Triage Health Estate Planning Toolkit: Alaska

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Alaska probate courts accept written and holographic wills.

To make a valid written will in Alaska:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will, in front of two witnesses who are not included in your will.
3. Your two witnesses need to sign the will.
4. Your will does not need to be notarized to be legal in Alaska. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, sign an affidavit in front of a notary to prove your identity and that all parties had knowledge of the will.

A holographic will is one that is handwritten by you. To make a valid holographic will in Alaska:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. Your entire will must be written in your handwriting and you must sign it.

If you use a holographic will in Alaska, you do not need witnesses to sign it. However, most estate planning experts do not recommend relying on holographic wills, because it is more difficult to prove that they are valid in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Alaska's power of attorney statutory form allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint an alternate agent, who can act jointly with the first person you appoint, or separately if the first person cannot act. This person can make all financial decisions for you, or you can limit their powers to specific assets, like filing taxes or banking. This document takes effect immediately after you sign it or you can indicate it should take effect later. You can also indicate whether this document should take or remain in effect if you become incapacitated. If you indicate that it will remain in effect if you become incapacitated, this is a durable power of attorney. Once in effect, this document will remain in effect until you die, unless you specify a specific date to terminate, or revoke your power of attorney.

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Part III of this toolkit includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to make decisions for yourself. To authorize this document in Alaska, you must be at least eighteen years old and of sound mind.

In Alaska, this document contains five parts:

1. **Durable Power of Attorney for Health Care Decisions:** You can appoint someone to make any and all health care decisions for you, if your doctor determines you can no longer make these decisions yourself for any reason. However, if you would like to give your agent immediate authority, you can mark a box that indicates that the agent can begin making health care decisions immediately. You can also choose an alternate person if the first person you appoint is not available.
2. **Instructions for Health Care:** Sometimes called a "living will," this document lets you indicate your preferences for end-of-life health care if you become unable to speak for yourself. Alaska's form provides choices on provision, withholding, or withdrawal of treatment, including artificial nutrition and hydration and pain relief medication. You can provide instructions for specific situations, including permanent unconsciousness and terminal conditions.
3. **Anatomical Gift at Death:** You can indicate whether or not you would like your organs to be given to someone after your death. This is an optional part of the form.
4. **Mental Health Treatment:** You can indicate your preferences for certain types of mental health treatment, including mental health facilities. This is an optional part of the form.
5. **Primary Physician:** You can use this form to designate a physician you would like to be primarily responsible for your health care. This is an optional part of the form.

To make this document legal, your AHCD must be in writing, signed by you (the principal), and witnessed in one of two ways:

1. Signed by two adults you know. The following rules apply:
    - At least one of these people must not be related to you by blood, adoption, or marriage, or included in your will
    - They cannot be a health care provider, or other individual, employed where you are receiving care or an employee of an individual providing you care
    - They cannot be appointed as your agent
2. Acknowledged before a notary public in Alaska.

There are limits to AHCDs in Alaska:

- If you are pregnant or become pregnant, your choices will not be followed if it is likely that the fetus could develop to the point of live birth if life-sustaining procedures were provided
- Your proxy does not have the authority to authorize psychosurgery, sterilization, abortion, or removal of bodily organs on your behalf, unless doing so would save your life or prevent serious impairment to your health

Your AHCD goes into effect once your doctor determines you are unable to communicate, unless you specify other conditions in your AHCD. You can modify or revoke any part of your AHCD at any time, unless you are determined not to be competent under the law.

You can find a sample form in Part III of this toolkit.

State Laws About POLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance health care directive. You can complete a POLST form

with your doctor. If you become unable to communicate and cannot complete the POLST form, a guardian, health care proxy, or a family member (spouse, adult child, parent, or adult sibling) may complete a POLST form for you.

In Alaska, this form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or food offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes. This form cannot be modified, so if changes are necessary it is important for you and your physician to complete a new form.

You can find this form in Part III of this toolkit.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Alaska does not have a funeral designation form. However, they do have a law allowing you to provide directions for what will happen to your remains after you pass away or choose an agent to control the disposition of your remains.

This document must substantially follow the disposition form as set forth by Alaska Statute, provided in Part III of this packet. In order for this document to be valid, you must sign the document and have it notarized. This can be a free-standing form, incorporated in your will, or another document.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Alaska does not have a death with dignity law. But, you can indicate other preferences for end-of-life care through an advanced health care directive or POLST.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA allows your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, who will get the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information. You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Health Estate Planning Toolkit: Alaska

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advance Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form

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Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

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Power of Attorney

This packet contains the Alaska form for a Power of Attorney. Alaska Legal Services Corporation provides this as a service to you and does not take responsibility for how you fill it out. The law allows you to fill out this form on your own. This packet contains general information to assist you. However, if you have questions, please contact an attorney. The Alaska Bar Association (272-0352 or 1-800-770-9999 outside Anchorage) can provide you with a list of attorneys. If you cannot afford an attorney or if you are 60 years or older, Alaska Legal Services 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) 391-1475; Fairbanks, 452-5181 or (800) 478-5401; Juneau, 586-6425 or (800) 789-6426; Kenai (953-7608); Ketchikan, 225-6420; Kotzebue, 442-3500 or (877) 622-9797; and Nome, 443-2230 or (888) 495-6663.

This booklet is provided by 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.

Alaska Legal Services Corporation, 1016 West Sixth Avenue, Suite 200, Anchorage, Alaska 99501, Telephone toll-free 888-478-2572 (in Anchorage, 272-9431)

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

February 2009

DIRECTIONS

What is a Power of Attorney?

You make a variety of decisions every day. If you sign a *Power of Attorney,* you give another person (your agent) the right to make decisions for you and you give them the authority to carry the decisions out. The form provided here is based upon the Alaska Statutes (AS 13.26.332-335) and it can be tailored to meet your specific needs. For instance, you can grant your agent broad powers to do almost anything you could do for yourself (general power of attorney) or you can pick and choose the powers you want to give an agent (specific power of attorney). You can choose to appoint an agent immediately or you can make the appointment effective only if you become disabled. You can limit the time your agent will have power to act on your behalf or you can make the appointment "durable," which means your agent will have powers even if you become disabled. You can also state that the appointment will be revoked upon your incapacity.

Please note, Alaska now has a separate law addressing health care advance directives. Issues addressed include the designation of a health care agent, end-of-life treatment decisions (living wills), mental health care treatment options, and organ donation (see AS 13.52). There is a separate pamphlet and form titled the *Alaska Advance Health Care Directive* that should be used for all health care related issues.

Section 1. Naming your agent.

It is critically important that you thoroughly trust the person you name in your *Power of Attorney*. The authority you give as the "principal" can have a major impact on you. For instance, your agent may sell your house, withdraw money from your accounts, or place you in a nursing home. Unlike a guardian or conservator, a person acting with a *Power of Attorney* does not have to answer to a court. There will be no formal oversight of your agent regarding the decisions he or she makes. In addition, it is very important to make sure the agent understands what your wishes are. Therefore, it is highly recommended that you discuss your wishes and desires with the person you name in your *Power of Attorney*. However, as long as you are competent, you do have the right to revoke a *Power of Attorney*.

Section 2. Choosing which powers to grant on *Power of Attorney* form.

You do not have to give your agent authority for all of the powers listed in Section 2 of the *Power of Attorney* form. You can limit which powers you give by **crossing out** any undesired provisions **AND** putting your initials on the line in front of it. Any power (A-O) that is not crossed out and initialed will be granted to your agent. You can find more detailed information about what powers each provision grants by asking an attorney or reading Alaska Statute Section 13.26.344.

Section 3.

You can name more than one person to act on your behalf. If you name more than one agent in Section 1, you must mark the first or second statement in Section 3. Mark the first statement if you want to allow each agent to make decisions without getting approval from the other. If you want both agents to act together, jointly, mark the second sentence.

Section 4.

Sections 4, 5, and 6 let you decide when and for how long you want the *Power of Attorney* to be effective. If you mark the first sentence in Section 4, the document will become effective immediately and the person you named as your agent will have the power to act on your behalf. Some people do not want this. Instead, you may want to designate an agent only in the event you cannot act on your own behalf. **Marking the second sentence makes the appointment of an agent effective only when you become incapacitated.**

Section 5.

If you choose to make your Power of Attorney effective immediately, then in Section 5 you must decide whether it will be "durable." A durable power of attorney remains effective in the event you become incapacitated. If you want your agent to continue to have authority under such circumstances, mark the first sentence in Section 5. If not, mark the second sentence in Section 5.

Section 6.

This section allows you to pick a date on which the *Power of Attorney* will no longer be valid. If you want to appoint someone as your agent to accomplish a specific task or only for a limited period of time, you should complete this section. Do not complete this section if you want your power of attorney to be "durable" or to become effective only if you become disabled.

Section 7.

You can revoke the *Power of Attorney* for any reason at any time, provided you are mentally competent to do so. **To revoke your *Power of Attorney***, destroy the original and either (1) complete a new *Power of Attorney*, if you wish to name another person, OR (2) create a *Notice of Revocation* by writing a brief notarized statement revoking the old *Power of Attorney*. The new *Power of Attorney*, or the *Notice of Revocation*, needs to be distributed in the same manner as you distributed the old *Power of Attorney*. To be safe, you may want to send the *Notice of Revocation* directly to the agent via first class mail, return receipt requested. You may also wish to record the *Notice of Revocation* with a state Recorder's office.

Section 8.

This section is optional. If you have executed an advanced health care directive, you may want to indicate this fact by marking the appropriate statement.

Section 9.

This section is optional. It's possible that the person you name as your agent will not be able to perform his or her duties. For instance, your agent may move out of state, die, or otherwise become incapable of performing. To address this possibility, you may want to name a replacement just in case.

Signatures

Finally, the *Power of Attorney* must be signed in front of a notary and sealed by him or her. Once you have completed the *Power of Attorney*, you should give the original to whomever you named as the power of attorney, distribute copies to important people (doctor, banker, etc.), and keep a copy for yourself. If you later revoke the *Power of Attorney*, you should distribute the revocation in the same manner as you distributed the original.

POWER OF ATTORNEY

The powers granted from the principal to the agent or agents in the following document are very broad. They may include the power to dispose, sell, convey, and encumber your real and personal property. Accordingly, the following document should only be used after careful consideration. If you have any questions about this document, you should seek competent advice. You may revoke this power of attorney at any time.

Section 1. Pursuant to A.S.13.26.338 - 13.26.353,

I, _____ , of _____, do hereby appoint
(Name of principal) (Address of principal)

_____ as
(Name and address of agent or agents)

my attorney(s)-in-fact to act as I have checked below in my name, place and stead in any way which I myself could do, if I were personally present, with respect to the following matters, as each of them is defined in AS 13.26.344, to the full extent that I am permitted by law to act through an agent:

Section 2. The agent or agents you have appointed will have all the powers listed below **UNLESS** you draw a line through a category; **AND** initial the space before that category.

_____(A) Real estate transactions
_____(B) Transactions involving tangible personal property, chattels, and goods
_____(C) Bonds, shares, and commodities transactions
_____(D) Banking transactions
_____(E) Business operating transactions
_____(F) Insurance transactions
_____(G) Estate transactions
_____(H) Gift transactions
_____(I) Claims and litigation
_____(J) Personal relationships and affairs
_____(K) Benefits from government programs and military service
_____(L) (repealed)
_____(M) Records, reports, and statements
_____(N) Delegation
_____(O) All other matters, including those specified as follows:
_____
_____

Section 3. If you have appointed more than one agent, check one of the following:

_____Each agent may exercise the powers conferred separately, without the consent of any other agent.
_____All agents shall exercise the powers conferred jointly, with the consent of all other agents.

DURABLE POWER OF ATTORNEY OPTIONS

(Sections 4, 5 and 6 allow you to choose whether or not you want this to be a durable power of attorney and when you want it to go into effect.)

Section 4. To indicate when this document shall become effective, check one of the following:

_____This document shall become effective upon the date of my signature.

_____This document shall become effective upon the date of my disability and shall not otherwise be affected by my disability.

Section 5. If you have indicated that this document shall become effective on the date of your signature check one of the following:

_____This document shall not be affected by my subsequent disability.

_____This document shall be revoked by my subsequent disability.

If you want this to be a durable power of attorney, do not limit the term of this document in Section 6.

Section 6. If you have indicated that this document shall become effective upon the date of your signature and want to limit the term of this document, complete the following:

This document shall only continue in effect for _____(____) years from the date of my signature.

Section 7. Notice of revocation of the powers granted in this document.

You may revoke one or more of the powers granted in this document. Unless otherwise provided in this document, you may revoke a specific power granted in this power of attorney by completing a special power of attorney that includes the specific power in this document that you want to revoke. Unless otherwise provided in this document, you may revoke all the powers granted in this power of attorney by completing a subsequent power of attorney.

Additional Provisions

Section 8. If you have given an agent authority regarding health care services, complete the following:

_____I have executed a separate declaration under AS 13.52 known as an “Alaska Advance Health Care Directive."

_____I have not executed an “Alaska Advance Health Care Directive."

Section 9. You may designate an alternate attorney-in-fact. Any alternate you designate will be able to exercise the same powers as the agent(s) you named at the beginning of this document. If you wish to designate an alternate or alternates, complete the following:

If the agent(s) named at the beginning of this document is unable or unwilling to serve or continue to serve, then I appoint the following agent to serve with the same powers:

First alternate or successor attorney-in-fact_____

(Name and address of alternate)

Second alternate or successor attorney-in-fact _____

(Name and address of alternate)

Section 10. Notice to Third Parties

A third party who relies on the reasonable representations of an attorney-in-fact as to a matter relating to a power granted by a properly executed statutory power of attorney does not incur any liability to the principal or to the principals heirs, assigns, or estate as a result of permitting the attorney-in-fact to exercise the authority granted by the power of attorney. A third party who fails to honor a properly executed statutory form power of attorney may be liable to the principal, the attorney-in-fact, the principal's heirs, assigns, or estate for civil penalty, plus damages, costs, and fees associated with the failure to comply with the statutory form power of attorney. If the power of attorney is one which becomes effective upon the disability of the principal, the disability of the principal is established by an affidavit, as required by law.

In Witness Whereof, I have hereunto signed my name this _____ day of _____, 20____.

_____
(Signature of principal)

STATE OF ALASKA)
) ss.
__ JUDICIAL DISTRICT)

Acknowledged before me at_____on the_____day of_____, 20__.

_____
Signature of officer or notary. Serial number, if any; date commission expires.

TRANSLATION CLAUSE (if needed)

I certify that I have translated the provisions of the foregoing *Power of Attorney* from the English language to the _____ language to the best of my ability.

_____
Translator

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

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EXPLANATION

OVERVIEW

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.

Part 1 of this form is a **Durable Power of Attorney for Health Care.** A "Durable Power of Attorney for Health Care" is 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.

AGENT POWERS

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;

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(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.

OVERVIEW (Continued)

INDIVIDUAL INSTRUCTIONS

Part 2 of this form lets you give specific instructions for any aspect of your health care to the extent allowed by law. 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.

ANATOMICAL GIFTS

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

MENTAL HEALTH TREATMENT

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

PRIMARY PHYSICIAN

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

EXECUTION

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 and alternate agent to make sure that the person understands your wishes and is willing to take the responsibility.

REVOCATION

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.

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ALASKA ADVANCE HEALTH CARE DIRECTIVE
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PART 1: DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

WRITE THE NAME OF YOUR AGENT

_____
(name of individual you choose as agent)

WRITE YOUR AGENT'S ADDRESS AND PHONE NUMBERS

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

_____ _____
(home telephone) (work telephone)

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 alternate agent:

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

_____
(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 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:

ADD PERSONAL INSTRUCTIONS (IF ANY)
ADD ADDITIONAL SHEETS IF NEEDED

_____
_____
_____

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PART 1: DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS (Continued)

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. My agent's authority ceases to be effective upon determination that I have recovered my ability to make my own health care decisions. 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

MARK THIS BOX ONLY IF YOU WOULD LIKE YOUR AGENT'S AUTHORITY TO TAKE EFFECT IMMEDIATELY

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PART 1: DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS (Continued)

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 agent whom I have named above.

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PART 2: INSTRUCTIONS FOR HEALTH CARE (OPTIONAL)

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.

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:

INITIAL ONLY ONE OF THESE BOXES

[☐] 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:

INITIAL ALL BOXES THAT APPLY TO YOUR WISHES

[☐] 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

ADD ANY ADDITIONAL INSTRUCTIONS THAT YOU HAVE

[☐] 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;

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PART 2: INSTRUCTIONS FOR HEALTH CARE (Continued)

INITIAL ONLY ONE

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

[ ] 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

[ ] I do not wish to receive artificial nutrition and hydration.

ADD ANY INSTRUCTIONS THAT YOU HAVE

[ ] Other instructions:

_____

_____

_____

INITIAL ONLY ONE CHOICE THAT APPLIES AND ADD ANY INSTRUCTIONS THAT YOU HAVE

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:

_____

_____

_____

ADD YOUR INSTRUCTIONS

Should I become unconscious and am pregnant, I direct that

_____

_____

_____

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ALASKA ADVANCE HEALTH CARE DIRECTIVE
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PART 2: INSTRUCTIONS FOR HEALTH CARE (Continued)

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:

ADD OTHER INSTRUCTIONS, CONDITIONS, OR LIMITATIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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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.

INITIAL ONLY ONE CHOICE

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:

WRITE YOUR INSTRUCTIONS

_____
_____
_____
_____

OR

[☐] I refuse to make an anatomical gift.

My gift above is for the following purposes:

INITIAL ALL CHOICES THAT APPLY

[☐] transplant;
[☐] therapy;
[☐] research;
[☐] education

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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.

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:

INITIAL ONLY ONE

[☐] I consent to the administration of the following medications: _____

[☐] I do not consent to the administration of the following medications: _____

ADD ANY CONDITIONS OR LIMITATIONS

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:

INITIAL ONLY ONE

[☐] I consent to the administration of electroconvulsive treatment: _____

ADD ANY CONDITIONS OR LIMITATIONS

[☐] I do not consent to the administration of electroconvulsive treatment: _____

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Conditions or limitations:

_____

_____

PART 4: MENTAL HEALTH TREATMENT (OPTIONAL)

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:

INITIAL ONLY ONE

[☐] 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.) **OR**

[☐] I do not consent to being admitted to a mental health facility for mental health treatment.

Other Wishes or Instructions:

ADD ANY ADDITIONAL WISHES OR INSTRUCTIONS REGARDING YOUR MENTAL HEALTH TREATMENT

_____

_____

_____

_____

_____

_____

Conditions or limitations:

ADD ANY ADDITIONAL CONDITIONS OR LIMITATIONS REGARDING YOUR MENTAL HEALTH TREATMENT

_____

_____

_____

_____

_____

_____

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ALASKA ADVANCE HEALTH CARE DIRECTIVE
(PAGE 12 OF 16)

PART 5: PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

WRITE THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR PHYSICIAN

_____
(name of physician)

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

_____ _____
(home telephone) (work 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:

WRITE THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR ALTERNATE PHYSICIAN

_____
(name of physician)

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

_____ _____
(home telephone) (work telephone)

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YOU MAY EXECUTE THIS ADVANCE DIRECTIVE IN ONE OF TWO WAYS

IF YOU CHOOSE TO SIGN WITH WITNESSES, USE ALTERNATIVE 1, BELOW

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW

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EXECUTION

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. (Use Alternative 1, below, if you decide to have your signature witnessed.)

OR

(B) acknowledged before a notary public in the state. (Use Alternative 2, below, if you decide to have your signature notarized.)

SIGN AND DATE YOUR ADVANCE DIRECTIVE

ALTERNATIVE NO. 1 (SIGN WITH WITNESSES)

IN WITNESS WHEREOF, I have hereunto signed my name this _____ day of _____, _____.
(Day) (Month) (Year)

_____
(Signature of Principal)

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.

WITNESS 1 OF 2: DATE, SIGN AND PRINT YOUR NAME AND ADDRESS

_____ _____
(date) (signature of witness)

_____
(printed name of witness)

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

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ALTERNATIVE NO. 1 (SIGN WITH WITNESSES) (Continued)

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 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)

WITNESS 2 OF 2: DATE, SIGN AND PRINT YOUR NAME AND ADDRESS

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SIGN AND DATE YOUR ADVANCE DIRECTIVE

HAVE YOUR ADVANCE DIRECTIVE NOTARIZED BY A NOTARY PUBLIC

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ALASKA ADVANCE HEALTH CARE DIRECTIVE
(PAGE 16 OF 16)

ALTERNATIVE NO. 2 (SIGN BEFORE A NOTARY)

IN WITNESS WHEREOF, I have hereunto signed my name this _____ day of _____, _____.
(Day) (Month) (Year)

_____
(Signature of Principal)

State of Alaska

_____ Judicial District

On this ____ day of _____, in the year _____,
(Day) (Month) (Year)

before me, _____,
(Name of Notary Public)

appeared _____,
(Principal)

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)

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

Triage Health Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

Physician Orders for Life Sustaining Treatment (POLST)

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Medical Record #:

Alaska POLST (Physician Orders for Life Sustaining Treatment) Form

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an Advance Directive.

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/_____ State where form was completed:_____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location, unless another treatment preference is documented in Section C of this form.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Discussed but no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (optional)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (optional)

If other than patient, print full name of person consenting (or non-opposition in instance of guardian)		**Authority:**

F. SIGNATURE: Health Care Provider (required, eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have confirmed that this order was discussed with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in Alaska may sign this order.]

✖ (required)	**Date** (mm/dd/yyyy): Required / /	**Phone # :**
Printed Full Name:		**License/Cert. #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. Version 1, June 3, 2020.

Patient Full Name:

Form Completion Information (required)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed:_____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Physician's Assistant ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Contact Information (optional)

Patient's Emergency Contact. (Note: Listing a person here does <u>not</u> grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )

Primary Care Provider Name: Phone: ( )

☐ Patient is enrolled in hospice Name of Agency:

Agency Phone: ( )

Form Information & Instructions

- Completing a POLST form:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by Alaska Statute, and in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in Alaska (M.D./D.O.) can sign this form.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
  - The most recently completed valid POLST form supersedes all previously completed POLST forms.
- Using a POLST form:
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- Reviewing a POLST form: This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- Modifying a POLST form: This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- Voiding a POLST form:
  - If a patient or patient representative (for patients lacking capacity) wants to void the form: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable).
  - For health care providers: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- This form may be added to a secure electronic registry so health care providers can find it.

For Barcodes / ID Sticker

Triage Health Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

HIPAA Authorization Form

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Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524