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## **ALASKA ADVANCE DIRECTIVE**

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# Alaska Advance Health Care Directive

This booklet contains the Alaska statutory form for an Advance Health Care Directive. Alaska Legal Services Corporation (ALSC) provides this as a service to you and does not take responsibility for how you fill it out. The law allows you to prepare this form on your own. This booklet contains general information to assist you. However, if you have questions, please contact an attorney or other knowledgeable source. The Alaska Bar Association's Lawyer Referral Service can provide you with a list of private attorneys (272-0352 or 1-800-770-9999 outside Anchorage). If you cannot afford an attorney or if you are 60 years or older, ALSC may be able to assist you. Anchorage 272-9431 or (888) 478-2572; Bethel 543-2237 or (800) 478-2230; Dillingham 842-1452 or (888) 383-2448; Fairbanks 452-5181 or (800) 478-5401; Juneau 586-6425 or (800) 789-6426; Kenai 395-0352 or (855)-395-0352; Ketchikan 225-6420 or (877) 525-6420; Kotzebue 442-7737 or (877) 622-9797; Nome 443-2230 or (888) 495-6663; Palmer (746-4636) or (855) 996-4636; or Utqiagvik (Barrow) (855-8998) or (855) 755-8998.

This booklet is provided by the Alaska Legal Services Corporation, a statewide private nonprofit organization. Nothing contained in this publication is to be considered as the rendering of legal advice for specific cases and readers are responsible for obtaining such advice from an attorney.

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For information regarding many other legal topics, see [www.alaskalawhelp.org](http://www.alaskalawhelp.org)

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**ADVANCE HEALTH CARE DIRECTIVE**  
**Alaska Statutes 13.52**

Introduction

You have the right to give instructions about your own health care to the extent allowed by law. You also have the right to name someone else to make health care decisions for you to the extent allowed by law. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form if the form complies with the requirements of AS 13.52.

**Part 1** of this form is a durable power of attorney for health care. A "durable power of attorney for health care" means the designation of an agent to make health care decisions for you. Part 1 lets you name another individual as an agent to make health care decisions for you if you do not have the capacity to make your own decisions or if you want someone else to make those decisions for you now even though you still have the capacity to make those decisions. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you that you could legally make for yourself. This form has a place for you to limit the authority of your agent. You do not have to limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right, to the extent allowed by law, to

- (a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including the administration or discontinuation of psychotropic medication;
- (b) select or discharge health care providers and institutions;
- (c) approve or disapprove proposed diagnostic tests, surgical procedures, and programs of medication;
- (d) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care; and

(e) make an anatomical gift following your death.

**Part 2** of this form lets you give specific instructions for any aspect of your health care to the extent allowed by law, except you may not authorize mercy killing, assisted suicide, or euthanasia. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

**Part 3** of this form lets you express an intention to make an anatomical gift following your death.

**Part 4** of this form lets you make decisions in advance about certain types of mental health treatment.

**Part 5** of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as your agent to make sure that the person understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time, except that you may not revoke this declaration when you are determined not to be competent by a court, by two physicians, at least one of whom shall be a psychiatrist, or by both a physician and a professional mental health clinician. In this advance health care directive, "competent" means that you have the capacity

(1) to assimilate relevant facts and to appreciate and understand your situation with regard to those facts; and

(2) to participate in treatment decisions by means of a rational thought process.

**PART 1**  
**DURABLE POWER OF ATTORNEY FOR**  
**HEALTH CARE DECISIONS**

**(1) DESIGNATION OF AGENT.** I designate the following individual as my agent to make health care decisions for me:

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(name of individual you choose as agent)

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(address) (city) (state) (zip code)

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(telephone contact)

**DESIGNATION OF FIRST ALTERNATE (OPTIONAL):** If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent

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(name of individual you choose as first alternate agent)

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(address) (city) (state) (zip code)

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(telephone contact)

**DESIGNATION OF SECOND ALTERNATE (OPTIONAL):** If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent

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(name of individual you choose as second alternate agent)

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(address) (city) (state) (zip code)

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(telephone contact)

**(2) AGENT'S AUTHORITY.** My agent is authorized and directed to follow my individual instructions and my other wishes to the extent known to the agent in making all health care decisions for me. If these are not known, my agent is authorized to make these decisions in accordance with my best interest, including decisions to provide, withhold, or withdraw artificial hydration and nutrition and other forms of health care to keep me alive, except as I state here:

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(Add additional sheets if needed.)

Under this authority, "*best interest*" means that the benefits to you resulting from a treatment outweigh the burdens to you resulting from that treatment after assessing

(A) the effect of the treatment on your physical, emotional, and cognitive functions;

(B) the degree of physical pain or discomfort caused to you by the treatment or the withholding or withdrawal of the treatment;

(C) the degree to which your medical condition, the treatment, or the withholding or withdrawal of treatment, results in a severe and continuing impairment;

(D) the effect of the treatment on your life expectancy;

(E) your prognosis for recovery, with and without the treatment;

(F) the risks, side effects, and benefits of the treatment or the withholding of treatment; and

(G) your religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

**(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE.**

*Except in the case of mental illness, my agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. In the case of mental illness, unless I mark the following box, my agent's authority becomes effective when a court determines I am unable to make my own decisions, or, in an emergency, if my primary physician or another health care provider determines I am unable to make my own decisions.*

If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

**(4) AGENT'S OBLIGATION.** My agent shall make health care decisions for me in accordance with this durable power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent

known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**(5) NOMINATION OF GUARDIAN.** If a guardian needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named under (1) above, in the order designated.

## **PART 2 INSTRUCTIONS FOR HEALTH CARE**

If you are satisfied to allow your agent to determine what is best for you in making health care decisions, you do not need to fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want. There is a state protocol that governs the use of do not resuscitate orders by physicians and other health care providers. You may obtain a copy of the protocol from the Alaska Department of Health and Social Services. A "do not resuscitate order" means a directive from a licensed physician that emergency cardiopulmonary resuscitation should not be administered to you.

**(6) END-OF-LIFE DECISIONS.** Except to the extent prohibited by law, I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: *(Check only one box.)*

(A) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards; OR

(B) Choice Not To Prolong Life

I want comfort care only and I do not want my life to be prolonged with medical treatment if, in the judgment of my physician, I have *(check all choices that represent your wishes)*

(i) a condition of permanent unconsciousness: a condition that, to a high degree of medical certainty, will last permanently without improvement; in which, to a high degree of medical certainty, thought, sensation, purposeful action, social interaction, and awareness of myself and the environment are absent; and for which, to a high degree of medical certainty, initiating or

continuing life-sustaining procedures for me, in light of my medical outcome, will provide only minimal medical benefit for me; or

(ii) a terminal condition: an incurable or irreversible illness or injury that without the administration of life-sustaining procedures will result in my death in a short period of time, for which there is no reasonable prospect of cure or recovery, that imposes severe pain or otherwise imposes an inhumane burden on me, and for which, in light of my medical condition, initiating or continuing life-sustaining procedures will provide only minimal medical benefit;

Additional instructions: \_\_\_\_\_

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(C) Artificial Nutrition and Hydration. If I am unable to safely take nutrition, fluids, or nutrition and fluids (*check your choices or write your instructions*),

I wish to receive artificial nutrition and hydration indefinitely;

I wish to receive artificial nutrition and hydration indefinitely, unless it clearly increases my suffering and is no longer in my best interest;

I wish to receive artificial nutrition and hydration on a limited trial basis to see if I can improve;

In accordance with my choices in (6)(B) above, I do not wish to receive artificial nutrition and hydration.

Other instructions: \_\_\_\_\_

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(D) Relief from Pain.

I direct that adequate treatment be provided at all times for the sole purpose of the alleviation of pain or discomfort; or

I give these instructions:

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(E) Should I become unconscious and I am pregnant, I direct that

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**(7) OTHER WISHES.** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that

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Conditions or limitations: \_\_\_\_\_

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(Add additional sheets if needed.)

**PART 3**  
**ANATOMICAL GIFT AT DEATH**  
**(Optional)**

If you are satisfied to allow your agent to determine whether to make an anatomical gift at your death, you do not need to fill out this part of the form.

**(8) Upon my death:** *(mark applicable box)*

OR  (A) I give any needed organs, tissues, or other body parts,

(B) I give the following organs, tissues, or other body parts only \_\_\_\_\_

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(C) My gift is for the following purposes *(mark any of the following you want)*:

- (i) transplant;
- (ii) therapy;
- (iii) research;
- (iv) education.

(D) I refuse to make an anatomical gift.

**PART 4**  
**MENTAL HEALTH TREATMENT**  
**(optional)**

This part of the declaration allows you to make decisions in advance about mental health treatment. The instructions that you include in this declaration will be followed only if a court, two physicians that include a psychiatrist, or a physician and a professional mental health clinician believe that you are not competent and cannot make treatment decisions. Otherwise, you will be considered to be competent and to have the capacity to give or withhold consent for the treatments.

If you are satisfied to allow your agent to determine what is best for you in making these mental health decisions, you do not need to fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

**(9) PSYCHOTROPIC MEDICATIONS.** If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

\_\_\_\_\_ I consent to the administration of the following medications:

\_\_\_\_\_

\_\_\_\_\_ I do not consent to the administration of the following medications:

\_\_\_\_\_

Conditions or limitations: \_\_\_\_\_  
\_\_\_\_\_.

**(10) ELECTROCONVULSIVE TREATMENT.** If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

\_\_\_\_\_ I consent to the administration of electroconvulsive treatment.

\_\_\_\_\_ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: \_\_\_\_\_  
\_\_\_\_\_.

**(11) ADMISSION TO AND RETENTION IN FACILITY.** If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding admission to and retention in a mental health facility for mental health treatment are as follows:

\_\_\_\_\_ I consent to being admitted to a mental health facility for mental health treatment for up to \_\_\_\_\_ days. (The number of days not to exceed 17.)

\_\_\_\_\_ I do not consent to being admitted to a mental health facility for mental health treatment.

Conditions or limitations: \_\_\_\_\_  
\_\_\_\_\_.

**OTHER WISHES OR INSTRUCTIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Conditions or limitations: \_\_\_\_\_  
\_\_\_\_\_.

**PART 5  
PRIMARY PHYSICIAN  
(Optional)**

**(12) I designate the following physician as my primary physician:**

\_\_\_\_\_  
(name of physician)

\_\_\_\_\_  
(address) (city) (state) (zip code)

\_\_\_\_\_  
(telephone)

**OPTIONAL:** If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

\_\_\_\_\_  
(name of physician)

\_\_\_\_\_  
(address) (city) (state) (zip code)

\_\_\_\_\_  
(telephone)

**(13) EFFECT OF COPY.** A copy of this form has the same effect as the original.

**(14) SIGNATURES.** Sign and date the form here:

DATE \_\_\_\_\_  
\_\_\_\_\_ (sign your name)

BIRTHDATE \_\_\_\_\_

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(address) (city) (state) (zip code)

**(15) WITNESSES.** This advance care health directive will not be valid for making health care decisions unless it is

(A) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature. The witnesses may not be a health care provider employed at the health care institution or health care facility where you are receiving health care, an employee of the health care provider who is providing health care to you, an employee of the health care institution or health care facility where you are receiving health care, or the person appointed as your agent by this document. At least one of the two witnesses may not be related to you by blood, marriage, or adoption or entitled to a portion of your estate upon your death under your will or codicil; **or**

(B) acknowledged before a notary public in the state.

**ALTERNATIVE NO. 1**  
**Witnesses Who are NOT RELATED to the Principal or**  
**Who DO NOT BENEFIT Under the Terms of the Principal's**  
**Will**

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not (1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care; (2) an employee of the health care provider providing health care to the principal; (3) an employee of the health care institution or health care facility where the principal is receiving health care; (4) the person appointed as agent by this document; (5) related to the principal by blood, marriage, or adoption; or (6) entitled to a portion of the principal's estate upon the principal's death under a will or codicil.

DATE \_\_\_\_\_  
\_\_\_\_\_ (signature of witness)

\_\_\_\_\_  
(printed name of witness)

\_\_\_\_\_  
(address) (city) (state) (zip code)

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not (1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care; (2) an employee of the health care provider who is providing health care to the principal; (3) an employee of the health care institution or health care facility where the principal is receiving health care; or (4) the person appointed as agent by this document; (5) related to the principal by blood, marriage, or adoption; or (6) entitled to a portion of the principal's estate upon the principal's death under a will or codicil.

DATE \_\_\_\_\_  
\_\_\_\_\_ (signature of witness)

\_\_\_\_\_  
(printed name of witness)

\_\_\_\_\_  
(address) (city) (state) (zip code)

**ALTERNATIVE NO. 2**

State of Alaska )  
\_\_\_\_\_ Judicial District )

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me appeared \_\_\_\_\_, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that the person executed it.

Notary Seal

\_\_\_\_\_  
(signature of notary public)



## **CRITICAL STEP: SHARE YOUR COMPLETED DOCUMENT!**

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**Your document is only helpful if people know where to find it when it is needed.** It's important to discuss the decisions outlined in your document with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your document once it has been completed and satisfies the legal requirements for your state (if applicable).

### **WHO NEEDS A COPY OF YOUR DOCUMENT?**

- Anyone assigned a decision-making role in the document
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

### **HOW TO SHARE YOUR DOCUMENT**

- 1) **Use Cake!** Upload your document to a free Cake account for safekeeping. Share 24/7 secure document access with anyone that has an email address\*

**Create your free Cake account:** [www.joincake.com/share-free](http://www.joincake.com/share-free)

- 2) **Or, print** and provide copies to everyone who needs one

### **WHY PLAN & SHARE WITH CAKE?**

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print all your end-of-life documents
- Share 24/7 document access with anyone that has an email address\*

**Create your free Cake account:** [www.joincake.com/share-free](http://www.joincake.com/share-free)

*\* Some healthcare providers may require a paper copy of your document to be able to enter it into their records.*