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Indiana's New Health Care Advance Directive

Indiana Continuing Legal Education Forum (ICLEF)

Indiana's New Health Care Advance Directive
February 16, 2023

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INDIANA'S NEW HEALTH CARE ADVANCE DIRECTIVE

February 16, 2023

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DISCLAIMER

The information and procedures set forth in this practice manual are subject to constant change and therefore should serve only as a foundation for further investigation and study of the current law and procedures related to the subject matter covered herein. Further, the forms contained within this manual are samples only and were designed for use in a particular situation involving parties which had certain needs which these documents met. All information, procedures and forms contained herein should be very carefully reviewed and should serve only as a guide for use in specific situations.

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INDIANA'S NEW HEALTH CARE ADVANCE DIRECTIVE

Overview

Senate Enrolled Act 204 (P.L. 50-2021) became effective on July 1, 2021. It created a new single type of healthcare advance directive to appoint one or more healthcare representatives and/or state-specific instructions, wishes, and/or treatment preferences.

By the time this seminar occurs, the new-style health care advance directive will have replaced the durable power of attorney for health care under I.C. § 30-5-5-16, the appointment of health care representative under I.C. § 16-36-1-7, and the living will declaration under I.C. § 16-36-4-10. The most notable feature of this "replacement" aspect of the new statute is that healthcare powers included in general powers of attorney signed after December 31, 2022, will be void.

Join Bob Fechtman for this convenient one-hour webcast as he guides you through the key elements, signing requirements, remote signing options, presumptions, and optional provisions of the new healthcare advance directive.

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February 16, 2023

Indiana's New Health Care Advance Directive

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February 16, 2023

ROBERT W. FECHTMAN, JD, CELA

Robert Fechtman is a life-long resident of Indiana. He graduated from Northwestern University with a degree in music and a major in economics, and he received his JD from Rutgers School of Law. He also attended the University of San Diego's Institute on International and Comparative Law at Magdalen College, Oxford University. In 6th and 7th grade, Mr. Fechtman went away to school to sing with the American Boychoir in Princeton, New Jersey.

Mr. Fechtman focuses his practice on the problems of older and disabled persons, particularly special needs trusts, estate planning and trusts, health law, Medicaid planning, guardianships and decedents' estates. He is a frequent writer and speaker on a variety of estate planning, disability and elder law topics. He has been certified as an elder law attorney by the National Elder Law Foundation.

Mr. Fechtman is a member of the National Academy of Elder Law Attorneys, and he is a two-time Past President of the Indiana Chapter of the National Academy of Elder Law Attorneys. He is a member and a Past President of the Special Needs Alliance, which is a national, not-for-profit, invitation-only network of lawyers dedicated to disability and public benefits law. He is also a member of the Elder Law Section and the Probate, Real Property and Trusts Section of the Indiana State Bar Association, and a member of the Indianapolis Bar Association. Mr. Fechtman is a sustaining member of the Indiana Trial Lawyers Association. He is currently serving on the Board of Directors of the National Elder Law Foundation, which is the accrediting organization for elder law attorneys, and he is the immediate Past-President of the Board of The Indianapolis Children's Choir.

Indiana's New Health Care Advance Directive

by Robert W. Fechtman

I. Indiana's New Advance Directive for Health Care

Senate Enrolled Act 204 (P.L. 50-2021) became effective on July 1, 2021. It created a new single type of health care advance directive that could be signed and used anytime on or after July 1, 2021, to appoint one or more health care representatives and/or state specific instructions, wishes, and/or treatment preferences. This is codified under I.C. § 16-36-7.

There was a one-and-a-half-year transition period that ended on December 31, 2022. At that point, the new-style health care advance directive replaced the durable power of attorney for health care under I.C. § 30-5-5-16, the appointment of health care representative under I.C. § 16-36-1-7, and the living will declaration under I.C. § 16-36-4-10. The most notable feature of this "replacement" aspect of the new statute is that health care powers included in general powers of attorney signed after December 31, 2022, will be void.

Indiana's advance directive statutes were in great need of this update, due to conflicts between the statutes, outdated language, and unclear decision standards for legal representatives. Moreover, the old statutes required forms to be signed "in the physical presence" of the declarant, which posed technology and transportation barriers.

II. The Basic Elements of the New Indiana Advance Directive

1. There is no official or mandatory form for the advance directive;
2. The declarant my name one or more health care representatives;

3. The declarant may state specific health care decisions and/or treatment preferences, including preferences for life-prolonging procedures or palliative care; and,
4. The declarant may disqualify named individuals from serving as health care representative or receiving delegated authority from a health care representative.

III. New and More Flexible Signing Requirements

1. The declarant may sign on paper or electronically, OR may direct someone else to sign the declarant's name in the declarant's physical presence;
2. The declarant may sign in the "presence" of two adult witnesses, OR in the "presence" of a notary public; and,
3. The two witnesses or the notary public may also sign the advance directive on paper OR electronically.

IV. Three Options for Signing the New Advance Directive Remotely

1. The declarant and the two witnesses OR the declarant and the notary public sign identical counterparts on paper and interact using two-way audiovisual technology, in which case the signed counterparts must be assembled within ten business days;
2. The declarant and the two witnesses OR the declarant and the notary public sign electronically using two-way audiovisual technology; or,
3. The declarant and two witnesses sign with audio-only interaction by telephone during signing.

V. Basic Presumptions and Rules If the Advance Directive Does Not Explicitly State Otherwise

1. The advance directive is effective upon signing and remains in effect until or unless the advance directive is revoked in writing;
2. A later-signed advance directive supersedes and revokes an earlier-signed advance directive;
3. Unless the health care representatives are listed in priority order, two or more health care representatives named in the same advance directive have concurrent, equal, and independently exercisable authority and are not required to act jointly;
4. If the declarant still has capacity to consent to health care, orders and instructions by the declarant will control over any decisions by a health care representative;
5. Any health care representative can delegate authority under the advance directive in writing to any competent adult or adults;
6. The health care representative has authority to complete anatomical gifts, to authorize an autopsy, and to arrange for burial or cremation of the declarant's remains after the declarant's death;
7. The health care representative can access the declarant's medical records and health information without a specific HIPAA release;
8. The health care representative has authority to consent to mental health treatment for the declarant;
9. Each health care representative has authority to sign a POST form or an out-of-hospital Do Not Resuscitate (DNR) declaration for the declarant;

10. The health care representative has authority to apply for public benefits (including Medicaid) for the declarant and to access the declarant's financial records for that purpose; and,

11. Each health care representative is entitled to reasonable compensation and expense reimbursement for services performed and payments made for or on behalf of the declarant.

VI. Some of the Optional Provisions That May Be Added to the Advance Directive

1. The advance directive may prohibit or restrict the delegation of authority by the health care representative to other specific persons;

2. The advance directive may require another person to witness or approve a revocation of or amendment to the advance directive;

3. The advance directive may name two or more health care representatives in a stated order of priority;

4. The advance directive may require multiple health care representatives to act jointly or on a majority-vote basis to exercise some or all health care powers;

5. The advance directive may prohibit a health care representative from being compensated, or may state an hourly rate or other standard for determining reasonable compensation; and,

6. The advance directive may designate some person other than the health care representative to serve as an advocate or monitor.

VII. An Update on a Health Care Proxy's Authority to Sign an Out-of-Hospital DNR or a POST form

There are changes to the out-of-hospital DNR statute and the POST statute contained in House Bill 1458, which received a favorable hearing and a 13-to-0 "do pass" recommendation from the House Public Health Committee on January 24th.

The existing wording of those two statutes has led many doctors and clinicians to draw the inaccurate conclusion that only a legal guardian or an individual appointed as a health care representative by the patient could sign the out-of-hospital DNR declaration or the POST for the patient. The fix to both statutes will make it clear that a health care "proxy" who has priority to act under I.C. §§ 16-36-1-5(a) or 16-36-7-42 will be third in line, after the guardian and the appointed health care representative, to act on behalf of the patient to sign an out-of-hospital DNR declaration or a POST.

VIII. Forms and Links to Forms

Attached hereto as Appendices A through C are PDFs of three sample Advance Directive forms (short, mid-size, and longer) that have been shared previously by our friend and colleague, Jeff Dible, and a two-page Quick Reference Guide that was created and shared by Jeff Dible and another friend and colleague, Dr. Susan Hickman.

Mr. Dible has also recommended information available on the website of the Indiana Patient Preferences Coalition https://www.indianapost.org/patients/#advancedirectives, included two simple Advance Directive forms that were designed to be received, read, and completed by adults who have capacity to consent to health care but who have relatively low levels of functional literacy, *without* the participation or assistance of lawyer. Many hospitals, clinics, and

nursing facilities may start offering these Advance Directive forms (or forms similar to them) to patients at the time of treatment or admission.

Yet another friend and colleague, Keith Huffman, has been extremely helpful and informative in this area of patient preferences.

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 A-V inter-action with witnesses or notary _____	Signed by Declarant and witnesses or notary in 2 or more paper counterparts _____	Signed by Declarant and two witnesses 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

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant**.

_____
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 A-V inter-action with witnesses or notary _____	Signed by Declarant and witnesses or notary in 2 or more paper counterparts _____	Signed by Declarant and two witnesses 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

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

_____
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 A-V inter-action with witnesses or notary _____	Signed by Declarant and witnesses or notary in 2 or more paper counterparts _____	Signed by Declarant and two witnesses 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

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

_____
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

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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 (Oral revocation possible only in the direct presence of a health care provider)

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

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		**Remote 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.

Indiana's New Health Care Advance Directive

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Indiana's New Advance Directive for Health Care: I.C. 16-36-7

This is a new single type of health care advance directive that will replace the old durable power of attorney for health care (I.C. 30-5-5-16), the old appointment of health care representative (I.C. 16-36-1-7, and the old living will declaration (I.C. 16-36-4-10) effective January 1, 2023.

Health care powers included in general powers of attorney executed after December 31, 2022, will be void!

Reasons for the New Advance Directive for Health Care

Conflicts between the three statutes.

Outdated language in the old statutes.

Unclear decision standards for legal representatives.

The old statutes required forms to be signed “in the physical presence” of the declarant, which posed technology and transportation barriers.

Basic Elements of the New Indiana Advance Directive

There is no official or mandatory form.

The declarant may name one or more health care representatives (HCRs).

The declarant may state specific health care decisions and/or treatment preferences, including preferences for life-prolonging procedures or palliative care.

The declarant may disqualify named individuals form serving as HCR or receiving delegated authority from an HCR.

New and More Flexible Signing Requirements

The declarant may sign on paper or electronically, OR may direct someone else to sign the declarant's name in the declarant's physical presence.

The declarant may sign in the "presence" of two adult witnesses, OR in the "presence" of a notary public.

The two witnesses or the notary public may also sign the advance directive on paper OR electronically.

Options for signing remotely

The declarant and the two witnesses OR the declarant and the notary sign identical counterparts on paper and interact using two-way audiovisual technology – signed counterparts must be assembled within ten business days.

The declarant and the two witnesses OR the declarant and the notary sign electronically using two-way audiovisual technology.

The declarant and two witnesses sign with audio-only interaction by telephone during signing.

Basic Presumptions if Advance Directive Does Not Say Otherwise

The advance directive (AD) is effective upon signing and remains in effect until or unless revoked in writing.

A later-signed AD supersedes and revokes an earlier-signed AD.

Unless HCRs are listed in priority order, two or more HCRs have concurrent, equal, and independently exercisable authority and are not required to act jointly.

If the declarant still has capacity, then orders and instructions by the declarant will control over decisions by an HCR.

Basic Presumptions if Advance Directive Does Not Say Otherwise

Any HCR can delegate authority under the AD in writing to any competent adult or adults.

The HCR has authority regarding anatomical gifts, autopsies, and burial or cremation.

The HCR does not need a HIPAA release.

The HCR has authority to consent to mental health treatment.

Basic Presumptions if Advance Directive Does Not Say Otherwise

Each HCR has authority to sign a POST form or out-of-hospital DNR.

The HCR has authority to apply for public benefits (including Medicaid) and to access the financial records for that purpose.

Each HCR is entitled to reasonable compensation and reimbursement.

Optional Provisions that May Be Added to the Advance Directive

The AD may restrict the delegation authority of the HCR.

The AD may name two or more HCRs in a stated order of priority.

The AD may require multiple HCRs to act jointly or on a majority-vote basis.

The AD may prohibit an HCR from being compensated, or may state an hourly rate, etc.

This is not an exhaustive list.

Update on Health Care Proxy's Authority to Sign DNR and POST

House Bill 1458 will fix problems in I.C. 16-36-7 related to confusion about who can sign an out-of-hospital DNR or a POST on behalf of the patient.

Existing wording leads to some believing that only a guardian or an individual appointed as an HCR by the patient can do so.

New law will clarify that a health care "proxy" who has priority to act under I.C. 16-36-1(5) and 16-36-7-42 will be third in line after guardian and the appointed HCR.

Forms and Links to Forms

The appendices include three forms of an AD (short, mid-size, and longer) graciously supplied by Jeff Dible, and a 2-page Quick Reference Guide created and shared by Jeff Dible and Dr. Susan Hickman.

There is also a link to information available on the website of the Indiana Patient Preferences Coalition that includes two simple AD forms that were designed to be received, read, and completed by adults who have capacity to consent to health care but who have relatively low levels of functional literacy.