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: ______________________________

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

1. Consent to or refuse any medical care, treatment, service or procedure including:
   - Diagnostic tests, medications or surgery.
   - Withholding or withdrawing artificial nutrition and hydration.
   - Move me to an assisted living home; nursing facility, hospice or hospital – wherever I can be best cared for.
   - Hire or fire health care workers to provide the best care for me.
   - Do not resuscitate orders.
   - Donating my organs or tissues as allowed by the State of Alaska.

2. Make all health care decisions for me including looking at my medical records and personal papers.

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

4. Make medical choices for me or take legal action to carry out my medical wishes. 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: ______________________________

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 whatever my health care choices are, I will get the best care possible.

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 it means I need extended intensive care and life support.

OR

______ The **quality of my life** is most important to me. I wish to avoid extended intensive care and life support.

Comments: ____

If I have a serious injury or illness that cannot be cured, **I would not** want my life prolonged if (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: ____

My medical preferences at the end of my life are (**initial the one** that matters most to you):

______ If possible, 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.

OR

______ If possible, I wish to spend the last days of my life in the hospital or a medical home.

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 important things to know (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 or tissues.

______ I want to donate only the following organs or tissues: ____________________________________

______ I do not want to donate any of my organs or tissues.

______ 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)

In the event that my heart stops beating and my breathing stops (**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.

<u>OR</u>

______ I want CPR unless I have any of the following:

- An injury or illness that cannot be cured, and I am dying.
- No reasonable chance for surviving my illness or injury.
- Little chance for survival and my medical providers think CPR would be more harmful than helpful.

<u>OR</u>

______ I do not want CPR. If my heart stops beating or my breathing stops, I wish to allow 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.

In the event that I am unable to speak for myself or make my own decisions:

- And/or have an incurable or irreversible condition that will result in my death.
- And/or I am unconscious and not expected to wake up.
- And/or the harm of medical treatment would cause more suffering than good.

Initial the one that matters most to you:

______ I want life support treatments to help me live as long as possible when medically appropriate.

OR

______ I want to try 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 do not want life support treatments. I wish to allow natural death with medical treatments focused on providing comfort only.

Other wishes: ____

____

Artificial Nutrition

In the event that I am 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, 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.

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, and 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.

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: ______________________