# 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. Please call: 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. Funding for this booklet came from the State of Alaska, Department of Health and Social Services, Division of Senior and Disabilities Services. 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.

For information regarding many other legal topics, see www.alaskalawhelp.org

January 2017

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

## Introduction

As a competent adult, 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.

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. You also 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 1) determined to be "not competent" by a court; or 2) determined to be "not competent" by two physicians (at least one of whom is a psychiatrist); or 3) determined to be "not competent" by both a physician and a professional mental health clinician.

Ideally, you should discuss your decisions and instructions with your agent before signing the form in order to make sure that the person is willing to take the responsibility and understands your wishes.

The form is divided into several parts covering a variety of health care topics. **Part 1** of this form contains a *Durable Power of Attorney for Health Care*. In *Section 1* of the form, you may designate an agent to make health care decisions for you if you do not have the capacity to make your own decisions. "Capacity" is defined as an individual's ability to receive and evaluate information effectively and to make and effectively communicate health care decisions.

You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Although you can choose just about any adult to serve as your agent, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care, unless he or she is related to you.

Your agent may make all health care decisions for you that you could legally make for yourself. However, in *Section 2* of the form, you can 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:

- 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;

- select or discharge health care providers and institutions;

- approve or disapprove proposed diagnostic tests, surgical procedures, and programs of medication;

- direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care; and

- make an anatomical gift following your death, such as organ donation.

In *Section 3* of the form, if you desire, you may allow your agent's authority to make health care decisions to become effective immediately, even though you still have the capacity to make those decisions or to revoke your agent's authority. *Section 4* of the form outlines the obligation of the agent to act according to your known wishes or in your best interest if your wishes are not know. *Section 5* states that the person designated as your agent would also be your choice to serve as your guardian if one is needed to be appointed by a court even if you have nominated someone else in a separate *General Power of Attorney* form.

**Part 2** of the form contains language frequently referred to as a *Living Will*. In *Sections 6 and 7*, you have the opportunity to 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. You may express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration. You may also express your wishes regarding pain management and relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

**Part 3** *(Section 8)* lets you express an intention to make an anatomical gift (such as an organ donation) following your death.

In **Part 4** *(Sections, 9, 10, and 11)*, you may make decisions in advance about certain types of mental health treatment, such as medications and electroconvulsive treatment (shock treatment). In the event that you do not have the capacity to give or withhold informed consent for mental health treatment, you may state in advance whether you consent to admission to a mental health facility and if so, under what limitations.

**Part 5** *(Section 12)* of the form lets you name a physician to have primary responsibility for your health care. This can be helpful if you have a long-standing relationship with a doctor.

In order for your advance directive to be valid, you must sign the form and it must be witnessed by one of two alternative methods described in the form *(Sections 13, 14, and 15)*.

After your advance directive form is signed and witnessed, you should give a copy of it to your doctor, 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. A copy of the form has the same effect as the original.

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## 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:

_____
(name of individual you choose as agent)

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

_____
(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

_____
(name of individual you choose as first alternate agent)

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

_____
(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

_____
(name of individual you choose as second alternate agent)

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

_____
(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 AN AGENT'S AUTHORITY BECOMES EFFECTIVE.**

*Unless I mark the following box*, the authority of my agent becomes effective only upon a determination that I lack capacity and it ceases to be effective upon a determination that I have recovered capacity. Such a determination shall be made by my primary physician (except in the case of mental illness). In the case of mental illness, such a determination shall be made by a court or my primary physician or another health care provider in the event of an emergency.

**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 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. This nomination takes priority over any other nomination I may have made, including a nomination contained in a separate general *Power of Attorney* form.

## PART 2
## INSTRUCTIONS FOR HEALTH CARE

If you are comfortable in allowing 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. If you do that, you should place your initials next to the wording you cross out. Note: there is a separate form that governs the use of "Do Not Resuscitate" orders. A "Do Not Resuscitate" order is a directive from a licensed physician stating that emergency cardiopulmonary resuscitation should not be administered to you. These orders can only be issued by a doctor and other health care providers. You may obtain information regarding Alaska's Comfort One program from the Alaska Department of Health and Social Services' website at http://dhss.alaska.gov/dph/Emergency/Pages/ems/programs/comfort_one.aspx

**(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: _____
_____

(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; or

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

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

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

☐ - Other instructions:_____
_____

(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:_____
_____

(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: _____

_____

(Attach 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 the time of your death, you do not need to fill out this part of the form.

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

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

OR

☐ - (B) I only give the following organs, tissues, or other body parts: _____

_____

☐ - (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 your advance directive allows you to make decisions regarding possible 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 *(choose one and initial):*

_____ 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 (shock) 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 *(choose one and initial):*

_____ 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

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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)

Alternate (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) SIGNATURE.** Sign and date your advance directive here:

DATE _____ _____
(sign your name)

_____
(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.

**WITNESS ALTERNATIVE NO. 1**
**For 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 #1)

_____
(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 #2)

_____
(printed name of witness)

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

**WITNESS ALTERNATIVE NO. 2**
**for a Notary Public**

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)