

ALASKA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
1731 King St., Suite 100, 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.

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:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

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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, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. 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.
6. 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.

Introduction to Your Alaska Advance Directive

This packet contains five parts 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, in addition to allowing you to make anatomical gifts and designate a physician to have primary responsibility for your health care.

1. Part 1 is a **Durable Power of Attorney for Healthcare**. This form lets you name someone to make decisions about your medical care. A Durable Power of Attorney is typically used if you can no longer speak for yourself, but it also can be used 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 also name an alternate agent to act for you if your first choice is not willing, able, or available. However, your agent may not be an owner, operator, or employee of a healthcare institution where you are receiving care. Unless otherwise specified, the Durable Power of Attorney goes into effect when your doctor determines that you are unable to communicate your healthcare decisions.
2. Part 2 contains your **Individual for Healthcare**. It lets you state your wishes about medical care and may be limited to take effect only if a specified condition arises (e.g., in the event that you develop a terminal condition and can no longer make your own medical decisions). Note that there is a state protocol that governs the use of Do Not Resuscitate orders by physicians and other health care providers.
3. Part 3 lets you express an intention to make an **Anatomical Gift**.
4. Part 4 lets you make decisions in advance about certain types of mental health treatment.
5. Part 5 lets you designate a physician to have primary responsibility for your health care.

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

Completing Your Alaska Durable Power of Attorney for Healthcare

Whom should I appoint as my durable power of attorney for healthcare?

A durable power of attorney for healthcare is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself.

Your durable power of attorney may be a family member or a close friend whom you trust to make serious decisions. The person you name as your durable power of attorney clearly should understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A durable power of attorney may also be called an “agent” or “proxy.”)

Your agent will have access to your medical information and records and will be able to consent to or refuse general medical care. Your agent will make health care decisions in accordance with your individual instructions and other wishes to the extent known to your agent. Otherwise, your agent will make the decision in accordance with his or her determination of your best interest. In determining the your best interest, your agent will consider your personal values to the extent known to him or her. You may also limit the authority of your agent.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as durable power of attorney is unable, unwilling or unavailable to act for you.

How do I make my Alaska Durable Power of Attorney for Healthcare legal?

The law requires that your Durable Power of Attorney for Healthcare be in writing, contain a date of execution, be signed by you (the “principal”), and witnessed by one of the following methods: (1) signed by at least two individuals who are personally known by the principal, each of whom either witnessed the signing of the instrument or the principal’s acknowledgement of the signature of the instrument; or (2) acknowledged before a notary public at a place in the state. The witness may not be, however, the agent, or a healthcare provider or employee of the healthcare institution or facility where you are receiving healthcare. At least one of the individual witnesses must be someone who is (1) not related to you by blood, marriage, or adoption; (2) not entitled to a portion of your estate upon death under a will at the time of the execution.

Should I add personal instructions to my Alaska Durable Power of Attorney for Healthcare?

One of the strongest reasons for naming an agent 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 agent’s power to act in your best interest. Talk with your agent about your future medical care and describe what you consider to be an acceptable “quality of life”. If you want to record your wishes about specific treatments or conditions, you should use your Alaska Individual Instructions.

Completing Your Alaska Durable Power of Attorney for Healthcare (continued)

What if I change my mind?

Except in the case of mental illness, you may revoke the designation of your Durable Power of Attorney for Healthcare only by a signed writing or by personally informing the supervising healthcare provider. Except in the case of mental illness, you may revoke all or part of an advance healthcare directive (other than designating a new agent), at any time and in any manner that communicates your intent to revoke. If you are mentally ill, an advance directive may be revoked in whole or in part at any time by you if you do not lack capacity and are competent.

What other facts should I know?

On page 2 of your Alaska Durable Power of Attorney for Healthcare, you may name a guardian or surrogate in the event you need to have one appointed. A guardian or surrogate shall make healthcare decisions in accordance with your individual instructions or other advance healthcare directives, if any, and other wishes to the extent known. A surrogate or agent may withhold or withdraw life-sustaining procedures when a qualifying condition exists when there is: (1) a durable power of attorney or other writing clearly expressing the patient's intent that the procedures be withheld or withdrawn; or (2) no durable power of attorney or other writing that clearly expresses the patient's intent to the contrary, and withholding or withdrawing the procedure(s) would be consistent with the patient's best interest.

You also may designate an individual to act as your surrogate by personally informing your supervising health care provider. This surrogate may make a healthcare decision for you if any agent or guardian has not been appointed or the agent or guardian is not reasonably available, and if you have been determined by your primary physician to lack capacity. In the absence of such designation, or if your designee is not reasonably available, a member of the following classes of your family who is reasonably available, in descending order of priority, may act as your surrogate: your spouse, unless legally separated; an adult child; a parent; or an adult sibling. If none of these individuals is reasonably available, an adult who has exhibited special care and concern for you, who is familiar with your personal values, and who is reasonably available may act as your surrogate.

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.

INSTRUCTIONS:

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.

INSTRUCTIONS:

WRITE THE NAME
AND ADDRESS OF
YOUR AGENT

WRITE THE NAME
AND ADDRESS OF
YOUR ALTERNATE
AGENT, IF YOU
WANT TO
DESIGNATE ONE

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

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**PART 1: ALASKA DURABLE POWER OF ATTORNEY FOR HEALTH
CARE DECISIONS** SINDI PAGE 1 OF 2

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)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonable to make a health care decision for me, I designate as my first alternate agent

(name of individual you choose as alternate agent)

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

(home telephone) (work telephone)

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 decision to provide, withhold, or withdraw arterial hydration and nutrition and other forms of health care to keep me alive, except as I state here:

PART 1: ALASKA DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
SINDI PAGE 2 OF 2

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:

1. The effect of treatment on your physical, emotional and cognitive functions.
2. The degree of physical pain or discomfort caused to you by the treatment or the withholding or withdrawal of the treatment;
3. The degree to which your medical condition, the treatment, or the withholding or withdrawal of treatment, results in a severe and continuing impairment;
4. The effect of the treatment on your life expectancy;
5. Your prognosis for recovery, with and without the treatment;
6. The risks, side effects, and benefits of the treatment or the withholding of treatment; and
7. Your religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

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.

AGENT'S OBLIGATIONS: 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.

NOMINATION OF GUARDIAN: If a guardian of my person 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 above, in the order designated.

**PART 2: ALASKA INSTRUCTIONS FOR HEALTH CARE
– PAGE 1 OF 2**

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.

CHECK ONLY ONE OF THESE BOXES

END-OF-LIFE DECISIONS. Except to the extent prohibited by law, I direct that my health care providers and others involved in my care provider, withhold, or withdraw treatment in accordance with the choice I have marked below:

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

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:

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

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: _____

CHECK ALL BOXES THAT APPLY TO YOUR WISHES

ADD ANY ADDITIONAL INSTRUCTIONS THAT YOU HAVE

INSTRUCTIONS:

CHECK ALL CHOICES THAT APPLY

ADD ANY INSTRUCTIONS THAT YOU HAVE

CHECK THE CHOICE THAT APPLIES AND ADD ANY INSTRUCTIONS THAT YOU HAVE

ADD YOUR INSTRUCTIONS

ADD YOUR INSTRUCTIONS

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PART 2: ALASKA INSTRUCTIONS FOR HEALTH CARE - PAGE 2 OF 2

Artificial Nutrition and Hydration. If I am unable safely to take nutrition, fluids or nutrition and fluids:

- 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 above, I do not wish to receive artificial nutrition and hydration.
Other instructions:

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:

Should I become unconscious and am pregnant, I direct that:

Optional 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 instructions to the above, do so here.

I direct that:

Conditions or limitations:

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PART 3: ALASKA ANATOMICAL GIFT AT DEATH (OPTIONAL)
– PAGE 1 OF 1

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.

Upon my death:

I give any needed organs, tissues, or other body parts,

OR

I give the following organs, tissues, or other body parts only:

My gift above is for the following purposes:

transplant;

therapy;

research;

education.

I refuse to make an anatomical gift.

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PART 4: ALASKA MENTAL HEALTH TREATMENT (OPTIONAL)
– PAGE 1 OF 2

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.

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: _____

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: _____

CHECK THE CHOICE
THAT APPLIES

CHECK THE CHOICE
THAT APPLIES

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PART 4: ALASKA MENTAL HEALTH TREATMENT (OPTIONAL)
- PAGE 2 OF 2

CHECK THE CHOICE
THAT APPLIES

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:

OTHER WISHES OR
INSTRUCTIONS

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**PART 5: ALASKA PRIMARY PHYSICIAN (OPTIONAL)
– PAGE 1 OF 1**

WRITE THE NAME,
ADDRESS, AND
TELEPHONE
NUMBER OF YOUR
PRIMARY
PHYSICIAN

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)

WRITE THE NAME,
ADDRESS, AND
TELEPHONE
NUMBER OF YOUR
PRIMARY
PHYSICIAN

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ALASKA ADVANCE DIRECTIVE WITNESSES PROCEDURE
– PAGE 1 OF 2

WITNESSES
PROCEDURE

This advance care health directive will not be valid for making health care decisions unless it is EITHER:

(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

Witness Who is Not Related to or a Devisee of the Principal

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)

**ALASKA ADVANCE DIRECTIVE WITNESSES PROCEDURE
– PAGE 2 OF 2**

WITNESSES
PROCEDURE

Witness Who May be Related to or a Devisee of the Principal

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.

_____ (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 _____, in the year _____, before me, _____ (insert name of notary public) 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)

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You Have Filled Out Your Advance Directive, Now What?

1. Your Alaska Individual Instruction and Alaska Durable Power of Attorney for Healthcare 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 alternate(s), 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 a photocopy of your documents placed in your medical records.

3. Be sure to talk to your attorney-in-fact, 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 make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your Alaska documents.
6. Be aware that your Alaska 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.**