For further information regarding Health Care Declarations in Indiana, consult with your legal counsel, or contact:

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Midland at Home does not make any recommendations regarding selection of legal advice. This information about **Scout Advocacy** and **Ken Bennett** is provided as a courtesy, as he prepared the Health Care Declaration form for our use and his firm is directly focused on assisting with care issues.

HEALTH CARE DECLARATION AND POWER OF ATTORNEY

AND LIVING WILL

OF

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I. APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I, ______________________________, a resident of ____________ County, Indiana, hereby designate and appoint _______________________, as my attorney-in-fact for health care decisions ("Health Care Representative") who is authorized to act for me in all matters of health care in accordance with IC 16-36-1 and IC 30-5. If ___________________ is unavailable or unable to act as my Health Care Representative I designate and appoint _______________________________, to act under the same terms.

Without limiting the powers of my Health Care Representative as set for in IC 16-36-1 and IC 30-5, my Health Care Representative shall expressly have the following powers:

1. To employ any Christian Science Practitioner or Christian Science Nurse, and to discharge any Christian Science Practitioner or Christian Science Nurse as my agent may deem necessary for my physical, mental and emotional well-being; and to pay them, or any of them, reasonable compensation.

2. To employ any medical practitioner (including a medical doctor or dentist) or nurse to provide health services of a more or less mechanical nature, such as the pulling of a tooth, setting of a broken bone, or the taking of stitches, as consistent with the tenets and practices of Christian Science.

3. To arrange for or modify nursing care in any accredited Christian Science Nursing Facility, or home care by a Christian Science Nurse.

(a) Specific authority of my Health Care Representatives to decide to withhold or withdraw treatment:

I authorize my Health Care Representative to make decisions in my best interest concerning withdrawal or withholding of health care, consistent with my religious principles as set forth in Section (b) Care Instructions below. If at any time, based on my previously expressed preferences, 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, and/or would not be consistent with my religious principles, 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 Representatives must try to discuss this decision with me. However, if I am unable to communicate, my Health Care Representatives may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers and other advisers.

(b) Care Instructions.

I am a member of the Church of Christ, Scientist, also known as the Christian Science denomination. The tenets and practices of Christian Science include healing entirely by prayer or spiritual means. It is my desire to rely entirely and exclusively upon Christian Science treatment for all my health care needs. Therefore, in lieu of any and all forms of medical treatment, including those thought necessary to sustain my life, I authorize and direct my agent to arrange for my health care by spiritual means through prayer, exclusively, in accordance with the tenets and practices of Christian Science. I desire to receive such Christian Science treatment, at home, from a Christian Science Practitioner. If any nursing care is necessary, I prefer to receive it from a Christian Science Nurse, if one is reasonably available, and not from a medical nurse. Should I require nursing care outside the home, I prefer my agent to arrange for such care at an accredited Christian Science Nursing Facility. However, I do not wish to be hospitalized or placed in any convalescent or other facility which does not subscribe exclusively to the tenets and practices of Christian Science.

The foregoing to the contrary notwithstanding, my agent may, if my agent determines it appropriate, cause me to receive assistance from a medical doctor or a dentist, as the case may be, where such assistance consists of a more or less mechanical nature, such as the pulling of a tooth, setting of a broken bone, or the taking of stitches. Such assistance is consistent with the tenets and practices of Christian Science.

Other than as stated above, I do not wish to receive medical life-prolonging care, surgery, medicine, diagnostic testing, shock treatment, or drugs of any kind.

I have made my wishes known to my agent and have asked my agent to carry out those wishes if I am unable to act on my own behalf. I request that no governmental agency nor any other group or individual intervene to cause medical treatment to be given to me or to cause me to be hospitalized against my stated wishes or against the instructions and decisions of my agent. By arranging for Christian Science treatment for me in lieu of medical treatment, even in a situation which may be deemed life-threatening, my agent shall not be subject to civil or criminal liability.

All references to Christian Science Practitioners and Christian Science Nurses shall mean those listed in the then current edition of the "Christian Science Journal" or nurses affiliated and recommended by a Christian Science facility. All references to an accredited Christian Science Nursing Facility shall mean a Christian Science sanatorium or nursing facility accredited by either by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., or the Organization for Accreditation of Christian Science Care Facilities. If the agent is unable to gain admission for me in a fully accredited Christian Science sanitorium or nursing facility, my agent is

authorized to use a non-accredited Christian Science sanitorium or nursing facility provided such sanitarium/facility requires its patients to be under the care of a Christian Science Practitioner.

My Health Care Representative's decision shall be controlling notwithstanding the assertions of other members of my family.

I authorize health care providers to rely on my Health Care Representative's decisions just as if I had made them myself and I hereby ratify and confirm all that my Health Care Representative shall do by virtue hereof.

(c) Release authority under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau Inc. or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give disclose and release to my Health Care Representative, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse. My Health Care Representative shall have full authority to authorize the release of confidential medical information on my behalf.

The authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date, continues during any period of my incapacity and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

II. DECLARATION UNDER INDIANA'S LIVING WILL STATUTE

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;

then 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, which Health Care Representative or attorney-in-fact with health care powers is named herein below.

III. DECLARATION IN RELATION TO HEALTH CARE IF I AM IN A COMA OR A PERSISTENT VEGETATIVE STATE

I intend to take full advantage of Indiana's Living Will Statute, however, I do not intend my right to refuse treatment to be limited to the terminal circumstances described in the Living Will Statute but also wish to exercise my Constitutional and Common Law right to refuse consent to health care if I am in a coma or a persistent vegetative state which is reasonably concluded to be irreversible.

Therefore, if at any time my attending physician certifies in writing that:

(1) I am in a coma or a persistent vegetative state;
(2) which is concluded to a high level of medical certainty to be irreversible by my attending physician; and
(3) the use of life prolonging procedures would serve only to artificially prolong the dying process;

then 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.

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which Health Care Representative or attorney-in-fact with health care powers is named herein below.

I further authorize my Health Care Representative to direct the withholding or withdrawal of treatments in such circumstances.

I understand the full import of this Declaration and Health Care Power of Attorney and I am executing this document as a statement of my intent this _______________________, 20____.

____
Declarant, ____________________________

STATE OF INDIANA)
) SS:
COUNTY OF _________________)

Before me, a Notary Public in and for said County and State, personally ________________, who acknowledged the execution of the foregoing Health Care Declaration and Power of Attorney.

WITNESS my hand and Notarial seal, this _____________________, 20____.

[SEAL]

Commission Expires: ___________________

____
Notary Public

County of Residence: ___________________

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Name (printed)