 55. IC 16-36-5-18 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 18. (a) A declarant may at any time revoke an out of hospital DNR declaration and order by any of the following:

(1) A signed, dated writing.
(2) Physical cancellation or destruction of the declaration and order by the declarant or another in the declarant's presence and at the declarant's direction.
(3) An oral expression by the declarant of intent to revoke.

(b) A declarant's representative may revoke an out of hospital DNR declaration and order under this chapter only if the declarant is incompetent.

(c) A revocation is effective upon communication to a health care provider.

(d) A health care provider to whom the revocation of an out of hospital DNR declaration and order is communicated shall immediately notify the declarant's attending physician, **advanced practice registered nurse, or physician assistant,** if known, of the revocation.

(e) An attending physician, **advanced practice registered nurse, or physician assistant** notified of the revocation of an out of hospital DNR declaration and order shall immediately:

(1) add the revocation to the declarant's medical file, noting the time, date, and place of revocation, if known, and the time, date, and place that the physician, **advanced practice registered nurse, or physician assistant** was notified;

(2) cancel the out of hospital DNR declaration and order by entering the word "VOID" on each page of the out of hospital DNR declaration and order in the declarant's medical file; and

(3) notify any health care facility staff responsible for the declarant's care of the revocation.

SECTION 56. IC 16-36-5-19 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 19. (a) A health care provider shall withhold or discontinue CPR to a patient in an out of hospital location if the health care provider has actual knowledge of:

(1) an original or a copy of a signed out of hospital DNR declaration and order executed by the patient; or

(2) an out of hospital DNR identification device worn by the patient or in the patient's possession.

(b) A health care provider shall disregard an out of hospital DNR declaration and order and perform CPR if:

(1) the declarant is conscious and states a desire for resuscitative measures;

(2) the health care provider believes in good faith that the out of hospital DNR declaration and order has been revoked;

(3) the health care provider is ordered by the attending physician, **advanced practice registered nurse, or physician assistant** to disregard the out of hospital DNR declaration and order; or

(4) the health care provider believes in good faith that the out of hospital DNR declaration and order must be disregarded to avoid verbal or physical confrontation at the scene.

(c) A health care provider transporting a declarant shall document on the transport form:

(1) the presence of an out of hospital DNR declaration and order;

(2) the attending physician's, **advanced practice registered**

nurse's, or physician assistant's name; and

(3) the date the out of hospital DNR declaration and order was signed.

(d) An out of hospital DNR identification device must accompany a declarant whenever the declarant is transported.

SECTION 57. IC 16-36-5-22 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 22. (a) A person may challenge the validity of an out of hospital DNR declaration and order by filing a petition for review in a court in the county in which the declarant resides.

(b) A petition filed under subsection (a) must include the name and address of the declarant's attending physician, **advanced practice registered nurse, or physician assistant.**

(c) A court in which a petition is filed under subsection (a) may declare an out of hospital DNR declaration and order void if the court finds that the out of hospital DNR declaration and order was executed:

(1) when the declarant was incapacitated due to insanity, mental illness, mental deficiency, duress, undue influence, fraud, excessive use of drugs, confinement, or other disability;

(2) contrary to the declarant's wishes; or

(3) when the declarant was not a qualified person.

(d) If a court finds that the out of hospital DNR declaration and order is void, the court shall cause notice of the finding to be sent to the declarant's attending physician, **advanced practice registered nurse, or physician assistant.**

(e) Upon notice under subsection (d), the declarant's attending physician, **advanced practice registered nurse, or physician assistant** shall follow the procedures under section 18(e) of this chapter.

SECTION 58. IC 16-36-5-26 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 26. The act of withholding or withdrawing CPR, when done under:

(1) an out of hospital DNR declaration and order issued under this chapter;

(2) a court order or decision of a court appointed guardian; or

(3) a good faith medical decision by the attending physician, **advanced practice registered nurse, or physician assistant** that the patient has a terminal illness;

is not an intervening force and does not affect the chain of proximate cause between the conduct of a person that placed the patient in a terminal condition and the patient's death.

SECTION 59. IC 16-36-6-3 IS REPEALED [EFFECTIVE JULY 1,

2021]. ~~Sec. 3. (a) As used in this chapter, "life prolonging procedure" means 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.~~

~~(b) The term does not include the performance or provision of any medical procedure or medication necessary to provide comfort care or to alleviate pain.~~

SECTION 60. IC 16-36-6-7, AS AMENDED BY P.L.139-2019, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 7. (a) The following individuals may complete a POST form:

(1) A qualified person who is:

(A) either:

(i) at least eighteen (18) years of age; or

(ii) less than eighteen (18) years of age but authorized to consent under IC 16-36-1-3(a)(2) (except under IC 16-36-1-3(a)(2)(E)); and

(B) of sound mind.

(2) A qualified person's representative, if the qualified person:

(A) is less than eighteen (18) years of age and is not authorized to consent under IC 16-36-1-3(a)(2); or

(B) has been determined to be incapable of making decisions about the qualified person's health care by a treating physician, advanced practice registered nurse, or physician assistant acting in good faith and the representative has been:

(i) appointed by the individual under IC 16-36-1-7 to serve as the individual's health care representative;

(ii) authorized to act under IC 30-5-5-16 and IC 30-5-5-17 as the individual's attorney in fact with authority to consent to or refuse health care for the individual;

(iii) appointed by a court as the individual's health care representative under IC 16-36-1-8; ~~or~~

(iv) appointed by a court as the guardian of the person with the authority to make health care decisions under IC 29-3; **or**

(v) appointed by the individual under IC 16-36-7 to serve as the individual's health care representative.

(b) In order to complete a POST form, a person described in subsection (a) and the qualified person's treating physician, advanced practice registered nurse, or physician assistant or the physician's,

advanced practice registered nurse's, or physician assistant's designee must do the following:

(1) Discuss the qualified person's goals and treatment options available to the qualified person based on the qualified person's health.

(2) Complete the POST form, to the extent possible, based on the qualified person's preferences determined during the discussion in subdivision (1).

(c) When completing a POST form on behalf of a qualified person, a representative shall act:

(1) in good faith; and

(2) in:

(A) accordance with the qualified person's express or implied intentions, if known; or

(B) the best interest of the qualified person, if the qualified person's express or implied intentions are not known.

(d) A copy of the executed POST form shall be maintained in the qualified person's medical file.

SECTION 61. IC 16-36-6-9, AS AMENDED BY P.L.10-2019, SECTION 74, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 9. (a) The state department shall develop a standardized POST form and distribute the POST form.

(b) The POST form developed under this section must include the following:

(1) A medical order specifying whether cardiopulmonary resuscitation (CPR) should be performed if the qualified person is in cardiopulmonary arrest.

(2) A medical order concerning the level of medical intervention that should be provided to the qualified person, including the following:

(A) Comfort measures.

(B) Limited additional interventions.

(C) Full intervention.

(3) A medical order specifying whether antibiotics should be provided to the qualified person.

(4) A medical order specifying whether artificially administered nutrition should be provided to the qualified person.

(5) A signature line for the treating physician, advanced practice registered nurse, or physician assistant, including the following information:

(A) The physician's, advanced practice registered nurse's, or physician assistant's printed name.

(B) The physician's, advanced practice registered nurse's, or physician assistant's telephone number.

(C) The physician's medical license number, advanced practice registered nurse's nursing license number, or physician assistant's state license number.

(D) The date of the physician's, advanced practice registered nurse's, or physician assistant's signature.

As used in this subdivision, "signature" includes an electronic or physician, advanced practice registered nurse, or physician assistant controlled stamp signature.

(6) A signature line for the qualified person or representative, including the following information:

(A) The qualified person's or representative's printed name.

(B) The relationship of the representative signing the POST form to the qualified person covered by the POST form.

(C) The date of the signature.

As used in this subdivision, "signature" includes an electronic signature.

(7) A section presenting the option to allow a declarant to appoint a representative (as defined in IC 16-36-1-2) under IC 16-36-1-7 **or IC 16-36-7** to serve as the declarant's health care representative.

(c) The state department shall place the POST form on its Internet web site.

(d) The state department is not liable for any use or misuse of the POST form.

SECTION 62. IC 16-36-6-20, AS AMENDED BY P.L.2-2014, SECTION 78, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 20. The execution or revocation of a POST form by or for a qualified person does not revoke or impair the validity of any of the following:

(1) A power of attorney that is executed by a qualified person when the qualified person is competent.

(2) Health care powers that are granted to an attorney in fact under IC 30-5-5-16 or IC 30-5-5-17.

(3) An appointment of a health care representative that is executed by a qualified person, except to the extent that the POST form contains a superseding appointment of a new health care representative under section 9(b)(7) of this chapter.

(4) The authority of a health care representative under ~~IC 16-36-1~~ **IC 16-36-1-7 or IC 16-36-7** to consent to health care on behalf of the qualified person.

(5) The authority of an attorney in fact holding health care powers under IC 30-5-5-16 or IC 30-5-5-17 to issue and enforce instructions under IC 30-5-7 concerning the qualified person's health care.

SECTION 63. IC 16-36-7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

Chapter 7. Health Care Advance Directives

Sec. 1. (a) A death as a result of the withholding or withdrawal of life prolonging procedures in accordance with:

(1) a declarant's advance directive; or

(2) any provision of this chapter;

does not constitute a suicide.

(b) This chapter does not authorize euthanasia or any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

(c) This chapter does not establish the only legal means that an individual may use to:

(1) communicate or confirm the individual's desires or preferences to receive or refuse life prolonging treatment or other health care; or

(2) give one (1) or more other persons authority to consent to health care or make health care decisions on the individual's behalf.

(d) This chapter does not affect the consent provisions set forth in:

(1) IC 16-34; or

(2) IC 16-36-1-3.5.

(e) This chapter does not modify any requirements or procedures under IC 33-42 concerning the performance of valid notarial acts.

(f) Nothing in this chapter prohibits a health care provider from relying on a document that:

(1) is signed by an adult who has not been determined to be incapacitated; and

(2) in the context of the relevant circumstances, clearly communicates the individual's intention to give one (1) or more specified persons authority to consent to health care or make health care decisions on the individual's behalf.

Sec. 2. As used in this chapter, "advance directive" means a written declaration of a declarant who:

(1) gives instructions or expresses preferences or desires

concerning any aspect of the declarant's health care or health information, including the designation of a health care representative, a living will declaration made under IC 16-36-4-10, or an anatomical gift made under IC 29-2-16.1; and

(2) complies with the requirements of this chapter.

Sec. 3. As used in this chapter, "best interests" means the promotion of the individual's welfare, based on consideration of material factors, including relief of suffering, preservation or restoration of function, and quality of life.

Sec. 4. As used in this chapter, "declarant" means a competent adult who has executed an advance directive.

Sec. 5. As used in this chapter, "declaration" means a written document, voluntarily executed by a declarant for the declarant under section 28 of this chapter.

Sec. 6. As used in this chapter, "electronic" has the meaning set forth in IC 26-2-8-102(7).

Sec. 7. As used in this chapter, "electronic record" has the meaning set forth in IC 26-2-8-102(9).

Sec. 8. As used in this chapter, "electronic signature" has the meaning set forth in IC 26-2-8-102(10).

Sec. 9. As used in this chapter, "health care" means any care, treatment, service, supplies, or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including preventive, therapeutic, rehabilitative, maintenance, or palliative care, and counseling.

Sec. 10. As used in this chapter, "health care decision" means the following:

(1) Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life prolonging procedures and mental health treatment, unless otherwise stated in the advance directive.

(2) The decision to apply for private, public, government, or veterans' benefits to defray the cost of health care.

(3) The right of access to health information of the declarant reasonably necessary for a health care representative or proxy to make decisions involving health care and to apply for benefits.

(4) The decision to make an anatomical gift under IC 29-2-16.1.

Sec. 11. As used in this chapter, "health care facility" includes the following:

(1) An ambulatory outpatient surgical center licensed under IC 16-21-2.
(2) A health facility licensed under IC 16-28-2 or IC 16-28-3.
(3) A home health agency licensed under IC 16-27-1.
(4) A hospice program licensed under IC 16-25-3.
(5) A hospital licensed under IC 16-21-2.
(6) A health maintenance organization (as defined in IC 27-13-1-19).

Sec. 12. As used in this chapter, "health care provider" means any person licensed, certified, or authorized by law to administer health care in the ordinary course of business or practice of a profession.

Sec. 13. As used in this chapter, "health care representative" means a competent adult designated by a declarant in an advance directive to:
(1) make health care decisions; and
(2) receive health information;
regarding the declarant. The term includes a person who receives and holds validly delegated authority from a designated health care representative.

Sec. 14. As used in this chapter, "health information" has the meaning set forth in 45 CFR 160.103.

Sec. 15. As used in this chapter, "incapacity" and "incapacitated" mean that an individual is unable to comprehend and weigh relevant information and to make and communicate a reasoned health care decision. For the purposes of making an anatomical gift, the terms include an individual who is deceased.

Sec. 16. As used in this chapter, "informed consent" means consent voluntarily given by an individual after a sufficient explanation and disclosure of the subject matter involved to enable that individual to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedure, and to make a knowing health care decision without coercion or undue influence.

Sec. 17. As used in this chapter, "notarial officer" means a person who is authorized under IC 33-42-9-7 to perform a notarial act (as defined in IC 33-42-0.5-18). The term includes a notary public.

Sec. 18. (a) As used in this chapter and with respect to interactions between a declarant and a witness, "observe" means to perceive another's actions or expressions of intent through the

senses of eyesight or hearing, or both. A person is able to observe another's actions or expressions of intent even if the person uses technology or learned skills to:

(1) assist the person's capabilities of eyesight or hearing, or both; or

(2) compensate for an impairment of the person's capabilities of eyesight or hearing, or both.

(b) As used in this chapter and with respect to interactions between a declarant and a notarial officer, "observe" means that the notarial officer is able to see and hear, in real time, the declarant's actions and expressions of intent either in the declarant's physical presence or through audiovisual communication as defined in IC 33-42-0.5-5.

Sec. 19. (a) As used in this chapter and with respect to interactions between a declarant and a witness who signs or participates in the signing of an advance directive or other document under this chapter, "presence", "present", and "to be present" means that throughout the process of signing and witnessing the advance directive or other document the following must occur:

(1) The declarant and the witness are:

(A) directly present with each other in the same physical space;

(B) able to interact with each other in real time through the use of any audiovisual technology now known or later developed; or

(C) able to speak to and hear each other in real time through telephonic interaction when:

(i) the identity of the declarant is personally known to the witness;

(ii) the witness is able to view a government issued, photographic identification of the declarant; or

(iii) the witness is able to ask any question of the declarant that authenticates the identity of the declarant and establishes the capacity and sound mind of the declarant to the satisfaction of the witness.

(2) The witnesses are able to positively identify the declarant by viewing a government issued, photographic identification of the declarant, or by receiving accurate answers from the declarant that authenticate the identity of the declarant and establish the capacity and sound mind of the declarant to the satisfaction of the witness.

(3) Each witness is able to interact with the declarant and each other witness, if any, by observing:
(A) the declarant's expression of intent to execute an advance directive or other document under this chapter;
(B) the declarant's actions in executing or directing the execution of the advance directive or other document under this chapter; and
(C) the actions of each other witness in signing the advance directive or other document.

The requirements of subdivisions (2) and (3) are satisfied even if the declarant and one (1) or all witnesses use technology to assist with one (1) or more of the capabilities of hearing, eyesight, or speech to compensate for impairments of any one (1) or more of those capabilities.

(b) As used in this chapter and with respect to interactions between a declarant and a notarial officer who signs or participates in the signing of an advance directive or other document under this chapter, "presence", "present", and "to be present" means that throughout the process of signing, acknowledging, and notarizing the advance directive or other document the following must occur:
(1) The declarant and the notarial officer are:
(A) directly present with each other in the same physical space; or
(B) able to interact with each other in real time through the use of any audiovisual technology, now known or later developed, whose use complies with IC 33-42.
(2) The notarial officer is able to positively identify the declarant by using an identity proofing method permitted under IC 33-42-0.5-16.
(3) Each witness or the notarial officer is able to interact with the declarant and each other witness, if any, by observing the declarant's:
(A) expression of intent to execute an advance directive or other document under this chapter; and
(B) actions in executing or directing the execution of the advance directive or other document under this chapter.

If the declarant appears before the notarial officer in a manner that satisfies the definitions of "appear" and "appearance" as defined in IC 33-42-0.5, then the declarant and the notarial officer satisfy the presence requirement described in this chapter. The requirements specified in subdivisions (2) and (3) are satisfied even

if the testator and the notarial officer use technology to assist with one (1) or more of the capabilities of hearing, eyesight, or speech to compensate for impairments of any one (1) or more of those capabilities.

Sec. 20. As used in this chapter, "proxy" means a competent adult who:

(1) has not been expressly designated in a declaration to make health care decisions for a particular incapacitated individual; and

(2) is authorized and willing to make health care decisions for the individual under section 42 of this chapter.

Sec. 21. As used in this chapter, "reasonably available" means a health care representative or proxy for an individual who is:

(1) readily able to be contacted without undue effort; and

(2) willing and able to act in a timely manner considering the urgency of that individual's health care needs or health decisions.

Sec. 22. As used in this chapter, "sign" includes the valid use of an electronic signature.

Sec. 23. As used in this chapter, "signature" means the authorized use of the name or mark of a declarant or other person to authenticate an electronic record or other writing. The term includes an electronic signature and an electronic notarial certificate completed by a notarial officer.

Sec. 24. As used in this chapter, "telephonic interaction" means interaction through the use of any technology, now known or later developed, that enables two (2) or more persons to speak to and hear each other in real time, even if one (1) or more persons cannot see each other.

Sec. 25. As used in this chapter, "treating physician" means a licensed physician who is overseeing, directing, or performing health care to an individual at the pertinent time.

Sec. 26. As used in this chapter, "written" and "writing" include the use of any method to inscribe information in or on a tangible medium or to store the information in an electronic or other medium that can retrieve, view, and print the information in perceivable form.

Sec. 27. (a) Except when an individual has been determined to be incapacitated under section 35 of this chapter, an individual may consent to the individual's own health care if the individual is:

(1) an adult; or

(2) a minor, and:

(A) is emancipated;
(B) is:
(i) at least fourteen (14) years of age;
(ii) not dependent on a parent or guardian for support;
(iii) living apart from the minor's parents or from an individual in loco parentis; and
(iv) managing the minor's own affairs;
(C) is or has been married;
(D) is in the military service of the United States; or
(E) is authorized to consent to health care by another statute.

(b) A person at least seventeen (17) years of age is eligible to donate blood in a voluntary and noncompensatory blood program without obtaining permission from a parent or guardian.

(c) A person who is sixteen (16) years of age is eligible to donate blood in a voluntary and noncompensatory blood program if the person has obtained written permission from the person's parent.

(d) An individual who has, could be expected to have exposure to, or has been exposed to a venereal disease is competent to give consent for medical or hospital care or treatment, including preventive treatment, of the individual.

(e) If:
(1) an individual:
(A) has a signed advance directive that is in effect; and
(B) has not been determined to be incapacitated under section 35 of this chapter; and
(2) the individual's decisions and the health care representative's decisions present a material conflict;
the health care decisions by that individual take precedence over decisions made by a health care representative designated in that individual's advance directive.

(f) Nothing in this chapter prohibits or restricts a health care provider's right to follow or rely on a health care decision or the designation of a health care representative on a permanent or temporary basis that is:
(1) made by a competent individual described in subsection (a);
(2) communicated orally by the individual to a health care provider in the direct physical presence of the individual; and
(3) reduced to or confirmed in writing by the health care provider on a reasonably contemporaneous basis and made a part of the health care provider's medical records for the

individual.

(g) If:

(1) an individual later signs an advance directive under section 28 of this chapter; and

(2) the advance directive conflicts with the recorded earlier oral instructions of the individual with respect to health care decisions or the designation of a health care representative;

the advance directive controls.

Sec. 28. (a) An advance directive signed by or for a declarant under this section may accomplish or communicate one (1) or more of the following:

(1) Designate one (1) or more competent adult individuals or other persons as a health care representative to make health care decisions for the declarant or receive health information on behalf of the declarant, or both.

(2) State specific health care decisions by the declarant.

(3) State the declarant's preferences or desires regarding the provision, continuation, termination, or refusal of life prolonging procedures, palliative care, comfort care, or assistance with activities of daily living.

(4) Specifically disqualify one (1) or more named individuals from:

(A) being appointed as a health care representative for the declarant;

(B) acting as a proxy for the declarant under section 42 of this chapter; or

(C) receiving and exercising delegated authority from the declarant's health care representative.

(b) An advance directive under this section must be signed by or for the declarant using one (1) of the following methods:

(1) Signed by the declarant in the presence of two (2) adult witnesses or in the presence of a notarial officer.

(2) Signing of the declarant's name by another adult individual at the specific direction of the declarant, in the declarant's presence, and in the presence of the two (2) adult witnesses or a notarial officer. However, an individual who signs the declarant's name on the advance directive may not be a witness, the notarial officer, or a health care representative designated in the advance directive.

(c) An advance directive signed under this section must be witnessed or acknowledged in one (1) of the following ways:

(1) Signed in the declarant's direct physical presence by two

(2) adult witnesses, at least one (1) of whom may not be the spouse or other relative of the declarant.

(2) Signed or acknowledged by the declarant in the presence of a notarial officer, who completes and signs a notarial certificate under IC 33-42-9-12 and makes it a part of the advance directive.

If the advance directive complies with either subdivision (1) or (2), but contains additional witness signatures or a notarial certificate that is not needed, the advance directive is still validly witnessed and acknowledged. A remote online notarization or electronic notarization of an advance directive that complies with IC 33-42-17 complies with subdivision (2).

(d) A competent declarant and the witnesses or a notarial officer may complete and sign an advance directive in two (2) or more counterparts in tangible paper form, with the declarant's signature placed on one (1) original counterpart and with the signatures of the witnesses, if any, or the notarial officer's signature and certificate on one (1) or more different counterparts in tangible paper form, so long as the declarant and the witnesses or notarial officer comply with the presence requirement as described in section 19 of this chapter, and so long as the text of the advance directive states that it is being signed in separate paper counterparts. If an advance directive is signed in counterparts under this subsection:

(1) the declarant;

(2) a health care representative who is designated in the advance directive;

(3) a person who supervised the signing of the advance directive in that person's presence; or

(4) any other person who was present during the signing of the advance directive;

must combine all of the separately signed paper counterparts of the advance directive into a single composite document that contains the text of the advance directive, the signature of the declarant, and the signatures of the witnesses, if any, or the notarial officer. The person who combines the separately signed counterparts into a single composite document must do so not later than ten (10) business days after the person receives all of the separately signed paper counterparts. Any scanned copy, photocopy, or other accurate copy of the composite document that contains the complete text of the advance directive and all signatures will be treated as validly signed under this section. The person who creates

the signed composite document under this subsection may include information about compliance within this subsection in an optional affidavit that is signed under section 41 of this chapter.

(e) If facts and circumstances, including physical impairments or physical isolation of a competent declarant, make it impossible or impractical for the declarant to use audiovisual technology to interact with the two (2) witnesses and to satisfy the presence requirement under section 19 of this chapter, the declarant and the witnesses may use telephonic interaction throughout the signing process. A potential witness cannot be compelled to use telephonic interaction alone to accomplish the signing of an advance directive under this section. A declarant and a notarial officer may not use telephonic interaction to accomplish the signing of an advance directive or other document under this chapter.

(f) If an advance directive is signed under subsection (e), the witnesses must be able to positively identify the declarant by receiving accurate answers from the declarant that:

(1) authenticate the identity of the declarant; and

(2) establish the capacity and sound mind of the declarant to the satisfaction of the witness.

(g) The text of the advance directive signed under subsection (e) must state that the declarant and the witnesses used telephonic interaction throughout the signing process to satisfy the presence requirement.

(h) An advance directive signed under subsection (e) is presumed to be valid if it recites that the declarant and the witnesses signed the advance directive in compliance with Indiana law.

(i) A health care provider or other person who disputes the validity of an advance directive signed under subsection (e) has the burden of proving the invalidity of the advance directive or noncompliance with subsection (e) by a reasonable preponderance of the evidence.

(j) If a declarant resides in or is located in a jurisdiction other than Indiana at the time when the declarant signs a writing that communicates the information described in subsection (a), the writing must be treated as a validly signed advance directive under this chapter if the declarant was not incapacitated at the time of signing and if the writing was:

(1) signed and witnessed or acknowledged in a manner that complies with subsections (b) and (c); or

(2) signed in a manner that complies with the applicable law

of the jurisdiction in which the declarant was residing or was physically located at the time of signing.

Sec. 29. An advance directive signed by a declarant under this section may contain any of the following additional provisions:

(1) A provision that delays:

(A) the effectiveness of an instruction or decision by the declarant; or

(B) the effectiveness of the authority of a designated health care representative;

until a stated date or the occurrence of a specifically defined event.

(2) If the advance directive explicitly provides that a health care decision or instruction or the authority of one (1) or more health care representatives is to be effective upon the future incapacity, disability, or incompetence of the declarant, a provision that:

(A) specifies the person or persons who are authorized to participate in the determination of incapacity, disability, or incompetence and the evidence or information to be used for the determination;

(B) is not more stringent than the procedure described in section 35 of this chapter; and

(C) does not allow a medical determination by a physician, psychologist, or other health care professional to be superseded by the subjective judgment or veto of another person or by nonmedical evidence regarding the declarant's capacity or incapacity.

(3) A provision that terminates the authority of a designated health care representative on:

(A) a stated date; or

(B) upon the occurrence of a specifically defined event.

(4) A provision that designates two (2) or more health care representatives as having authority to act individually to make health care decisions for the declarant in a specified order of priority.

(5) A provision that designates two (2) or more health care representatives and permits them to act individually and independently, or that requires them to act jointly, on a majority vote basis, or under a combination of requirements to make all health care decisions or specified health care decisions for the declarant. The advance directive may include a provision for a successor health care representative to act

according to different requirements.

(6) A provision that states a fee or presumptive reasonable hourly rate for the compensation that a health care representative may collect for acting on behalf of the declarant or providing caregiving services to the declarant.

(7) A provision that prohibits a health care representative from collecting compensation for acting under the advance directive.

(8) A provision that requires a professional adviser or other additional person to witness, ratify, or approve the declarant's revocation or amendment of a designation of one (1) or more health care representatives within the advance directive.

(9) A provision that:

(A) prohibits a designated health care representative from consenting to mental health treatment for the declarant; or

(B) designates a different health care representative to consent to mental health treatment.

(10) A provision that designates an adult individual or another person as an advocate with the authority to:

(A) receive:

(i) health information about the declarant; and

(ii) information and documents from a health care representative about the health care representative's actions on behalf of the declarant;

(B) monitor, audit, and evaluate the actions of a health care representative designated by the declarant; and

(C) take remedial action in the best interests of the declarant, including revoking or limiting the authority of any health care representative or filing a petition with a court for appropriate relief.

(11) Any other provision concerning the:

(A) declarant's health care or health information; or

(B) implementation of the declarant's advance directive.

Sec. 30. (a) The state department shall maintain a list of resources on its Internet web site, including sample advance directive forms that are consistent with this chapter.

(b) A declarant is not required to use any official or unofficial form to prepare and sign a valid advance directive.

Sec. 31. (a) A complete copy of the signed and witnessed or notarized advance directive must be given to each health care representative who:

(1) is specifically designated by name in the advance directive;

and

(2) has authority to make health care decisions that are immediately effective under the explicit terms of the advance directive or under section 34(1) of this chapter.

If the advance directive is signed with electronic signatures, a complete copy that is generated or converted from the original electronic record and that is viewable and printable is valid and may be relied upon as the equivalent to the original.

(b) A declarant who has capacity is responsible for giving a complete copy of the declarant's advance directive to a health care provider. If a declarant has signed an advance directive but lacks the capacity to make health care decisions or provide informed consent, any health care representative designated in the advance directive or any other interested person shall give a complete copy of the declarant's advance directive to a health care provider. Upon receipt of the declarant's advance directive, the health care provider shall put a copy of the advance directive in the declarant's medical records.

Sec. 32. (a) The declarant who signs an advance directive may revoke that advance directive by any of the following:

(1) Signing, in a manner that complies with section 28 of this chapter, another advance directive.

(2) Signing, in a manner that complies with section 28 of this chapter, a document that:

(A) states in writing that the declarant is revoking the previously signed advance directive; and

(B) confirms the declarant's compliance with any explicit additional conditions for valid revocation that are stated in the advance directive.

(3) Orally expressing the declarant's present intention, in the direct physical presence of a health care provider, to:

(A) revoke the entire advance directive;

(B) revoke a designation of one (1) or more health care representatives within the advance directive; or

(C) revoke one (1) or more specific health care decisions or one (1) or more desires or treatment preferences within the advance directive.

However, if a declarant has not been determined to be incapacitated under section 35 of this chapter, the declarant always has the right to orally revoke a health care decision that is included within an advance directive under section 28(a)(2) of this chapter or a statement of desires or treatment preferences that is included

within an advance directive under section 28(a)(3) of this chapter, despite any contrary wording in the advance directive.

(b) Until a health care representative or health care provider has actual knowledge of a valid revocation of an advance directive:

(1) actions and health care decisions by a health care representative designated in the advance directive are valid and binding on the declarant; and

(2) health care providers may continue to rely on health care decisions by the health care representative.

(c) A declarant who has signed a valid advance directive may amend or restate that advance directive in a writing that is signed in compliance with section 28 of this chapter and witnessed or acknowledged in compliance with section 28(c), 28(d), or 28(e) of this chapter. The amendment or restatement may take any action that could have been included in the former or original advance directive.

Sec. 33. (a) Except when the terms of the advance directive explicitly prohibit or restrict delegation, a health care representative who is designated by name in an advance directive may make a written delegation of some or all of the health care representative's authority to one (1) or more other competent adults or other persons, on a temporary or open ended basis as stated in the written delegation document.

(b) A written delegation document under this section must be signed in compliance with section 28 of this chapter and witnessed or acknowledged in compliance with section 28(c), 28(d), or 28(e) of this chapter.

(c) A written delegation of authority that does not state an expiration date continues until it is revoked, in a manner complying with section 32 of this chapter, by the competent declarant or by the health care representative who signed the written delegation.

(d) If the advance directive explicitly states a date or event that triggers termination of the advance directive or termination of the authority of a health care representative who makes a written delegation under this section, the delegated authority terminates upon the triggering event or expiration date.

Sec. 34. An advance directive must be interpreted to carry out the known or demonstrable intent of the declarant. The following presumptions apply to an advance directive unless the terms of the advance directive explicitly prevent a presumption from applying:

(1) If the advance directive does not state a delayed effective

date or a future triggering event for effectiveness, the advance directive is effective immediately upon signing and witnessing or acknowledgment in compliance with section 28 of this chapter. However, if the declarant has capacity to consent to health care, the declarant has the right to make health care decisions, give consent, or provide instructions that supersede or overturn any decision that is made or could be made by the declarant's health care representative.

(2) If the advance directive does not explicitly state an expiration date or a triggering event for termination, the advance directive and the authority of each designated health care representative continues until the death of the declarant or until an earlier valid revocation of the advance directive.

(3) If an advance directive designates two (2) or more health care representatives and does not specify that:

(A) the health care representative's respective authority to act is subject to an order of priority; or

(B) the health care representatives must act jointly or on a majority vote basis;

each health care representative has concurrent authority to act individually and independently to make health care decisions for the declarant. If two (2) or more health care representatives who are required to act jointly disagree about a health care decision, or if two (2) or more health care representatives who are authorized to act independently give conflicting instructions to a health care provider, the health care provider may decline to comply with the conflicting instructions, and in an urgent or emergency situation, the health care provider may provide treatment consistent with the instructions of one (1) physician or one (1) advanced practice registered nurse who examines or evaluates the declarant.

(4) If:

(A) an individual signs more than one (1) advance directive at different times; and

(B) the later signed advance directive does not explicitly state that one (1) or more of the previous advance directives by the declarant remain in effect;

each previous advance directive is superseded and revoked by the last signed advance directive.

(5) Unless the advance directive explicitly provides otherwise, each health care representative who is designated in an

advance directive continues to have authority after the death of the declarant to do the following:

(A) Make anatomical gifts on the declarant's behalf, subject to any previous written direction by the declarant.

(B) Request or authorize an autopsy.

(C) Make plans for the disposition of the declarant's body, including executing a funeral planning declaration on behalf of the declarant under IC 29-2-19.

(6) Each health care representative who is designated in an advance directive and who has current authority to act is a personal representative of the declarant for purposes of 45 CFR Parts 160 through 164.

(7) If an advance directive explicitly provides that the authority of one (1) or more health care representatives is to be effective upon the future incapacity, disability, or incompetence of the declarant but if the advance directive does not specify a method or procedure for determining the incapacity, disability, or incompetence of the declarant:

(A) the health care representative's authority to act becomes effective upon a determination that the declarant is incapacitated that is stated in a writing or other record by a physician, licensed psychologist, or judge; and

(B) each health care representative who is designated in the advance directive is authorized to act as the declarant's personal representative under 45 CFR 164.502(g) to obtain access to the declarant's information, and to communicate with the declarant's health care providers, for the purpose of gathering information necessary for determinations under this subdivision.

(8) Each health care representative who is designated in an advance directive and who has current authority to make health care decisions for the declarant has authority to consent to mental health treatment for the declarant.

(9) If the advance directive is silent on the issue of compensation for a health care representative designated in the advance directive, then each health care representative is entitled to receive the following:

(A) Reasonable compensation from the declarant's property for services or acts actually performed by the health care representative and for the declarant.

(B) Reasonable reimbursement from the declarant's property for out-of-pocket expenses actually incurred and

paid by the health care representative from the health care representative's own funds in the course of performing services or acts for the declarant under the advance directive.

Any health care representative may waive part or all of the compensation or expense reimbursements that the health care representative would be entitled to receive under the terms of the advance directive or under this subdivision.

(10) If an advance directive explicitly provides that the authority of a health care representative is effective only at times when the declarant is incapacitated or unable to consent to health care, then unless the advance directive explicitly states another procedure:

(A) the health care representative's authority becomes effective when a determination of the declarant's incapacity is noted in the declarant's medical records under section 35(d) of this chapter; and

(B) the health care representative's authority becomes inactive when the declarant regains capacity.

(11) If the authority of a health care representative under the advance directive is effective immediately upon signing by the declarant, the health care representative's authority may be rescinded or superseded by the direct decisions of the declarant at all times when the declarant has not been determined to be incapacitated.

(12) If:

(A) an advance directive designates one (1) or more health care representatives;

(B) a health care representative is not reasonably available to act for the declarant; and

(C) the declarant is incapacitated or not competent to make personal health care decisions;

then subject to any order of priority explicitly stated in the advance directive, each health care representative designated in the advance directive must be given the opportunity to exercise authority for the declarant.

(13) If explicitly allowed or required in the advance directive, each person who may act as a proxy for the declarant under sections 42 and 43 of this chapter, if an advance directive had not existed, has the right to make a written demand for and to receive from a health care representative a narrative description or other appropriate accounting of the actions

taken and decisions made by a health care representative under the advance directive. Notwithstanding any provision in the advance directive, a health care representative who prepares a narrative description or accounting in response to a written demand is entitled to reasonable compensation for the time and effort spent in doing so.

(14) Notwithstanding any provision in the advance directive, if a declarant is not competent to amend or revoke the declarant's advance directive, then a person who may act as a proxy for the declarant under sections 42 and 43 of this chapter has the right to petition a probate court with jurisdiction over the declarant for any of the following relief:

(A) An order modifying or terminating the advance directive.

(B) An order removing a health care representative or terminating the authority of a person who holds delegated authority under the advance directive, on the grounds that the health care representative or person is not acting or is declining to act in the best interests of the declarant.

(C) An order directing a health care representative to make or carry out a specific health care decision for the declarant.

(D) An order appointing a new or additional health care representative, on the grounds that all health care representatives designated in the advance directive are not reasonably available to act.

Before issuing an order under this subdivision, the court must hold a hearing after notice to the declarant, to each health care representative, and any other person whose rights or authority could be affected by the order, and to any persons who have the highest priority under sections 42 and 43 of this chapter to serve as a proxy for the declarant if an advance directive had not existed. An order issued under this subdivision must be guided by the declarant's best interests and the declarant's known or demonstrable intent.

Sec. 35. (a) For purposes of this section, the term "declarant" includes an individual who has not executed an advance directive or who has no unrevoked advance directive in effect.

(b) A declarant is presumed to be capable of making health care decisions for the declarant unless the declarant is determined to be incapacitated. The declarant's desires are controlling while a declarant has decision making capacity. Each physician or health

care provider must clearly communicate to a declarant who has decision making capacity the treatment plan and any change to the treatment plan before implementation of the plan or a change to the plan. Incapacity may not be inferred from a person's voluntary or involuntary hospitalization for mental illness or from the person's intellectual disability.

(c) When a declarant is incapacitated, a health care decision made on the declarant's behalf by a health care representative is effective to the same extent as a decision made by the declarant if the declarant were not incapacitated. However, if:

(1) a health care representative makes and communicates a health care decision; and

(2) a health care provider concludes that carrying out that health care decision would be medically inappropriate or clearly contrary to the declarant's best interests;

then the health care provider has the same right to refuse to carry out that decision as if that decision were made and communicated directly by the declarant at a time when the declarant was not incapacitated.

(d) If a declarant's capacity to make health care decisions or provide informed consent is in question, the declarant's treating physician shall evaluate the declarant's capacity and, if the treating physician concludes that the declarant lacks capacity, enter that evaluation in the declarant's medical record.

(e) If the treating physician is unable to reach a conclusion under subsection (d) about whether the declarant lacks capacity, the treating physician and other health care providers shall treat the declarant as still having capacity to make health care decisions and provide informed consent, until a later evaluation occurs under this section after the passage of time or after a change in the declarant's condition.

(f) This chapter does not limit the authority of a probate court under IC 29-3 to make determinations about an individual's incapacity or recovery from a period of incapacity.

(g) A determination made under this section that a declarant lacks capacity to make health care decisions may not be construed as a finding that a declarant lacks capacity for any other purpose.

Sec. 36. (a) Except when a health care representative's authority has been expressly limited by the declarant in an advance directive, the health care representative, in accordance with the declarant's instructions made while competent, has the following authority and responsibilities:

(1) The authority to act for the declarant and to make all health care decisions for the declarant at all times when the health care representative's authority is in effect, subject to the right of the competent declarant to act directly and personally.

(2) The authority and responsibility to be reasonably available to consult with appropriate health care providers to provide informed consent.

(3) The authority and responsibility to act in good faith and make only health care decisions for the declarant that the health care representative believes the declarant would have made under the circumstances if the declarant were capable of making the decisions, taking into account the express or implied intentions of the declarant or if the declarant's express or implied intentions are not known, the declarant's best interests.

(4) The authority and responsibility to provide written consent using an appropriate form when consent is required, including a physician's order not to resuscitate (IC 16-36-5 or IC 16-36-6).

(5) The authority to be provided access to the appropriate health information of the declarant.

(6) The authority to apply for public benefits, including Medicaid and the community and home options to institutional care for the elderly and disabled (CHOICE) program, for the declarant and have access to information regarding the declarant's income, assets, and banking and financial records to the extent required to make application.

(b) The health care representative may authorize the release of health information to appropriate persons to ensure the continuity of the declarant's health care and may authorize the admission, discharge, or transfer of the declarant to or from a health care facility or other health or residential facility or program licensed or registered by a state agency.

(c) If, after a declarant has designated one (1) or more health care representatives in an advance directive, a court appoints a guardian of the declarant's person, the authority of each designated health care representative continues unless the appointing court modifies or revokes the authority of one (1) or more health care representatives after a hearing upon notice under section 34(14) of this chapter. The court may order a health care representative to make appropriate or specified reports to the

guardian of the declarant's person or property.

Sec. 37. (a) A health care provider furnished with a copy of a declarant's advance directive shall make the declarant's advance directive a part of the declarant's medical records. If a change in or termination of the advance directive becomes known to the health care provider, the change or termination must be noted in the declarant's medical records.

(b) If a health care provider believes that an individual may lack the capacity to give informed consent to health care, then, until the individual is determined to have capacity under section 35 of this chapter, the health care provider shall consult with:

(1) a health care representative designated by the declarant; or

(2) if a health care representative has not been designated or if a health care representative is not reasonably available to act, a proxy under section 42 of this chapter;

who has authority and priority to act and who is reasonably available to act.

(c) Subject to the right of a competent declarant to directly make and communicate health care decisions for the declarant and to rescind a health care decision by a health care representative who is designated in an advance directive, the following conditions apply:

(1) A health care provider may continue to administer treatment for the declarant's comfort, care, or the alleviation of pain in addition to treatment made under the decision of the health care representative.

(2) Subject to subdivision (3), a health care provider shall comply with a health care decision made by a health care representative if the decision is communicated to the provider.

(3) If a health care provider is unwilling to comply with a health care decision made by a health care representative, the provider shall do the following:

(A) Notify the health care representative of the health care provider's unwillingness to comply with the decision.

(B) Promptly take all steps necessary to transfer the responsibility for the declarant's health care to another health care provider designated by the health care representative. However, a health care provider who takes steps for a transfer does not have a duty to look for or identify another health care provider who will accept the declarant.

However, if a health care provider is unwilling to comply with a health care decision made by a health care representative, and the declarant's health condition would make transfer of the declarant untenable or unadvisable, this subsection does not prohibit the health care provider from following the health care provider's dispute resolution procedure with the objective of reaching a decision in the best interest of the declarant.

Sec. 38. If a health care representative designated in an advance directive has authority to:

(1) make an anatomical gift on behalf of the declarant;

(2) authorize an autopsy of the declarant's remains; or

(3) direct the disposition of the declarant's remains;

under either the explicit provisions of the advance directive or section 34(5) of this chapter, the anatomical gift, autopsy, or remains disposition is considered the act of the declarant or of the person who has legal authority to make the necessary decisions.

Sec. 39. (a) A health care provider shall give a health care representative authorized to receive information under an advance directive the same access as the declarant has to examine and copy the declarant's health information and medical records, including records relating to mental health and other medical conditions held by a physician or other health care provider.

(b) The access to records under this section must be given at the declarant's expense and may be subject to reasonable rules of the provider to prevent disruption of the declarant's health care.

(c) A health care representative may release information obtained under this section to any person authorized to receive the information under IC 16-39.

Sec. 40. (a) A health care provider or other person who acts in good faith reliance on an advance directive or on a health care decision made by a health care representative with apparent authority is immune from liability to the declarant and to the declarant's heirs or other successors in interest to the same extent as if the health care provider or other person had dealt directly with the declarant and if the declarant had been competent and not incapacitated.

(b) A health care provider is not responsible for determining the validity of an advance directive.

Sec. 41. (a) A health care representative designated in an advance directive or a person who was present during the signing of the advance directive may furnish to a health care provider or

other person an affidavit that states, to the best knowledge of the health care representative:

(1) that the document attached to and furnished with the affidavit is a true copy of the named declarant's advance directive that is currently in effect;

(2) that the declarant is alive;

(3) that the advance directive was validly executed;

(4) if the effectiveness of the health care representative's authority to act under the advance directive begins upon the occurrence of a certain event, that the event has occurred and the health care representative has authority to act;

(5) if the health care representative who furnishes the affidavit does not have the highest priority to act under the explicit terms of the advance directive, an explanation that all health care representatives who are identified in the advance directive as having higher priority are not reasonably available to act; and

(6) that the relevant powers granted to the health care representative have not been altered or terminated.

An affidavit signed and furnished under this section may include information based on the affiant's personal knowledge about the manner in which the advance directive was signed under subsection (b) and section 28(c), 28(d), or 28(e) of this chapter. An affidavit under this section must be signed, sworn to, and acknowledged by the affiant in the presence of a notarial officer, unless the affiant swears or affirms to the accuracy of the affidavit's contents under the penalties for perjury.

(b) A health care provider or other person who:

(1) relies on an affidavit described in subsection (a); and

(2) acts in good faith;

is immune from liability that might otherwise arise from the health care provider's or other person's actions in reliance on the advance directive that is the subject of the affidavit.

Sec. 42. (a) For purposes of this section, the term "declarant" includes an individual who has not executed an advance directive or who does not have an advance directive currently in effect.

(b) This section applies only if a declarant is not capable of consenting to health care, and:

(1) the declarant has not executed an advance directive under this chapter or does not have an advance directive currently in effect; or

(2) the declarant has executed an advance directive and the

health care representative designated in the advance directive is not willing, able, or reasonably available to make health care decisions for the declarant.

(c) Except as provided in section 43 of this chapter, health care decisions may be made for the declarant by any of the following individuals to act as a proxy, in the following decreasing order of priority, if an individual in a prior class is not reasonably available, willing, and competent to act:

(1) The judicially appointed guardian of the declarant or a health care representative appointed under IC 16-36-1-8 or section 34(14) of this chapter.

(2) A spouse.

(3) An adult child.

(4) A parent.

(5) An adult sibling.

(6) A grandparent.

(7) An adult grandchild.

(8) The nearest other adult relative in the next degree of kinship who is not listed in subdivisions (2) through (7).

(9) A friend who:

(A) is an adult;

(B) has maintained regular contact with the individual; and

(C) is familiar with the individual's activities, health, and religious or moral beliefs.

(10) The individual's religious superior, if the individual is a member of a religious order.

(d) Any health care decision made under subsection (c) must be based on the proxy's informed consent and on the decision the proxy reasonably believes the declarant would have made under the circumstances, taking into account the declarant's express or implied intentions. If there is no reliable indication of what the declarant would have chosen, the proxy shall consider the declarant's best interests in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

(e) Before exercising the incapacitated declarant's rights to select or decline health care, the proxy must attempt to comply in good faith with:

(1) the instructions, desires, or preferences, if any, stated by the declarant regarding life prolonging procedures in an advance directive executed under IC 16-36-1, IC 16-36-4, or

IC 30-5; and

(2) IC 16-36-6, if a valid POST form (as defined by IC 16-36-6-4) executed by the patient is in effect.

However, a proxy's decision to withhold or withdraw life prolonging procedures must be supported by evidence that the decision would have been the one the declarant would have chosen had the declarant been competent or, if there is no reliable indication of what the declarant would have chosen, that the decision is in the declarant's best interests.

(f) If there are multiple individuals at the same priority level under this section, those individuals shall make a reasonable effort to reach a consensus as to the health care decisions on behalf of the declarant who is unable to provide health care consent. If the individuals at the same priority level disagree as to the health care decisions on behalf of the declarant who is unable to provide health care consent, a majority of the available individuals at the same priority level controls.

(g) Nothing in this section shall be construed to preempt the designation of persons who may consent to the medical care or treatment of minors established under IC 16-36-1-5(b).

Sec. 43. The following individuals may not serve as a proxy under section 42 of this chapter:

(1) An individual specifically disqualified in the declarant's advance directive.

(2) A spouse who:

(A) is legally separated; or

(B) has a petition for dissolution, legal separation, or annulment of marriage that is pending in a court;

from the individual.

(3) An individual who is subject to a protective order or other court order that directs that individual to avoid contact with the declarant.

(4) An individual who is subject to a pending criminal charge in which the declarant was the alleged victim.

Sec. 44. If a declarant has become and remains incapacitated and has previously executed a valid advance directive under this chapter and executed:

(1) an appointment of a health care representative executed under IC 16-36-1 before January 1, 2023;

(2) a durable power of attorney granting health care powers and executed under IC 30-5 before January 1, 2023; or

(3) a similar advance directive executed by the declarant

under the laws of another state in which the declarant was physically present at the time of signing; and

if a material conflict exists between multiple documents described in this section or if a material conflict exists between the health care decisions that different health care representatives or other authorized agents propose to make under the multiple documents, or if there is a material difference between the documents, then the document signed last by the declarant and the authority of the named representatives or agents in that document controls.

SECTION 64. IC 16-39-2-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 9. (a) For the purposes of this chapter, the following persons are entitled to exercise the patient's rights on the patient's behalf:

(1) If the patient is a minor, the parent, guardian, or other court appointed representative of the patient.

(2) If the provider determines that the patient is incapable of giving or withholding consent, the patient's guardian, a court appointed representative of the patient, a person possessing a health care power of attorney **under IC 30-5-5-16** for the patient, or the patient's health care representative **under IC 16-36-1-7 or IC 16-36-7.**

(b) A custodial parent and a noncustodial parent of a child have equal access to the child's mental health records unless:

(1) a court has issued an order that limits the noncustodial parent's access to the child's mental health records; and

(2) the provider has received a copy of the court order or has actual knowledge of the court order.

If the provider incurs an additional expense by allowing a parent equal access to a child's mental health records, the provider may require the parent requesting the equal access to pay a fee under IC 16-39-9 to cover the cost of the additional expense.

SECTION 65. IC 23-14-31-26, AS AMENDED BY P.L.190-2016, SECTION 32, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 26. (a) Except as provided in subsection (c), the following persons, in the priority listed, have the right to serve as an authorizing agent:

(1) A person:

(A) granted the authority to serve in a funeral planning declaration executed by the decedent under IC 29-2-19; or

(B) named in a United States Department of Defense form "Record of Emergency Data" (DD Form 93) or a successor form adopted by the United States Department of Defense, if

the decedent died while serving in any branch of the United States Armed Forces (as defined in 10 U.S.C. 1481) and completed the form.

(2) An individual specifically granted the authority to serve in a power of attorney or a health care power of attorney executed by the decedent under IC 30-5-5-16 **or a health care representative under IC 16-36-7.**

(3) The individual who was the spouse of the decedent at the time of the decedent's death, except when:

(A) a petition to dissolve the marriage or for legal separation of the decedent and spouse is pending with a court at the time of the decedent's death, unless a court finds that the decedent and spouse were reconciled before the decedent's death; or

(B) a court determines the decedent and spouse were physically and emotionally separated at the time of death and the separation was for an extended time that clearly demonstrates an absence of due affection, trust, and regard for the decedent.

(4) The decedent's surviving adult child or, if more than one (1) adult child is surviving, the majority of the adult children. However, less than half of the surviving adult children have the rights under this subdivision if the adult children have used reasonable efforts to notify the other surviving adult children of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the surviving adult children.

(5) The decedent's surviving parent or parents. If one (1) of the parents is absent, the parent who is present has authority under this subdivision if the parent who is present has used reasonable efforts to notify the absent parent.

(6) The decedent's surviving sibling or, if more than one (1) sibling is surviving, the majority of the surviving siblings. However, less than half of the surviving siblings have the rights under this subdivision if the siblings have used reasonable efforts to notify the other surviving siblings of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the surviving siblings.

(7) The individual in the next degree of kinship under IC 29-1-2-1 to inherit the estate of the decedent or, if more than one (1) individual of the same degree is surviving, the majority of those who are of the same degree. However, less than half of the individuals who are of the same degree of kinship have the rights

under this subdivision if they have used reasonable efforts to notify the other individuals who are of the same degree of kinship of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the individuals who are of the same degree of kinship.

(8) If none of the persons described in subdivisions (1) through (7) are available, or willing, to act and arrange for the final disposition of the decedent's remains, a stepchild (as defined in IC 6-4.1-1-3(f)) of the decedent. If more than one (1) stepchild survives the decedent, then a majority of the surviving stepchildren. However, less than half of the surviving stepchildren have the rights under this subdivision if they have used reasonable efforts to notify the other stepchildren of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the stepchildren.

(9) The person appointed to administer the decedent's estate under IC 29-1.

(10) If none of the persons described in subdivisions (1) through (9) are available, any other person willing to act and arrange for the final disposition of the decedent's remains, including a funeral home that:

(A) has a valid prepaid funeral plan executed under IC 30-2-13 that makes arrangements for the disposition of the decedent's remains; and

(B) attests in writing that a good faith effort has been made to contact any living individuals described in subdivisions (1) through (9).

(11) In the case of an indigent or other individual whose final disposition is the responsibility of the state or township, the following may serve as the authorizing agent:

(A) If none of the persons identified in subdivisions (1) through (10) are available:

(i) a public administrator, including a responsible township trustee or the trustee's designee; or

(ii) the coroner.

(B) A state appointed guardian.

However, an indigent decedent may not be cremated if a surviving family member objects to the cremation or if cremation would be contrary to the religious practices of the deceased individual as expressed by the individual or the individual's family.

(12) In the absence of any person under subdivisions (1) through

(11), any person willing to assume the responsibility as the authorizing agent, as specified in this article.

(b) When a body part of a nondeceased individual is to be cremated, a representative of the institution that has arranged with the crematory authority to cremate the body part may serve as the authorizing agent.

(c) If:

(1) the death of the decedent appears to have been the result of:

(A) murder (IC 35-42-1-1);

(B) voluntary manslaughter (IC 35-42-1-3); or

(C) another criminal act, if the death does not result from the operation of a vehicle; and

(2) the coroner, in consultation with the law enforcement agency investigating the death of the decedent, determines that there is a reasonable suspicion that a person described in subsection (a) committed the offense;

the person referred to in subdivision (2) may not serve as the authorizing agent.

(d) The coroner, in consultation with the law enforcement agency investigating the death of the decedent, shall inform the crematory authority of the determination referred to in subsection (c)(2).

(e) If a person vested with a right under subsection (a) does not exercise that right not later than seventy-two (72) hours after the person receives notification of the death of the decedent, the person forfeits the person's right to determine the final disposition of the decedent's remains, and the right to determine final disposition passes to the next person described in subsection (a).

(f) A crematory authority owner has the right to rely, in good faith, on the representations of a person listed in subsection (a) that any other individuals of the same degree of kinship have been notified of the final disposition instructions.

(g) If there is a dispute concerning the disposition of a decedent's remains, a crematory authority is not liable for refusing to accept the remains of the decedent until the crematory authority receives:

(1) a court order; or

(2) a written agreement signed by the disputing parties;

that determines the final disposition of the decedent's remains. If a crematory authority agrees to shelter the remains of the decedent while the parties are in dispute, the crematory authority may collect any applicable fees for storing the remains, including legal fees that are incurred.

(h) Any cause of action filed under this section must be filed in the probate court in the county where the decedent resided, unless the

decedent was not a resident of Indiana.

(i) A spouse seeking a judicial determination under subsection (a)(3)(A) that the decedent and spouse were reconciled before the decedent's death may petition the court having jurisdiction over the dissolution or separation proceeding to make this determination by filing the petition under the same cause number as the dissolution or separation proceeding. A spouse who files a petition under this subsection is not required to pay a filing fee.

SECTION 66. IC 23-14-55-2, AS AMENDED BY P.L.190-2016, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 2. (a) Except as provided in subsection (c), the owner of a cemetery is authorized to inter, entomb, or inurn the body or cremated remains of a deceased human upon the receipt of a written authorization of an individual who professes either of the following:

(1) To be (in the priority listed) one (1) of the following:

(A) An individual granted the authority to serve in a funeral planning declaration executed by the decedent under IC 29-2-19, or the person named in a United States Department of Defense form "Record of Emergency Data" (DD Form 93) or a successor form adopted by the United States Department of Defense, if the decedent died while serving in any branch of the United States Armed Forces (as defined in 10 U.S.C. 1481) and completed the form.

(B) An individual specifically granted the authority in a power of attorney or a health care power of attorney executed by the decedent under IC 30-5-5-16 **or a health care representative under IC 16-36-7.**

(C) The individual who was the spouse of the decedent at the time of the decedent's death, except when:

(i) a petition to dissolve the marriage or for legal separation of the decedent and spouse is pending with a court at the time of the decedent's death, unless a court finds that the decedent and spouse were reconciled before the decedent's death; or

(ii) a court determines the decedent and spouse were physically and emotionally separated at the time of death and the separation was for an extended time that clearly demonstrates an absence of due affection, trust, and regard for the decedent.

(D) The decedent's surviving adult child or, if more than one (1) adult child is surviving, the majority of the adult children. However, less than half of the surviving adult children have

the rights under this clause if the adult children have used reasonable efforts to notify the other surviving adult children of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the surviving adult children.

(E) The decedent's surviving parent or parents. If one (1) of the parents is absent, the parent who is present has authority under this clause if the parent who is present has used reasonable efforts to notify the absent parent.

(F) The decedent's surviving sibling or, if more than one (1) sibling is surviving, the majority of the surviving siblings. However, less than half of the surviving siblings have the rights under this clause if the siblings have used reasonable efforts to notify the other surviving siblings of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the surviving siblings.

(G) The individual in the next degree of kinship under IC 29-1-2-1 to inherit the estate of the decedent or, if more than one (1) individual of the same degree of kinship is surviving, the majority of those who are of the same degree. However, less than half of the individuals who are of the same degree of kinship have the rights under this clause if they have used reasonable efforts to notify the other individuals who are of the same degree of kinship of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the individuals who are of the same degree of kinship.

(H) If none of the persons described in clauses (A) through (G) are available, or willing, to act and arrange for the final disposition of the decedent's remains, a stepchild (as defined in IC 6-4.1-1-3(f)) of the decedent. If more than one (1) stepchild survives the decedent, then a majority of the surviving stepchildren. However, less than half of the surviving stepchildren have the rights under this subdivision if they have used reasonable efforts to notify the other stepchildren of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the stepchildren.

(I) The person appointed to administer the decedent's estate under IC 29-1.

(J) If none of the persons described in clauses (A) through (I) are available, any other person willing to act and arrange for

the final disposition of the decedent's remains, including a funeral home that:

(i) has a valid prepaid funeral plan executed under IC 30-2-13 that makes arrangements for the disposition of the decedent's remains; and

(ii) attests in writing that a good faith effort has been made to contact any living individuals described in clauses (A) through (I).

(2) To have acquired by court order the right to control the disposition of the deceased human body or cremated remains.

The owner of a cemetery may accept the authorization of an individual only if all other individuals of the same priority or a higher priority (according to the priority listing in this subsection) are deceased, are barred from authorizing the disposition of the deceased human body or cremated remains under subsection (c), or are physically or mentally incapacitated from exercising the authorization, and the incapacity is certified to by a qualified medical doctor.

(b) An action may not be brought against the owner of a cemetery relating to the remains of a human that have been left in the possession of the cemetery owner without permanent interment, entombment, or inurnment for a period of three (3) years, unless the cemetery owner has entered into a written contract for the care of the remains.

(c) If:

(1) the death of the decedent appears to have been the result of:

(A) murder (IC 35-42-1-1);

(B) voluntary manslaughter (IC 35-42-1-3); or

(C) another criminal act, if the death does not result from the operation of a vehicle; and

(2) the coroner, in consultation with the law enforcement agency investigating the death of the decedent, determines that there is a reasonable suspicion that a person described in subsection (a) committed the offense;

the person referred to in subdivision (2) may not authorize the disposition of the decedent's body or cremated remains.

(d) The coroner, in consultation with the law enforcement agency investigating the death of the decedent, shall inform the cemetery owner of the determination referred to in subsection (c)(2).

(e) If a person vested with a right under subsection (a) does not exercise that right not less than seventy-two (72) hours after the person receives notification of the death of the decedent, the person forfeits the person's right to determine the final disposition of the decedent's remains and the right to determine final disposition passes to the next

person described in subsection (a).

(f) A cemetery owner has the right to rely, in good faith, on the representations of a person listed in subsection (a) that any other individuals of the same degree of kinship have been notified of the final disposition instructions.

(g) If there is a dispute concerning the disposition of a decedent's remains, a cemetery owner is not liable for refusing to accept the remains of the decedent until the cemetery owner receives:

(1) a court order; or

(2) a written agreement signed by the disputing parties;

that determines the final disposition of the decedent's remains. If a cemetery agrees to shelter the remains of the decedent while the parties are in dispute, the cemetery may collect any applicable fees for storing the remains, including legal fees that are incurred.

(h) Any cause of action filed under this section must be filed in the probate court in the county where the decedent resided, unless the decedent was not a resident of Indiana.

(i) A spouse seeking a judicial determination under subsection (a)(1)(C)(i) that the decedent and spouse were reconciled before the decedent's death may petition the court having jurisdiction over the dissolution or separation proceeding to make this determination by filing the petition under the same cause number as the dissolution or separation proceeding. A spouse who files a petition under this subsection is not required to pay a filing fee.

SECTION 67. IC 25-15-9-18, AS AMENDED BY P.L.190-2016, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 18. (a) Except as provided in subsection (b), the following persons, in the order of priority indicated, have the authority to designate the manner, type, and selection of the final disposition of human remains, to make arrangements for funeral services, and to make other ceremonial arrangements after an individual's death:

(1) A person:

(A) granted the authority to serve in a funeral planning declaration executed by the decedent under IC 29-2-19; or

(B) named in a United States Department of Defense form "Record of Emergency Data" (DD Form 93) or a successor form adopted by the United States Department of Defense, if the decedent died while serving in any branch of the United States Armed Forces (as defined in 10 U.S.C. 1481) and completed the form.

(2) An individual specifically granted the authority in a power of attorney or a health care power of attorney executed by the

decedent under IC 30-5-5-16 **or a health care representative under IC 16-36-7.**

(3) The individual who was the spouse of the decedent at the time of the decedent's death, except when:

(A) a petition to dissolve the marriage or for legal separation of the decedent and spouse is pending with a court at the time of the decedent's death, unless a court finds that the decedent and spouse were reconciled before the decedent's death; or

(B) a court determines the decedent and spouse were physically and emotionally separated at the time of death and the separation was for an extended time that clearly demonstrates an absence of due affection, trust, and regard for the decedent.

(4) The decedent's surviving adult child or, if more than one (1) adult child is surviving, the majority of the adult children. However, less than half of the surviving adult children have the rights under this subdivision if the adult children have used reasonable efforts to notify the other surviving adult children of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the surviving adult children.

(5) The decedent's surviving parent or parents. If one (1) of the parents is absent, the parent who is present has the rights under this subdivision if the parent who is present has used reasonable efforts to notify the absent parent.

(6) The decedent's surviving sibling or, if more than one (1) sibling is surviving, the majority of the surviving siblings. However, less than half of the surviving siblings have the rights under this subdivision if the siblings have used reasonable efforts to notify the other surviving siblings of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the surviving siblings.

(7) The individual in the next degree of kinship under IC 29-1-2-1 to inherit the estate of the decedent or, if more than one (1) individual of the same degree survives, the majority of those who are of the same degree of kinship. However, less than half of the individuals who are of the same degree of kinship have the rights under this subdivision if they have used reasonable efforts to notify the other individuals who are of the same degree of kinship of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the individuals who are of the same degree of kinship.

(8) If none of the persons described in subdivisions (1) through (7) are available, or willing, to act and arrange for the final disposition of the decedent's remains, a stepchild (as defined in IC 6-4.1-1-3(f)) of the decedent. If more than one (1) stepchild survives the decedent, then a majority of the surviving stepchildren. However, less than half of the surviving stepchildren have the rights under this subdivision if they have used reasonable efforts to notify the other stepchildren of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the stepchildren.

(9) The person appointed to administer the decedent's estate under IC 29-1.

(10) If none of the persons identified in subdivisions (1) through (9) are available, any other person willing to act and arrange for the final disposition of the decedent's remains, including a funeral home that:

(A) has a valid prepaid funeral plan executed under IC 30-2-13 that makes arrangements for the disposition of the decedent's remains; and

(B) attests in writing that a good faith effort has been made to contact any living individuals described in subdivisions (1) through (9).

(11) In the case of an indigent or other individual whose final disposition is the responsibility of the state or township, the following:

(A) If none of the persons identified in subdivisions (1) through (10) is available:

(i) a public administrator, including a responsible township trustee or the trustee's designee; or

(ii) the coroner.

(B) A state appointed guardian.

(b) If:

(1) the death of the decedent appears to have been the result of:

(A) murder (IC 35-42-1-1);

(B) voluntary manslaughter (IC 35-42-1-3); or

(C) another criminal act, if the death does not result from the operation of a vehicle; and

(2) the coroner, in consultation with the law enforcement agency investigating the death of the decedent, determines that there is a reasonable suspicion that a person described in subsection (a) committed the offense;

the person referred to in subdivision (2) may not authorize or designate

the manner, type, or selection of the final disposition of human remains.

(c) The coroner, in consultation with the law enforcement agency investigating the death of the decedent, shall inform the cemetery owner or crematory authority of the determination under subsection (b)(2).

(d) If the decedent had filed a protection order against a person described in subsection (a) and the protection order is currently in effect, the person described in subsection (a) may not authorize or designate the manner, type, or selection of the final disposition of human remains.

(e) A law enforcement agency shall determine if the protection order is in effect. If the law enforcement agency cannot determine the existence of a protection order that is in effect, the law enforcement agency shall consult the protective order registry established under IC 5-2-9-5.5.

(f) If a person vested with a right under subsection (a) does not exercise that right not later than seventy-two (72) hours after the person receives notification of the death of the decedent, the person forfeits the person's right to determine the final disposition of the decedent's remains and the right to determine final disposition passes to the next person described in subsection (a).

(g) A funeral home has the right to rely, in good faith, on the representations of a person listed in subsection (a) that any other individuals of the same degree of kinship have been notified of the final disposition instructions.

(h) If there is a dispute concerning the disposition of a decedent's remains, a funeral home is not liable for refusing to accept the remains of the decedent until the funeral home receives:

(1) a court order; or

(2) a written agreement signed by the disputing parties;

that determines the final disposition of the decedent's remains. If a funeral home agrees to shelter the remains of the decedent while the parties are in dispute, the funeral home may collect any applicable fees for storing the remains, including legal fees that are incurred.

(i) Any cause of action filed under this section must be filed in the probate court in the county where the decedent resided, unless the decedent was not a resident of Indiana.

(j) A spouse seeking a judicial determination under subsection (a)(3)(A) that the decedent and spouse were reconciled before the decedent's death may petition the court having jurisdiction over the dissolution or separation proceeding to make this determination by

filing the petition under the same cause number as the dissolution or separation proceeding. A spouse who files a petition under this subsection is not required to pay a filing fee.

SECTION 68. IC 29-2-16.1-1, AS AMENDED BY P.L.11-2020, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 1. The following definitions apply throughout this chapter:

(1) "Adult" means an individual at least eighteen (18) years of age.

(2) "Agent" means an individual who is:

(A) authorized to make health care decisions on behalf of another person by a health care power of attorney **under IC 30-5-5-16 or a health care representative under IC 16-36-7;** or

(B) expressly authorized to make an anatomical gift on behalf of another person by a document signed by the person.

(3) "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

(4) "Bank" or "storage facility" means a facility licensed, accredited, or approved under the laws of any state for storage of human bodies or parts of human bodies.

(5) "Decedent":

(A) means a deceased individual whose body or body part is or may be the source of an anatomical gift; and

(B) includes:

(i) a stillborn infant; and

(ii) except as restricted by any other law, a fetus.

(6) "Disinterested witness" means an individual other than a spouse, child, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift or another adult who exhibited special care and concern for the individual. This term does not include a person to whom an anatomical gift could pass under section 10 of this chapter.

(7) "Document of gift" means a donor card or other record used to make an anatomical gift, including a statement or symbol on:

(A) a driver's license;

(B) an identification card;

(C) a resident license to hunt, fish, or trap; or

(D) a donor registry.

(8) "Donor" means an individual whose body or body part is the

subject of an anatomical gift.
(9) "Donor registry" means:
(A) a data base maintained by:
(i) the bureau of motor vehicles; or
(ii) the equivalent agency in another state;
(B) the Donate Life Indiana Registry maintained by the Indiana Donation Alliance Foundation; or
(C) a donor registry maintained in another state;
that contains records of anatomical gifts and amendments to or revocations of anatomical gifts.
(10) "Driver's license" means a license or permit issued by the bureau of motor vehicles to operate a vehicle.
(11) "Eye bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes.
(12) "Guardian" means an individual appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. The term does not include a guardian ad litem.
(13) "Hospital" means a facility licensed as a hospital under the laws of any state or a facility operated as a hospital by the United States, a state, or a subdivision of a state.
(14) "Identification card" means an identification card issued by the bureau of motor vehicles.
(15) "Minor" means an individual under eighteen (18) years of age.
(16) "Organ procurement organization" means a person designated by the Secretary of the United States Department of Health and Human Services as an organ procurement organization.
(17) "Parent" means an individual whose parental rights have not been terminated.
(18) "Part" means an organ, an eye, or tissue of a human being. The term does not mean a whole body.
(19) "Pathologist" means a physician:
(A) certified by the American Board of Pathology; or
(B) holding an unlimited license to practice medicine in Indiana and acting under the direction of a physician certified by the American Board of Pathology.
(20) "Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association,

joint venture, public corporation, government or governmental subdivision, agency, instrumentality, or any other legal or commercial entity.

(21) "Physician" or "surgeon" means an individual authorized to practice medicine or osteopathy under the laws of any state.

(22) "Procurement organization" means an eye bank, organ procurement organization, or tissue bank.

(23) "Prospective donor" means an individual who is dead or near death and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research, or education. The term does not include an individual who has made an appropriate refusal.

(24) "Reasonably available" means:

(A) able to be contacted by a procurement organization without undue effort; and

(B) willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

(25) "Recipient" means an individual into whose body a decedent's part has been or is intended to be transplanted.

(26) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

(27) "Refusal" means a record created under section 6 of this chapter that expressly states the intent to bar another person from making an anatomical gift of an individual's body or part.

(28) "Sign" means, with the present intent to authenticate or adopt a record:

(A) to execute or adopt a tangible symbol; or

(B) to attach to or logically associate with the record an electronic symbol, sound, or process.

(29) "State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(30) "Technician" means an individual determined to be qualified to remove or process parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law. The term includes an eye enucleator.

(31) "Tissue" means a part of the human body other than an organ or an eye. The term does not include blood or other bodily fluids unless the blood or bodily fluids are donated for the purpose of

research or education.

(32) "Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue.

(33) "Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of organ transplant patients.

SECTION 69. IC 29-2-16.1-3, AS ADDED BY P.L.147-2007, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 3. Subject to section 7 of this chapter, an anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in section 4 of this chapter by:

(1) the donor, if the donor is an adult or if the donor is a minor and is:

(A) emancipated; or

(B) authorized under state law to apply for a driver's license because the donor is at least sixteen (16) years of age;

(2) an agent, **a health care representative, or a proxy (as defined by IC 16-36-7-20)** of the donor, unless the health care power of attorney, **advance directive,** or other record prohibits the agent from making an anatomical gift;

(3) a parent of the donor, if the donor is not emancipated; or

(4) the donor's guardian.

SECTION 70. IC 29-2-19-10, AS ADDED BY P.L.143-2009, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 10. The provisions of a declarant's most recent declaration prevail over any other document executed by the declarant concerning any preferences described in section 9 of this chapter. However, this section may not be construed to invalidate a power of attorney executed under IC 30-5-5 or an appointment of a health care representative under IC 16-36-1 **or IC 16-36-7** with respect to any power or duty belonging to the attorney in fact or health care representative that is not related to a preference described in section 9 of this chapter.

SECTION 71. IC 29-2-19-17, AS AMENDED BY P.L.190-2016, SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 17. The right to control the disposition of a decedent's body, to make arrangements for funeral services, and to make other ceremonial arrangements after an individual's death devolves on the following, in the priority listed:

(1) A person:

(A) granted the authority to serve in a funeral planning declaration executed by the decedent under this chapter; or
(B) named in a United States Department of Defense form "Record of Emergency Data" (DD Form 93) or a successor form adopted by the United States Department of Defense, if the decedent died while serving in any branch of the United States Armed Forces (as defined in 10 U.S.C. 1481) and completed the form.

(2) An individual specifically granted the authority in a power of attorney or a health care power of attorney executed by the decedent under IC 30-5-5-16 **or a health care representative under IC 16-36-7.**

(3) The decedent's surviving spouse.

(4) A surviving adult child of the decedent or, if more than one (1) adult child is surviving, the majority of the other adult children. However, less than half of the surviving adult children have the rights under this subdivision if the adult children have used reasonable efforts to notify the other surviving adult children of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the surviving adult children.

(5) The surviving parent or parents of the decedent. If one (1) of the parents is absent, the parent who is present has the rights under this subdivision if the parent who is present has used reasonable efforts to notify the absent parent.

(6) The decedent's surviving sibling or, if more than one (1) sibling is surviving, the majority of the surviving siblings. However, less than half of the surviving siblings have the rights under this subdivision if the siblings have used reasonable efforts to notify the other surviving siblings of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the surviving siblings.

(7) An individual in the next degree of kinship under IC 29-1-2-1 to inherit the estate of the decedent or, if more than one (1) individual of the same degree survives, the majority of those who are of the same degree of kinship. However, less than half of the individuals who are of the same degree of kinship have the rights under this subdivision if they have used reasonable efforts to notify the other individuals who are of the same degree of kinship of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the individuals who are of the same degree of kinship.

(8) If none of the persons described in subdivisions (1) through (7) are available, or willing, to act and arrange for the final disposition of the decedent's remains, a stepchild (as defined in IC 6-4.1-1-3(f)) of the decedent. If more than one (1) stepchild survives the decedent, then a majority of the surviving stepchildren. However, less than half of the surviving stepchildren have the rights under this subdivision if they have used reasonable efforts to notify the other stepchildren of their intentions and are not aware of any opposition to the final disposition instructions by more than half of the stepchildren.

(9) The person appointed to administer the decedent's estate under IC 29-1.

(10) If none of the persons described in subdivisions (1) through (9) are available, any other person willing to act and arrange for the final disposition of the decedent's remains, including a funeral home that:

(A) has a valid prepaid funeral plan executed under IC 30-2-13 that makes arrangements for the disposition of the decedent's remains; and

(B) attests in writing that a good faith effort has been made to contact any living individuals described in subdivisions (1) through (9).

SECTION 72. IC 29-3-9-1, AS AMENDED BY P.L.74-2016, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 1. (a) As used in this section, "department" means the department of child services established by IC 31-25-1-1.

(b) As used in this section and except as otherwise provided in this section, "foster care" has the meaning set forth in IC 31-9-2-46.7.

(c) Except as provided in subsections (d) and (h), by a properly executed power of attorney, a parent of a minor or a guardian (other than a temporary guardian) of a protected person may delegate to another person for:

(1) any period during which the care and custody of the minor or protected person is entrusted to an institution furnishing care, custody, education, or training; or

(2) a period not exceeding twelve (12) months;

any powers regarding health care, support, custody, or property of the minor or protected person. A delegation described in this subsection is effective immediately unless otherwise stated in the power of attorney.

(d) A parent of a minor or a guardian of a protected person may not delegate under subsection (c) the power to:

(1) consent to the marriage or adoption of a protected person who

is a minor; or

(2) petition the court to request the authority to petition for dissolution of marriage, legal separation, or annulment of marriage on behalf of a protected person as provided under section 12.2 of this chapter.

(e) **Subject to IC 30-5-5-16,** a person having a power of attorney executed under subsection (c) has and shall exercise, for the period during which the power is effective, all other authority of the parent or guardian respecting the health care, support, custody, or property of the minor or protected person except any authority expressly excluded in the written instrument delegating the power. The parent or guardian remains responsible for any act or omission of the person having the power of attorney with respect to the affairs, property, and person of the minor or protected person as though the power of attorney had never been executed.

(f) A delegation of powers executed under subsection (c) does not, as a result of the execution of the power of attorney, subject any of the parties to any laws, rules, or regulations concerning the licensing or regulation of foster family homes, child placing agencies, or child caring institutions under IC 31-27.

(g) Any child who is the subject of a power of attorney executed under subsection (c) is not considered to be placed in foster care. The parties to a power of attorney executed under subsection (c), including a child, a protected person, a parent or guardian of a child or protected person, or an attorney-in-fact, are not, as a result of the execution of the power of attorney, subject to any foster care requirements or foster care licensing regulations.

(h) A foster family home licensed under IC 31-27-4 may not provide overnight or regular and continuous care and supervision to a child who is the subject of a power of attorney executed under subsection (c) while providing care to a child placed in the home by the department or under a juvenile court order under a foster family home license. Upon request, the department may grant an exception to this subsection.

(i) A parent who:

(1) is a member in the:

(A) active or reserve component of the armed forces of the United States, including the Army, Navy, Air Force, Marine Corps, National Guard, or Coast Guard; or

(B) commissioned corps of the:

(i) National Oceanic and Atmospheric Administration; or

(ii) Public Health Service of the United States Department

of Health and Human Services;

detailed by proper authority for duty with the Army or Navy of the United States; or

(2) is required to:

(A) enter or serve in the active military service of the United States under a call or order of the President of the United States; or

(B) serve on state active duty;

may delegate the powers designated in subsection (c) for a period longer than twelve (12) months if the parent is on active duty service. However, the term of delegation may not exceed the term of active duty service plus thirty (30) days. The power of attorney must indicate that the parent is required to enter or serve in the active military service of the United States and include the estimated beginning and ending dates of the active duty service.

(j) Except as otherwise stated in the power of attorney delegating powers under this section, a delegation of powers under this section may be revoked at any time by a written instrument of revocation that:

(1) identifies the power of attorney revoked; and

(2) is signed by the:

(A) parent of a minor; or

(B) guardian of a protected person;

who executed the power of attorney.

SECTION 73. IC 29-3-9-4.5, AS ADDED BY P.L.6-2010, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 4.5. (a) After notice to interested persons and upon authorization of the court, a guardian may, if the protected person has been found by the court to lack testamentary capacity, do any of the following:

(1) Make gifts.

(2) Exercise any power with respect to transfer on death or payable on death transfers that is described in IC 30-5-5-7.5.

(3) Convey, release, or disclaim contingent and expectant interests in property, including marital property rights and any right of survivorship incident to joint tenancy or tenancy by the entireties.

(4) Exercise or release a power of appointment.

(5) Create a revocable or irrevocable trust of all or part of the property of the estate, including a trust that extends beyond the duration of the guardianship.

(6) Revoke or amend a trust that is revocable by the protected person.

(7) Exercise rights to elect options and change beneficiaries under insurance policies, retirement plans, and annuities.

(8) Surrender an insurance policy or annuity for its cash value.

(9) Exercise any right to an elective share in the estate of the protected person's deceased spouse.

(10) Renounce or disclaim any interest by testate or intestate succession or by transfer inter vivos.

(b) Before approving a guardian's exercise of a power listed in subsection (a), the court shall consider primarily the decision that the protected person would have made, to the extent that the decision of the protected person can be ascertained. If the protected person has a will, the protected person's distribution of assets under the will is prima facie evidence of the protected person's intent. The court shall also consider:

(1) the financial needs of the protected person and the needs of individuals who are dependent on the protected person for support;

(2) the interests of creditors;

(3) the possible reduction of income taxes, estate taxes, inheritance taxes, or other federal, state, or local tax liabilities;

(4) the eligibility of the protected person for governmental assistance;

(5) the protected person's previous pattern of giving or level of support;

(6) the protected person's existing estate plan, if any;

(7) the protected person's life expectancy and the probability that the guardianship will terminate before the protected person's death; and

(8) any other factor the court considers relevant.

(c) A guardian may examine and receive, at the expense of the guardian, copies of the following documents of the protected person:

(1) A will.

(2) A trust.

(3) A power of attorney.

(4) A health care appointment.

(5) An advance directive.

~~(5)~~ **(6)** Any other estate planning document.

SECTION 74. IC 30-5-5-16, AS AMENDED BY P.L.81-2015, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 16. (a) This section does not prohibit an individual capable of consenting to the individual's own health care or to the health care of another from consenting to health care administered in

good faith under the religious tenets and practices of the individual requiring health care.

(b) Language conferring general authority with respect to health care powers means the principal authorizes the attorney in fact to do the following:

(1) Employ or contract with servants, companions, or health care providers to care for the principal.

(2) Consent to or refuse health care for the principal who is an individual in accordance with IC 16-36-4 and IC 16-36-1 by properly executing and attaching to the power of attorney a declaration or appointment, or both.

(3) Admit or release the principal from a hospital or health care facility.

(4) Have access to records, including medical records, concerning the principal's condition.

(5) Make anatomical gifts on the principal's behalf.

(6) Request an autopsy.

(7) Make plans for the disposition of the principal's body, including executing a funeral planning declaration on behalf of the principal in accordance with IC 29-2-19.

(c) Notwithstanding any other law, a document granting health care powers to an attorney in fact for health care may not be executed under this chapter after December 31, 2022. However, if a power of attorney that is executed after December 31, 2022, is written to grant both:

(1) health care powers; and

(2) nonhealth care powers under this chapter;

to an attorney in fact, the health care powers are void, but all other powers granted by the power of attorney will remain effective and enforceable under this article.

SECTION 75. IC 30-5-5-17, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2021 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 17. (a) If the attorney in fact has the authority to consent to or refuse health care under section ~~16(2)~~ **16(b)(2)** of this chapter, the attorney in fact may be empowered to ask in the name of the principal for health care to be withdrawn or withheld when it is not beneficial or when any benefit is outweighed by the demands of the treatment and death may result. To empower the attorney in fact to act under this section, the following language must be included in an appointment under IC 16-36-1 **or IC 16-36-7** in substantially the same form set forth below:

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. 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 health 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) Nothing in this section may be construed to authorize euthanasia.

SECTION 76. IC 30-5-7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 2. (a) A health care provider furnished with a copy of a declaration under IC 16-36-4 or an appointment under IC 16-36-1 **or IC 16-36-7** shall make the documents a part of the principal's medical records.

(b) If a change in or termination of a power of attorney becomes known to the health care provider, the change or termination shall be noted in the principal's medical records.

SECTION 77. IC 30-5-7-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 3. Whenever a health care provider believes a patient may lack the capacity to give informed consent to health care the provider considers necessary, the provider shall consult with the attorney in fact who has power to act for the patient under IC 16-36-4, IC 16-36-1, **IC 16-36-7,** or this article.

SECTION 78. IC 30-5-8-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 6. **Subject to IC 16-36-7,** appointments made under this article, IC 16-36-4, ~~and~~ IC 16-36-1, **and IC 16-36-7** can be made concurrently and will be given full effect under the law. However, the appointments may be executed independently and remain valid in their own right.

SECTION 79. IC 34-30-2-75.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 75.6. IC 16-36-7-40 (Concerning**

a health care provider's or other person's reliance on an advance directive).

SECTION 80. IC 34-30-2-75.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 75.7. IC 16-36-7-41 (Concerning a health care provider's or other person's reliance on an affidavit regarding an advance directive or decision of a health care representative).**

SECTION 81. IC 35-42-1-2.5, AS AMENDED BY P.L.158-2013, SECTION 412, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 2.5. (a) This section does not apply to the following:

(1) A licensed health care provider who administers, prescribes, or dispenses medications or procedures to relieve a person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, unless such medications or procedures are intended to cause death.

(2) The withholding or withdrawing of medical treatment or life-prolonging procedures by a licensed health care provider, including pursuant to IC 16-36-4 (living wills and life-prolonging procedures), IC 16-36-1 (health care consent), **IC 16-36-7 (advance directive),** or IC 30-5 ~~(power~~ **(health care power** of attorney).

(b) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following commits assisting suicide, a Level 5 felony:

(1) Provides the physical means by which the other person attempts or commits suicide.

(2) Participates in a physical act by which the other person attempts or commits suicide.

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: ____________________ Time: ____________________

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