Triage Health Estate Planning Toolkit: Indiana

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Indiana probate courts accept written and oral wills. To make a valid written will in Indiana:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old or under 18 and a member of the armed forces or merchant marines
    - Of "sound mind" (meaning you know what you're doing)
    - Acting without the "improper" or coercive influences of other people (e.g., you don't feel your beneficiaries are forcing you to leave certain property to them)

2. You need to sign the will, in front of two witnesses who are not included in your will, or inform them you have signed your will and they must sign in front of you and each other.

Some states require you to have your will notarized for it to be "self-proving," or accepted in probate court without the court needing to contact your witnesses. But, in Indiana, if you and your witnesses sign a document stating you appeared to be of sound mind, you all signed voluntarily, and were all 18 or older, the will may be self-proving.

Indiana allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing). This change was made permanent in 2021 through the Indiana House Enrolled Act 1255. However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

To make a valid oral will in Indiana, you must be in "imminent peril of death," from illness or some other condition. The oral will is only valid if you do in fact die as a result of the "impending peril." This will cannot be used to pass down property worth more than $1,000, unless you are a member of the armed forces during war. In that circumstance, your oral will could be used to pass down property worth up to $10,000. To create an oral will:

1. Declare that your statement is your will in front of two witnesses not included in your will
2. One witness should write down your will within 30 days of your declaration
3. Submit the will for probate within six months after your death

While oral wills are useful for extreme circumstances, experts recommend creating a written will.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

In Indiana, a general power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint a successor agent, and a second successor agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. If you do not specify that they should not be compensated, your agent is entitled to reasonable compensation for their help. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it. This document will remain in effect until you die, unless you revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive (AHCD) is a legal document you can use to name a health care representative (HCR) and provide written instructions, or state preferences, about your future medical care in case you become unable to communicate. An advance directive in Indiana used to include three different forms: an appointment of a health care representative form, a health care power of attorney, and a living will. As of 2021 with the passage of SEA 204, there is no longer a mandatory state form, nor is there required language that must be included, and the advanced directive is now contained in one document. It is possible to only appoint an HCR without listing instructions or you can appoint an HCR and include instructions in the same document. To be valid, an advanced directive must be:

1. Signed by you (or have someone sign it for you if they are in your presence and you are unable to sign)
2. Signed by either 2 adult witnesses or a notary. At least one of the witnesses may not be a spouse or other relative

It is possible to sign the AHCD remotely (e.g., during a video or phone call.)

You may revoke your declaration at any time by:

1. Signing another advance directive
2. Signing a written statement revoking your directive
3. Verbally expressing your desire to revoke your declaration in the direct physical presence of your health care provider

Canceling a declaration only takes effect when your physician is aware that you have taken one of these steps.

There are limits to your AHCD. If you are pregnant, your decision to have life-prolonging procedures withheld or withdrawn will not be honored.

Part III includes a sample form.

State Laws About POLST/MOLST

A physician orders for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Indiana, this form is called a physician order for scope of treatment (POST). The POST does not replace an advance health care directive.. You can complete a POST form with your health care provider.

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Use of antibiotics
- Medically assisted nutrition, or food and hydration offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your health care provider to review it regularly to make sure it still reflects your wishes. For a POST form to be valid, you (or your legal representative) and your health care provider (a licensed physician, advanced practice registered nurse, or physician's assistant) must read, sign and date it.

You or your legal representative may revoke a POST at any time by:

- Signing and dating a written statement of revocation
- Physically destroying the POST form
- Orally declaring your intent to revoke the form
- Directing another individual to revoke the form

Revoking a POST form is effective once it has been communicated to a health care provider.

Part III includes a sample POST form.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Indiana's funeral designation form is called a funeral planning declaration. The declaration cannot be included in a will, a power of attorney, or a similar document. If there is another document that includes preferences regarding funerals or other arrangements, the funeral planning declaration will prevail over those documents. However, the creation of a funeral planning declaration will not otherwise void a power of attorney or the appointment of a health care representative.

To be valid, a funeral planning declaration must be:

- Voluntary
- In writing
- Identify the individual to serve as the designee
- Signed and dated by the person making the declaration or by another person in the declarant's presence at the direction of the declarant
- Signed by two competent witnesses at least 18 years of age (the designee, the spouse, parent, child of the declarant, or an individual entitled to declarant's estate, either with or without a will, may not be a witness)

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Indiana does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care through an advance directive. During the 2024 legislative session Indiana lawmakers will consider a death with dignity bill, called the Indiana End of Life Options Act. Previous attempts to pass aid-in-dying legislation in Indiana have failed.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Health Estate Planning Toolkit: Indiana

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Funeral Planning Declaration
- Physician Order for Scope of Treatment (POST)
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

INDIANA DURABLE POWER OF ATTORNEY

THE POWERS YOU GRANT BELOW ARE EFFECTIVE EVEN IF YOU BECOME DISABLED OR INCOMPETENT

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL OR OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

I _____[Principal's Name] of _____ [Principal's Address] appoint _____[Agent's Name] of _____[Agent's Address] as my Agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects:

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (N) AND IGNORE THE LINES IN FRONT OF THE OTHER POWERS.

TO GRANT ONE OR MORE, BUT FEWER THAN ALL, OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF EACH POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF IT. YOU MAY, BUT NEED NOT, CROSS OUT EACH POWER WITHHELD.

Note: If you initial Item A or Item B, which follow, a notarized signature will be required on behalf of the Principal.

INITIAL

_____(A) Real property transactions. To lease, sell, mortgage, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, sale, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, tear down, alter, rebuild, improve manage, insure, move, rent, lease, sell, convey, subject to liens, mortgages, and security deeds, and in any way or manner deal with all or any part of any interest in real property whatsoever, including specifically, but without limitation, real property lying and being situated in the State of Indiana, under such terms and conditions, and under such covenants, as my Agent shall deem proper and may for all deferred

payments accept purchase money notes payable to me and secured by mortgages or deeds to secure debt, and may from time to time collect and cancel any of said notes, mortgages, security interests, or deeds to secure debt.

_____(B) Tangible personal property transactions. To lease, sell, mortgage, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, sale, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens or mortgages, or to take any other security interests in said property which are recognized under the Uniform Commercial Code as adopted at that time under the laws of the State of Indiana or any applicable state, or otherwise hypothecate (pledge), and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I own at the time of execution or may thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem proper.

_____(C) Stock and bond transactions. To purchase, sell, exchange, surrender, assign, redeem, vote at any meeting, or otherwise transfer any and all shares of stock, bonds, or other securities in any business, association, corporation, partnership, or other legal entity, whether private or public, now or hereafter belonging to me.

_____(D) Commodity and option transactions. To buy, sell, exchange, assign, convey, settle and exercise commodities futures contracts and call and put options on stocks and stock indices traded on a regulated options exchange and collect and receipt for all proceeds of any such transactions; establish or continue option accounts for the principal with any securities or futures broker; and, in general, exercise all powers with respect to commodities and options which the principal could if present and under no disability.

_____(E) Banking and other financial institution transactions. To make, receive, sign, endorse, execute, acknowledge, deliver and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of banks, savings and loans, credit unions, or other institutions or associations. To pay all sums of money, at any time or times, that may hereafter be owing by me upon any account, bill of exchange, check, draft, purchase, contract, note, or trade acceptance made, executed, endorsed, accepted, and delivered by me or for me in my name, by my Agent.
To borrow from time to time such sums of money as my Agent may deem

proper and execute promissory notes, security deeds or agreements, financing statements, or other security instruments in such form as the lender may request and renew said notes and security instruments from time to time in whole or in part. To have free access at any time or times to any safe deposit box or vault to which I might have access.

_____(F) Business operating transactions. To conduct, engage in, and otherwise transact the affairs of any and all lawful business ventures of whatever nature or kind that I may now or hereafter be involved in. To organize or continue and conduct any business which term includes, without limitation, any farming, manufacturing, service, mining, retailing or other type of business operation in any form, whether as a proprietorship, joint venture, partnership, corporation, trust or other legal entity; operate, buy, sell, expand, contract, terminate or liquidate any business; direct, control, supervise, manage or participate in the operation of any business and engage, compensate and discharge business managers, employees, agents, attorneys, accountants and consultants; and, in general, exercise all powers with respect to business interests and operations which the principal could if present and under no disability.

_____(G) Insurance and annuity transactions. To exercise or perform any act, power, duty, right, or obligation, in regard to any contract of life, accident, health, disability, liability, or other type of insurance or any combination of insurance; and to procure new or additional contracts of insurance for me and to designate the beneficiary of same; provided, however, that my Agent cannot designate himself or herself as beneficiary of any such insurance contracts.

_____(H) Estate, trust, and other beneficiary transactions. To accept, receipt for, exercise, release, reject, renounce, assign, disclaim, demand, sue for, claim and recover any legacy, bequest, devise, gift or other property interest or payment due or payable to or for the principal; assert any interest in and exercise any power over any trust, estate or property subject to fiduciary control; establish a revocable trust solely for the benefit of the principal that terminates at the death of the principal and is then distributable to the legal representative of the estate of the principal; and, in general, exercise all powers with respect to estates and trusts which the principal could exercise if present and under no disability; provided, however, that the Agent may not make or change a will and may not revoke or amend a trust revocable or amendable by the principal or require the trustee of any trust for the benefit of the principal to pay income or principal to the Agent unless specific authority to that end is given.

_____(I) Claims and litigation. To commence, prosecute, discontinue, or defend all actions or other legal proceedings touching my property, real or personal, or any part thereof, or touching any matter in which I, or, my property, real or personal, may be in any way concerned. To defend, settle, adjust, make allowances, compound, submit to arbitration, and compromise all accounts, reckonings, claims, and demands whatsoever that now are, or

hereafter shall be, pending between me and any person, firm, corporation, or other legal entity, in such manner and in all respects as my Agent shall deem proper.

_____(J) Personal and family maintenance. To hire accountants, attorneys at law, consultants, clerks, physicians, nurses, agents, servants, workmen, and others and to remove them, and to appoint others in their place, and to pay and allow the persons so employed such salaries, wages, or other remunerations, as my Agent shall deem proper.

_____(K) Benefits from Social Security, Medicare, Medicaid, or other governmental programs, or military service. To prepare, sign and file any claim or application for Social Security, unemployment or military service benefits; sue for, settle or abandon any claims to any benefit or assistance under any federal, state, local or foreign statute or regulation; control, deposit to any account, collect, receipt for, and take title to and hold all benefits under any Social Security, unemployment, military service or other state, federal, local or foreign statute or regulation; and, in general, exercise all powers with respect to Social Security, unemployment, military service, and governmental benefits, including but not limited to Medicare and Medicaid, which the principal could exercise if present and under no disability.

_____(L) Retirement plan transactions. To contribute to, withdraw from and deposit funds in any type of retirement plan (which term includes, without limitation, any tax qualified or nonqualified pension, profit sharing, stock bonus, employee savings and other retirement plan, individual retirement account, deferred compensation plan and any other type of employee benefit plan); select and change payment options for the principal under any retirement plan; make rollover contributions from any retirement plan to other retirement plans or individual retirement accounts; exercise all investment powers available under any type of self-directed retirement plan; and, in general, exercise all powers with respect to retirement plans and retirement plan account balances which the principal could if present and under no disability.

_____(M) Tax matters. To prepare, to make elections, to execute and to file all tax, social security, unemployment insurance, and informational returns required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, to execute, and to file all other papers and instruments which the Agent shall think to be desirable or necessary for safeguarding of me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, to compromise, or to contest or to apply for refunds in connection with any taxes or assessments for which I am or may be liable.

_____(N) ALL OF THE POWERS LISTED ABOVE. YOU NEED NOT INITIAL ANY OTHER LINES IF YOU INITIAL LINE (N).

SPECIAL INSTRUCTIONS:

ON THE FOLLOWING LINE YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

THIS POWER OF ATTORNEY SHALL BE CONSTRUED AS A GENERAL DURABLE POWER OF ATTORNEY AND SHALL CONTINUE TO BE EFFECTIVE EVEN IF I BECOME DISABLED, INCAPACITATED, OR INCOMPETENT.

(YOUR AGENT WILL HAVE AUTHORITY TO EMPLOY OTHER PERSONS AS NECESSARY TO ENABLE THE AGENT TO PROPERLY EXERCISE THE POWERS GRANTED IN THIS FORM, BUT YOUR AGENT WILL HAVE TO MAKE ALL DISCRETIONARY DECISIONS. IF YOU WANT TO GIVE YOUR AGENT THE RIGHT TO DELEGATE DISCRETIONARY DECISION-MAKING POWERS TO OTHERS, YOU SHOULD KEEP THE NEXT SENTENCE, OTHERWISE IT SHOULD BE STRICKEN.)

Authority to Delegate. My Agent shall have the right by written instrument to delegate any or all of the foregoing powers involving discretionary decision-making to any person or persons whom my Agent may select, but such delegation may be amended or revoked by any agent (including any successor) named by me who is acting under this power of attorney at the time of reference.

(YOUR AGENT WILL BE ENTITLED TO REIMBURSEMENT FOR ALL REASONABLE EXPENSES INCURRED IN ACTING UNDER THIS POWER OF ATTORNEY. STRIKE OUT THE NEXT SENTENCE IF YOU DO NOT WANT YOUR AGENT TO ALSO BE ENTITLED TO REASONABLE COMPENSATION FOR SERVICES AS AGENT.)

Right to Compensation. My Agent shall be entitled to reasonable compensation for services rendered as agent under this power of attorney.

(IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAME(S) AND ADDRESS(ES) OF SUCH SUCCESSOR(S) IN THE FOLLOWING PARAGRAPH.)

Successor Agent. If any Agent named by me shall die, become incompetent, resign or refuse to accept the office of Agent, I name the following (each to act alone and successively, in the order named) as successor(s) to such Agent:

_____

Choice of Law. THIS POWER OF ATTORNEY WILL BE GOVERNED BY THE LAWS OF THE STATE OF INDIANA WITHOUT REGARD FOR CONFLICTS OF LAWS PRINCIPLES. IT WAS EXECUTED IN THE STATE OF INDIANA AND IS INTENDED TO BE VALID IN ALL JURISDICTIONS OF THE UNITED STATES OF AMERICA AND ALL FOREIGN NATIONS.

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my Agent.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed this ____day of _____, 20___

_____

[Signature of Principal]

_____

[Signature of Agent]

_____

[Signature of Successor Agent (if any)]

Notary Acknowledgement (*Must be completed by Notary*)

State of _____ County of _____ Subscribed, Sworn and acknowledged before me by _____, the Principal, and subscribed and sworn to before me by _____, witness, this _____ day of _____.

_____
Notary Signature

Notary Public
In and for the County of _____State of ____
My commission expires: _____

Seal

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 56184 (11-16)
Indiana State Department of Health – IC 16-36-1; IC 16-36-6

INSTRUCTIONS: See instructions on back.

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday *(mm/dd/yyyy)*	Medical Record Number of Healthcare Facility or Provider *(optional)*	Healthcare Facility or Provider *(optional)*

Appointment of Health Care Representative

I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).

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.

I specify the following terms and conditions *(if any)*:

Name of Representative Appointed	Address of Representative *(number and street, city, state, and ZIP code)*	Telephone Number of Representative
Signature of Patient / Appointor or Designee *(must be signed in the appointor's presence)*	Printed Name of Patient / Appointor or Designee	Date of Appointment *(mm/dd/yyyy)*
Signature of Witness	Printed Name of Witness	Date *(mm/dd/yyyy)*

INSTRUCTIONS FOR STATE FORM 56184, INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

1. There are numerous types of advance directives. The Indiana State Department of Health encourages individuals to consult with their attorney, health planner, and health care providers in completing any advance directive.

2. This state form is not required for an appointment of a health care representative. An individual may use a form designed by their attorney or other entity to specifically meet the individual's needs. To be valid, any form must comply with statutory requirements.

3. An individual is not required to complete a health care representative appointment form. An individual may always chose to not appoint a health care representative. If there is no appointed representative, state medical consent laws would determine who may consent to your healthcare.

4. The medical record number and health care facility or provider is not required for the appointment to be effective. It may be included as a means of assisting the health care provider in identifying the correct patient and locating the appointment in the correct medical record.

5. The patient / appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.

6. The authority granted becomes effective according to the terms of the appointment.

7. The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the patient / appointor regains the capacity to consent.

8. 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 patient / appointor, except when the patient / appointor is capable of consenting.

9. The appointment of a health care representative must be witnessed by an adult other than the health care representative.

10. In making all decisions regarding the patient's / appointor's health care, the health care representative shall act:
    a. In the best interest of the patient / appointor consistent with the purpose expressed in the appointment.
    b. In good faith.

11. 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:
    a. The patient / appointor.
    b. The patient's / appointor's legal representative if one is known.
    c. The health care provider if the representative knows there is one.

12. An individual who is capable of consenting to health care may revoke:
    a. The appointment at any time by notifying the representative orally or in writing; or
    b. The authority granted to the representative by notifying the health care provider orally or in writing.

INDIANA LIVING WILL DECLARATION

State Form 55316 (6-13)
Indiana State Department of Health – IC 16-36-4

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

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 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 under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed _____

_____
City, County, and State of Residence

WITNESSES

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 *(month, day, year)* _____

Witness _____ Date *(month, day, year)* _____

INDIANA LIFE PROLONGING PROCEDURES DECLARATION

State Form 55315 (6-13)
Indiana State Department of Health – IC 16-36-4

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

LIFE PROLONGING PROCEDURES 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 desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

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 request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed _____

_____
City, County, and State of Residence

WITNESSES

The declarant has been personally known to me and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____ Date *(month, day, year)* _____

Witness _____ Date *(month, day, year)* _____

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

Indiana Physician Orders for Scope of Treatment (POST)
Information for Patients about POST
November 2016

The Indiana Physician Orders for Scope of Treatment (POST) form is a physician's order determined by the patient's goals and the treatment options available to a patient based on the individual's current health. The POST is intended to record a patient's wishes for medical treatment. The following is intended to provide you with general information about the POST form:

The POST form:

- The POST form is always voluntary. A health care provider or facility cannot require you to complete a POST form.
- The original POST form is the personal property of the patient. You are encouraged to keep the original POST form; however, photocopies, electronic copies, and faxes are also legal and valid. Your treating physician should retain a copy in your medical record.
- The State periodically updates the POST form. Previous completed versions of the form are still valid.
- HIPAA permits disclosure of the POST to health care professionals as necessary for treatment.
- The POST form may be printed on white paper. There is no requirement that a POST form be printed on a particular color of paper.

Completing the POST:

- A family member of an adult patient is not authorized to complete and sign a POST unless the family member has been appointed in writing as the legal representative for the patient.

Provisions of the Physician Orders for Scope of Treatment (POST):

- The POST should reflect your current treatment preferences.
- Any section of the form not completed implies authorization for full treatment for provisions described in that section.
- The POST is a medical order and requires the signature of the treating physician to be legally valid.

Changing Physician Orders for Scope of Treatment (POST):

- Once initial medical treatment is begun and the risks and benefits of further treatment are clear, your treatment wishes may change. You may change the POST at any time to reflect your current treatment wishes.

Reviewing Physician Orders for Scope of Treatment (POST): Your POST form should be reviewed in the following circumstances:

- There is a substantial change in your health status.
- You are transferred from one care setting or care level to another.
- Your treating physician changes.
- Your treatment preferences change.

Revoking Physician Orders for Scope of Treatment (POST):

- A person with capacity, or the valid representative of a person without capacity, can revoke the POST at any time by any of the following: a signed and dated writing; physical cancellation or destruction; by another individual at the direction of the declarant or representative; or an oral expression of an intent to revoke. The revocation is effective upon communication to a health care provider.

Advance Directives:

- No form can address all the medical treatment decisions that may need to be made. There are numerous types of advance directives. You are encouraged to discuss advance directives with your attorney, physician, or other qualified individual. Your physician can provide you with information about POST and whether it is appropriate for you.
- An advance directive, including appointing someone to speak on your behalf if you cannot speak for yourself, is recommended. The ISDH has an Advance Directive Resource Center at www.in.gov/isdh/25880 that provides a brochure, forms, and information about advance directives.

INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (R3 / 5-18)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name	Patient First Name	Middle Initial
Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing.

☐ Attempt Resuscitation / CPR ☐ Do Not Attempt Resuscitation / DNR

When not in cardiopulmonary arrest, follow orders in **B, C** and **D.**

B *Check One*

MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing.

☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

OPTIONAL ADDITIONAL ORDERS:

SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Patient Name:_____ Date of Birth *(mm/dd/yyyy)*:_____

	SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE: In order for the POST form to be effective, the patient or legally appointed representative must sign and date the form below.
E	**SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE** My signature below indicates that my physician or physician's designee discussed with me the above orders and the selected orders correctly represent my wishes.

Signature ***(required by statute)***	Print Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

F	**CONTACT INFORMATION FOR LEGALLY APPOINTED REPRESENTATIVE IN SECTION E *(IF APPLICABLE)*:** If the signature above is other than patient's, add contact information for the representative.

Relationship of representative identified in Section E if patient does not have capacity ***(required by statute)***	Address *(number and street, city, state, and ZIP code)*	Telephone Number

PHYSICIAN ORDER:

A POST form may be executed only by an individual's treating physician, advanced practice registered nurse, or physician assistant, and only if:

(1) the treating physician, advanced practice registered nurse, or physician assistant has determined that:
  (A) the individual is a qualified person; and
  (B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and
(2) the qualified person or representative has signed and dated the POST form

A qualified person is an individual who has at least one (1) of the following:

(1) An advanced chronic progressive illness.
(2) An advanced chronic progressive frailty.
(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:
  (A) there can be no recovery; and
  (B) death will occur from the condition within a short period without the provision of life prolonging procures.
(4) A medical condition 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.

G **DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:**

☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian
☐ Parent of Minor ☐ Health Care Power of Attorney

H **SIGNATURE OF TREATING PHYSICIAN / ADVANCED PRACTICE REGISTERED NURSE / PHYSICIAN ASSISTANT**

My signature below indicates that I or my designee have discussed with the patient or patient's representative the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Signature of Treating Physician / APRN / PA ***(required by statute)***	Print Treating Physician / APRN / PA Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

Physician / APRN / PA office telephone number ***(required by statute)***	Physician / APRN / PA License Number ***(required by statute)***	Health Care Professional preparing form if other than the physician / APRN / PA

I **APPOINTMENT OF HEALTH CARE REPRESENTATIVE:** As patient you have the option to appoint an individual to serve as your health care representative pursuant to IC 16-36-1-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the ISDH web site at http://www.in.gov/isdh/25880.htm.

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

⌘

HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524