INDIANA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

Please call the HelpLine at 800/658-8898 to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit www.nationalhospicefoundation.org/donate. Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #11241.

Support for this program is provided by a grant from
The Robert Wood Johnson Foundation, Princeton,
New Jersey.

Copyright © 2005 National Hospice and Palliative Care Organization. All rights reserved. Revised 2007. Reproduction and distribution by an organization or organized group without the written permission of the National Hospice and Palliative Care Organization is expressly forbidden.

Your Advance Care Planning Packet

Using these materials	3
Summary of the HIPAA Privacy Rule	4
Introduction to Indiana Advance Directive	6
Instructions for Completing Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative	7
Instructions for Completing Indiana Living Will Declaration	8
Instructions for Completing Indiana Life-Prolonging Procedures Declaration	9
Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative	10
Indiana Living Will Declaration	13
Indiana Life-Prolonging Procedures Declaration	15
You Have Filled Out Your Advance Directive, Now What?	16
Glossary	Appendix A
Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives	Appendix B

Using these materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.

2. These materials include:
   - Instructions for preparing your advance directive.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

3. Read the HIPAA Privacy Rule Summary on page 4.

4. Read all the instructions, on pages 7 through 8, as they will give you specific information about the requirements in your state.

5. Refer to the Glossary located in Appendix A if any of the terms are unclear.

ACTION STEPS

6. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

7. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.

8. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

9. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the state-specific contacts for Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives, located in Appendix B.

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
    - File a complaint with your provider or health insurer, or
    - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

INTRODUCTION TO YOUR INDIANA ADVANCE DIRECTIVE

This packet contains three legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. This document is especially useful because it allows you to appoint someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

2. The **Indiana Living Will Declaration (Declaration A)** lets you refuse life-prolonging procedures in the event that you develop a terminal condition and can no longer make your own medical decisions. The Declaration goes into effect only when your doctor certifies in writing that you have an injury, disease or illness from which, to a reasonable degree of medical certainty, there can be no recovery, and death will occur within a short period of time without the use of life prolonging procedures.

3. The **Indiana Life-Prolonging Procedures Declaration (Declaration B)** lets you request the use of all life-prolonging procedures in the event that you develop a terminal condition and can no longer make your own medical decisions.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

COMPLETING YOUR INDIANA POWER OF ATTORNEY FOR HEALTHCARE DECISIONS AND APPOINTMENT OF HEALTHCARE REPRESENTATIVE

Whom should I appoint as my attorney-in-fact and healthcare representative?

Your attorney-in-fact and healthcare representative is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your attorney-in-fact and healthcare representative can be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney-in-fact and healthcare representative should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A healthcare representative and attorney-in-fact may also be called an "agent" or "proxy.") Your attorney-in-fact and healthcare representative must be an adult, eighteen years of age or older.

You can appoint a second person as your alternate attorney-in-fact and healthcare representative. The alternate will step in if the first person you name as attorney-in-fact and healthcare representative is unable, unwilling or unavailable to act for you.

How do I make my Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative legal?

The law requires that you sign the document in the presence of a notary public.

Should I add personal instructions to my Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative?

One of the strongest reasons for naming an attorney-in-fact and healthcare representative is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your attorney-in-fact and healthcare representative's power to act in your best interest.

Talk with the person you appoint about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to refuse specific treatments or conditions, you should use your Indiana Living Will (Declaration A).

What if I change my mind?

Unless otherwise stated in your document, you may revoke your Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative only in a writing that:

- Identifies the Power of Attorney revoked; and
- Is signed by you.
- A revocation is not effective unless the attorney-in-fact or other person has actual knowledge of the revocation.

COMPLETING DECLARATION A: INDIANA LIVING WILL DECLARATION

How do I make my Indiana Living Will Declaration legal?

State law requires that you sign your Declaration, or direct another to sign it in your presence, in the presence of two competent witnesses, 18 years of age or older, who must also sign the document and state that they personally know you and believe you to be of sound mind, and that they do not fall into any of the categories of people who cannot be witnesses. These witnesses **cannot** be:

- the person who signed the Declaration on your behalf,
- your parent, spouse or child,
- entitled to any part of your estate, or
- directly financially responsible for your medical care.

Note: You do not need to notarize your Indiana Living Will Declaration.

Can I add personal instructions to my Declaration?

Yes. You can add personal instructions to your Living Will Declaration in the part of the document called "Other directions."

If you have appointed an attorney-in-fact and healthcare representative, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Declaration are to be decided by my attorney-in-fact and healthcare representative."

What if I change my mind?

You may revoke your Declaration at any time by:

- signing and dating a written revocation,
- orally expressing your intent to revoke your Declaration, or
- physically canceling or destroying the Declaration or directing another to do so in your presence.

Your revocation becomes effective once you notify your doctor.

What other important facts should I know?

A pregnant patient's Living Will Indiana Declaration will not be honored due to restrictions in the state law.

COMPLETING DECLARATION B: INDIANA LIFE-PROLONGING PROCEDURES DECLARATION

How do I make my Indiana Life-Prolonging Procedures Declaration legal?

State law requires that you sign your Life-Prolonging Procedures Declaration, or direct another to sign it, in the presence of two competent witnesses, 18 years of age or older, who must also sign the document to show that they personally know you and believe you to be of sound mind.

Note: You do not need to notarize your Indiana Life-Prolonging Procedures Declaration.

What if I change my mind?

You may revoke your Declaration by:

- signing and dating a written revocation,
- orally expressing your intent to revoke your Declaration, or
- physically canceling or destroying the Declaration or directing another to do so in your presence.

Your revocation becomes effective once you notify your doctor.

INSTRUCTIONS

INDIANA POWER OF ATTORNEY FOR HEALTH CARE DECISIONS AND APPOINTMENT OF HEALTH CARE REPRESENTATIVE – PAGE 1 OF 3

PRINT YOUR NAME AND ADDRESS

1) I, ____
(name)

of ____
(address)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ATTORNEY-IN-FACT

hereby appoint ______________________________________
(name of attorney-in-fact)

____
(address)

____
(home telephone number) (work telephone number)

as my attorney-in-fact to make health care decisions on my behalf whenever I am incapable of making my own health care decisions.

POWERS OF YOUR ATTORNEY-IN-FACT

I grant my attorney-in-fact the following powers in matters affecting my health care:

(1) to employ or contract with servants, companions, or health care providers involved in my health care;
(2) to admit or release me from a hospital or health care facility;
(3) to have access to my records, including medical records; concerning my condition;
(4) to make anatomical gifts on my behalf;
(5) to request an autopsy; and
(6) to make plans for the disposition of my body.

© 2005 National Hospice and Palliative Care Organization
2007 Revised.

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE ATTORNEY-IN-FACT

2) In the event the person I appoint above is unable, unwilling or unavailable to act as my attorney-in-fact, I hereby appoint:

____
(name of successor attorney-in-fact)

of ____
(address)

____

____
(home telephone number) (work telephone number)

as my successor attorney-in-fact.

APPOINTMENT AND POWERS OF HEALTH CARE REPRESENTATIVE

Appointment of my Attorney-in-Fact as my Health Care Representative; Decisions Regarding Withdrawing or Withholding Health Care

In addition to the powers granted above, I appoint my attorney-in-fact as my **health care representative**, and authorize my attorney-in-fact and health care representative to make decisions in my best interest concerning the consent, withdrawal or withholding of health care. I understand health care to include any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well-being. Health care also includes the providing of nutrition and hydration through intravenous, endotracheal or nasogastric tubes.

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.

© 2005 National Hospice and Palliative Care Organization 2007 Revised.

PRINT YOUR NAME AND THE DATE

I, ____, the principal, sign my name to this instrument this ________ day of ___________________ 20______,
(date) (month) (year)
and do hereby declare to the undersigned witness that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am eighteen years of age or older, of sound mind, and under no constraint or undue influence.

SIGN THE DOCUMENT

____
(principal)

A NOTARY PUBLIC MUST COMPLETE THIS SECTION OF YOUR DOCUMENT

Subscribed and acknowledged before me by ____________________________,

the principal, this ______ day of _______________________________, 20_______.

____
(notary public)

My Commission expires _____________________

© 2005 National Hospice and Palliative Care Organization
2007 Revised.

Courtesy of Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES ABOUT ARTIFICIAL FEEDING

ADD PERSONAL INSTRUCTIONS (IF ANY)

© 2005 National Hospice and Palliative Care Organization 2007 Revised.

DECLARATION A
TO WITHHOLD OR WITHDRAW LIFE-PROLONGING PROCEDURES

Declaration made this __________ day of ______________________________.
(day) (month, year)

I, ____,
(name)
being at least eighteen (18) years old 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 Indiana Code 16-36-1-7 or my attorney in fact with health care powers under Indiana Code 30-5-5.

Other directions:

INDIANA LIVING WILL DECLARATION - PAGE 2 OF 2

SIGN THE DOCUMENT AND PRINT YOUR PLACE OF RESIDENCE

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 importance of this declaration.

Signed ____

City, County, and State of Residence ______________________________

____

WITNESSING PROCEDURE

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.

WITNESSES MUST SIGN AND DATE THE DOCUMENT

Witness ____

Date ________________________

Witness ____

Date ________________________

© 2005 National Hospice and Palliative Care Organization
2007 Revised.

INSTRUCTIONS	
	INDIANA LIFE-PROLONGING PROCEDURES DECLARATION - PAGE 1 OF 1
PRINT THE DATE	DECLARATION B TO REQUEST THE USE OF LIFE-PROLONGING PROCEDURES
PRINT YOUR NAME	Declaration made this __________ day of ______________________________. (day) (month, year)
	I, ____, (name) being at least eighteen (18) years old 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.
SIGN AND PRINT YOUR PLACE OF RESIDENCE	I understand the full importance of this declaration. Signed ____ City, County, and State of Residence _________________________________ ____
WITNESSING PROCEDURE WITNESSES MUST SIGN AND DATE YOUR DOCUMENT	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 old. Witness ____ Date ___________________________ Witness ____ Date ___________________________
© 2005 National Hospice and Palliative Care Organization 2007 Revised.	*Courtesy of Caring Connections* *1700 Diagonal Road, Suite 625, Alexandria, VA 22314* *www.caringinfo.org, 800/658-8898*

You Have Filled Out Your Advance Directive, Now What?

1. Your Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative, Living Will Declaration and Life-Prolonging Procedures Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.

2. Give photocopies of the signed originals to your attorney-in-fact and healthcare representative and alternate, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.

3. Be sure to talk to your attorney-in-fact and healthcare representative and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. If you want to change your documents after they have been signed and witnessed, you should complete new forms.

5. Remember, you can always revoke one or both of your Indiana documents.

6. Be aware that your Indiana documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called “non-hospital do-not-resuscitate orders,” are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**

Appendix A

Glossary

Advance directive - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Artificial nutrition and hydration – Artificial nutrition and hydration supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Brain death – The irreversible loss of all brain function. Most states legally define death to include brain death.

Capacity - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary resuscitation - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

Do-Not-Resuscitate (DNR) order - A DNR order is a physician's written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

Emergency Medical Services (EMS)**:** A group of governmental and private agencies that provide emergency care, usually to persons outside of healthcare facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

***Healthcare agent*:** The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

Hospice - Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes. Support is provided to the persons loved ones as well.

Intubation- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

***Life-sustaining treatment* -** Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

Living will - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "healthcare declaration," or "medical directive."

Mechanical ventilation - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea).

Medical power of attorney - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a healthcare proxy, durable power of attorney for healthcare or appointment of a healthcare agent. The person appointed may be called a healthcare agent, surrogate, attorney-in-fact or proxy.

Palliative care - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms.

Power of attorney – A legal document allowing one person to act in a legal matter on another's behalf regarding to financial or real estate transactions.

***Respiratory arrest*:** The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Surrogate decision-making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

***Ventilator* –** A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or withdrawing treatment - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

Appendix B

Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives

LEGAL SERVICES

The Indiana Division of Disability, Aging & Rehab Services provides a listing of Area Agencies on Aging (AAA), each of whom contracts with legal providers for older individuals.

Anyone over the age of 60 and home bound can get legal information and advice about most issues, including:

- Power of Attorney
- Living Wills and Trusts
- Civil issues and more

- Must be over 60
- Free for individuals with low to moderate incomes, all others are asked to make a $2.00 donation.

To locate AAA in your area:
Call toll free: 800-986-3505

OR

Visit their website: http://www.iaaaa.org/members/aaalist.asp

END-OF-LIFE SERVICES

The Indiana Division of Disability, Aging & Rehab Services provides a listing of Area Agencies on Aging (AAA) and can connect people over 60 in Indiana with an AAA in their region who can assist them with other services.

AAA resources and services include, but are not limited to:

- Answering questions on Medicare and Medicaid
- Housing
- Home health services
- Adult Day Care
- Legal Referrals
- Respite care and much more

- Must be over 60
- Free to low to moderate income individuals, donations are encouraged

Visit the website for more information about the services:
http://www.iaaaa.org/members/aaalist.asp

For more information call toll free: 800-986-3505