INDIANA
DISABILITY RIGHTS

Advance Directive

Indiana Health Care Representative

A Health Care Representative is a person chosen by you to make healthcare decisions, including end of life decisions, if you are unable to make your own decisions. A doctor determines if a person is unable to make their own decisions.

My legal name is (also known as "Declarant")

_____

My Health Care Representative can make decisions for me if I cannot make and share my own health care decisions. My Health Care Representative **must** follow my wishes and values. My values include my ideas about dignity and quality of life. If my Health Care Representative does not know my wishes, my Health Care Representative must act in good faith and make decisions in my best interests. These decisions include:

- Agreeing to medical treatment;
- Refusing medical treatment;
- Stopping medical treatment; and
- Arranging comfort care.

I want the following person to be my Health Care Representative (HCR):

(HCR Name): _____

(HCR Phone Number): _____

If my primary HCR named above is not able or available to act for me, I want the following person to be my backup HCR.

(Backup HCR Name): _____

(Backup HCR Phone Number): _____

Equity Through Advocacy

The Protection and Advocacy System for the State of Indiana

4755 Kingsway Drive, Suite 100
Indianapolis, IN 46205
IndianaDisabilityRights.org

Phone: 317.722.5555
Toll Free: 800.622.4845
Fax: 317.722.5564

This Advanced Directive project was funded by the Indianapolis Bar Foundation.

By Signing this form, I hereby revoke any and all previous health care power of attorney and health care representative form(s).

_____ _____

Printed name (Declarant) Date

_____

Signature (Declarant or Representative)

_____

Print name of adult (if any) who signs for Declarant (if Declarant is physically unable to sign)

_____ I have initialed the space to the left if I signed this Advance Directive after talking with and listening to two (2) witnesses by telephone only.

Signature of Two Adult Witnesses

Each of the undersigned Witnesses confirm that they have received satisfactory proof of the identity of the Declarant, 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 Date

_____

Printed Name of Adult Witness 1

_____ _____

Signature of Adult Witness 2 Date

_____

Printed Name of Adult Witness 2