Advance Health Care Directive

You have the choice to make your own health care decisions and choose someone to make health care decisions for you if you cannot. This form will let you do EITHER or BOTH of these things. Filling out this form is your choice. You may change, cross out or add your own words to any part of this directive. When signed, dated and witnessed, this form meets the legal requirements for an Advance Health Care Directive under Alaska law.

Part I: Health Care Agent

If I cannot make my own health care decisions/choices as determined by my health care team, I trust the following person(s) to make my health care choices for me. This person is at least 18 years of age and is NOT my health care provider or employed by my health care provider (unless related by birth, marriage or adoption).

My Health Care Agent is my (relationship): _____

Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

If the above person is not willing or able to speak for me, I choose the following person as my Alternate Health Care Agent.

My Alternate Health Care Agent is my (relationship): _____

Alternate Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Second Alternate Health Care Agent is my (relationship): _____

Alternate Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

To the extent allowed by Alaska law, (unless crossed out below) my Health Care Agent has the right to:

1. Make all health care decisions for me, this includes the ability to consent to or refuse any medical care, treatment, service or procedure for any physical or mental condition, including:

- Diagnostic tests, medications or surgery
- Administration or discontinuation of behavioral health (psychotropic) medication
- Providing, withholding, or withdrawing artificial nutrition and hydration
- Move me to an assisted living home, nursing facility, hospice or hospital
- Hire or fire health care workers to provide the best care for me
- Do not resuscitate orders

2. See and approve release of my medical records and personal papers.

3. Donate my organs or tissues, as allowed by the State of Alaska..

4. Apply for medical financial aid programs, such as Medicaid and Medicare or other benefits for me.

5. My Health Care Agent will make medical choices for me based on my best interests. These wishes are based on instructions that I have given in this form or what I have told him/her is important to me.

Name: _____ Date of Birth: _____

updated May 11, 2022

Part II: Instructions for Health Care

If a time comes that I am very sick and not able to make my own health care choices or decisions, I want my medical providers and Health Care Agent to respect and follow my wishes as they are written here even if they are different than his or her own. I understand that I can change, cross-out, or add to these instructions. If my wishes change in the future, I can always fill out a new Advance Health Care Directive.

If I have a serious injury or illness that cannot be cured, the following is most important to me (**initial the one** that matters most to you):

_____ The length of my life is most important to me even if I may need intensive care and life support treatments long-term.

OR

_____ The quality of my life is most important to me. I wish to avoid long-term intensive care and life support treatments and allow a natural death when I am at the end of my life.

Comments: _____

IF the following health conditions will never improve, AND I have an advanced serious injury or illness that cannot be cured, I want medical treatments focused on comfort rather than making me live longer when:
You may initial more than one.

_____ I am not able to care for myself (feed, bathe, toilet, and dress without help).

_____ I cannot think clearly or make my own decisions.

_____ I do not recognize or cannot interact with my loved ones.

_____ I am showing signs of suffering that cannot be relieved.

Other: _____

IF I am at the end of my life (**initial the one** that matters most to you):

_____ I wish to spend the last days of my life at home or in a home-like setting where I can be cared for by family and friends when possible.

OR

_____ I wish to spend the last days of my life in the hospital or a medical home when possible.

OR

_____ Let my Health Care Agent decide.

Name:_____ Date of Birth: _____

Part II: Instructions for Health Care (Continued)

In the last days of my life, these are some ways that I may find strength and comfort (examples include personal messages, sharing ways to care, music to play, people you wish to see and/or spiritual practices/readings).

_____

_____

_____

After my death (**initial the one** that matters most to you):

_____ I want to donate any needed organs, tissues, or body parts.

_____ I want to donate only the following organs, tissues, or body parts: _____

_____ I do not want to donate any of my organs, tissues, or body parts.

_____ Let my Health Care Agent decide.

After my death I want (**initial the one** that matters most to you):

_____ To be buried.

_____ To be cremated.

_____ I want my loved ones to decide.

I want my final resting place to be: _____

Cardiopulmonary Resuscitation (CPR)

When my heart stops beating and my breathing stops and I am **at the end of my life** (initial the one that matters most to you):

_____ I want CPR. I want to try to be resuscitated no matter how sick or injured I am.

OR

_____ I do not want CPR. If my heart stops beating or my breathing stops, I wish to allow a natural death.

Name: _____ Date of Birth: _____

Part II: Instructions for Health Care (Continued)

Life Support Treatments

Life support treatments include any medical test, blood product, surgery, procedure, machine and/or medicine needed to prolong life.

If I am ever unable to speak for myself or make my own decisions:

- And/or I have an advanced serious illness or injury that will likely result in my death
- And/or I am unconscious and not expected to wake up

Initial the one that matters most to you:
Note- If you want CPR, ALL medical treatments should be selected.

_____ I want ALL medical treatments including all life support treatments to help me live as long as possible when medically appropriate.

OR

_____ I want ALL medical treatments including all life support treatments to see if I will get better, but I want them stopped if I am not getting better or it is clearly adding to my suffering.

OR

_____ I want SOME treatments if they will help me get better and live longer. This may include going to the emergency department and/or hospital to receive IV fluids, medications, breathing supports and antibiotics, BUT I want to avoid intensive care treatments such as ventilators for breathing and shocks to the heart.

OR

_____I want to allow a natural death with medical treatments ONLY focused on providing comfort through symptom management. I do not want to go to the hospital unless I cannot be kept comfortable in my current setting.

Other wishes: _____

_____

Artificial Nutrition

If I am ever unable to communicate or speak for myself and I am not able to eat food or drink fluids safely on my own: (**initial the one** that matters most to you):

_____ I want artificial nutrition when medically appropriate including consideration of surgically-placed tubes, unless it is clearly adding to my suffering.

OR

_____I want to try artificial nutrition for a short time to see if my condition improves, but I want it stopped if I am not getting better. I do not want surgically-placed tubes.

OR

_____ I do not want artificial nutrition.

Other wishes: _____

_____

Name: _____ Date of Birth: _____

Making Your Advance Health Care Directive Legal

Do not sign your Advance Health Care Directive until you are in front of **both witnesses** or a Notary Public.

I ask that my Advance Health Care Directive is honored and respected by my family, friends, health care providers and Health Care Agent to the best of their ability within the laws of the State of Alaska. This Advance Health Care Directive is to be used if/when I am no longer able to make my own medical decisions or speak for myself. I understand my health care rights and choices, and I am signing this Advance Health Care Directive without stress or influence from others. Any Advance Health Care Directive I have done before this date is no longer valid.

Signature: _____ Date: _____

Name: _____ Date of Birth: _____

Fill out this section if using witnesses to validate directive (two witnesses needed if not notarized):

I, the witness, personally know the person who filled out this Advance Health Care Directive, and **I am not the person's Health Care Agent.** The above person has signed this paper in my presence, and he/she appears to be clear thinking and without stress or influence from others. A witness can be a family member, friend or community member who meets the following criteria

As a witness, I am over 18 years of age and I am not:

- A Health Care Agent listed on this Advance Health Care Directive.
- A health care provider who takes care of this person.
- An employee of this person's health care provider or health clinic.

In addition at least one of the witnesses is not:

- Related by blood, marriage or adoption.
- Entitled to this person's money, property, shares or permits.

Signature of witness: _____

Printed name of witness: _____

Phone: _____

Address: _____

Address: _____

Date: _____

Signature of witness: _____

Printed name of witness: _____

Phone: _____

Address: _____

Address: _____

Date: _____

Or signed by Notary Public: State of Alaska _____ Judicial District

On this _____ day of _____, in the year 20_____, before me, _____ (name of notary public) appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to this document and that they freely and voluntarily executed it.

My Commission Expires: _____ (Seal)

Notary Public: _____