Power of Attorney &
Advanced Care Directives

Alaska Legal Services Corporation
Oct. 2, 2024

What is Alaska Legal Services?

- **Offers FREE civil legal services to low income Alaskans to protect their safety, health, and promote family stability.**

- **Help clients with CIVIL legal matters**
  - Housing
  - Divorce, custody
  - Domestic violence protective orders
  - Debt, bankruptcy / consumer issues
  - Access to health care and public benefits
  - Wills, life planning documents, probate

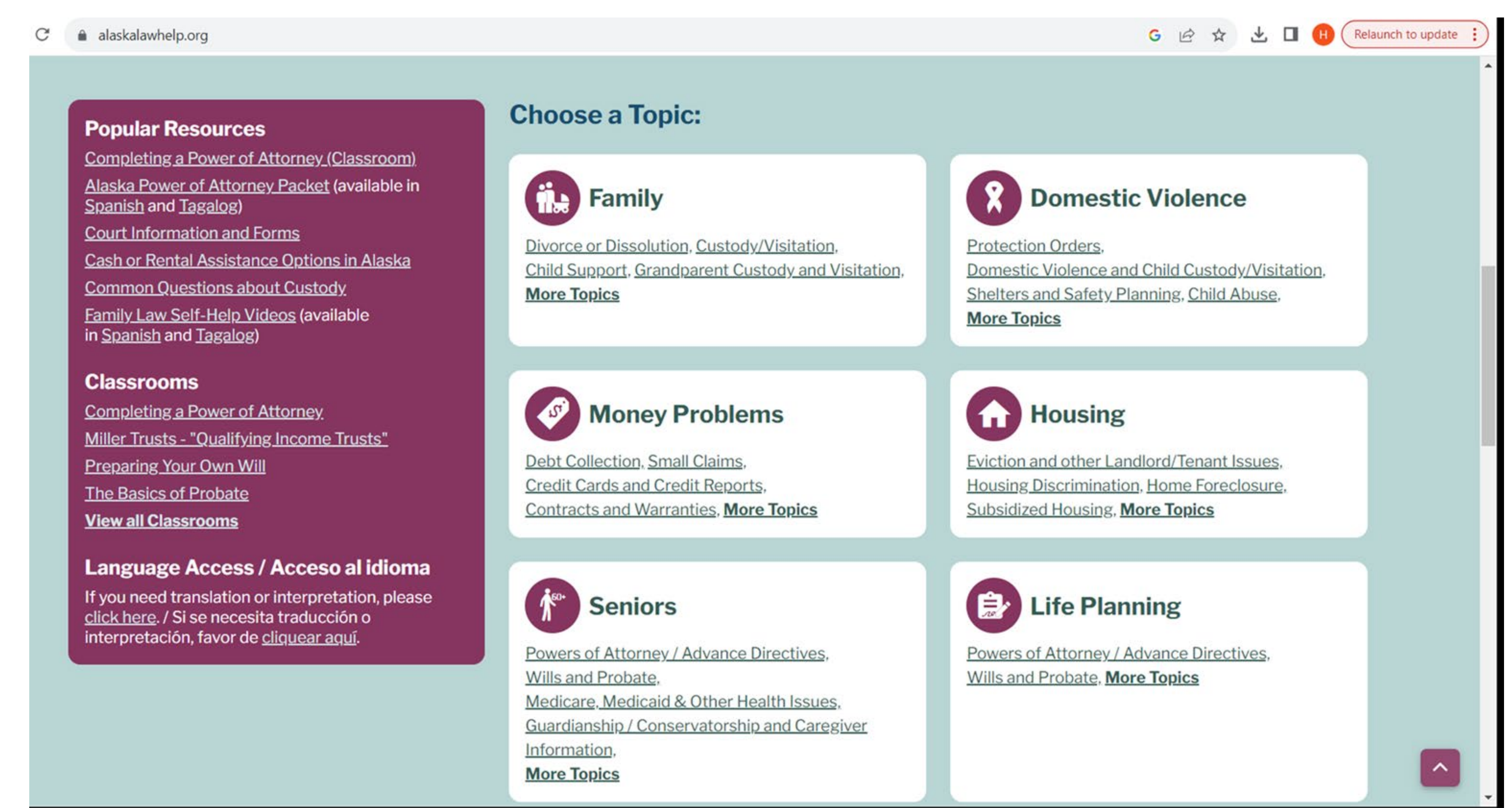
- **Eligibility:**
  - 125% - 200% Federal Poverty Income Guidelines for Alaska
  - No conflict of interest
  - Civil legal issue

Disclaimers

- Goal to provide guidance / steps on how to think about and get started on this process
- Experience working with clients with small estates
- Providing general legal information, not individual advice
- May want to finalize a will or life planning documents with an attorney

AlaskaLawHelp.org

- FREE website, managed by Alaska Legal Services
- Easy to use
- Links to videos, forms, information



AlaskaLawHelp.org

Forms (2)

Alaska Advance Health Care Directive Form

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This Advance Health Care Directive form lets Alaskans give specific instructions for any aspect of your health care to the extent allowed by law. That includes letting you express an intention to make an anatomical gift following your death, letting you make decisions in advance about certain types of mental health treatment, and letting you designate a physician that you want to have primary responsibility for your health care.

Content Detail

By: Alaska Legal Services Corp.
Other formats: DOCX

Power of Attorney form

This booklet contains the Alaska form for a Power of Attorney and instructions.

Read More

By: Alaska Legal Services Corporation
Read this in: Spanish / Español Tagalog / Pilipino

Completing an Advance Health Directive: Introduction to Advance Health Care Directives

Watch Read

Advance Health Care Directives Part 1

Advance Health Care Directive - Introduction

Watch later Share

Advance Health Care Directives

Alaska Legal Services Corporation

Watch on YouTube

Life Planning Documents

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. Alaska Bar Association (272-0352 or 1-800-770-9999 provide you with a list of attorneys. are 60 years or

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Life Planning Documents

- Help you make decisions on your finances and your care while you're still living
- Can provide peace of mind
- Can be helpful to your family if there's an emergency

Power of Attorney

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Power of Attorney

- Deals with financial decisions while you are still living; does not apply after death.
- Allows you to appoint an agent to deal with specific financial decisions.
- Must be notarized.
- AS 13.26.600-695.

Power of Attorney - Agent

- Does NOT apply to medical decisions
- Can limit power to your agent
- Agent can have a lot of power. Should be someone you trust.
- POA can be revoked at any time while beneficiary still has capacity *

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. Designation of Agent. Pursuant to A.S.13.26.600, 13.26.625 – 13.26.640, and 13.26.655 – 13.26.695.

I, ____
(Name and address of principal)

hereby designate the following person as my agent to act as I have indicated below 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 13.26.665, to the full extent that I am permitted by law to act through an agent:

Name of individual you choose as your agent: ______________________________

Address of agent: ______________________________

Telephone contact of agent: ______________________________

If you wish to name a second person to serve as your agent, please complete the section below:

Name of second individual you choose as your agent: ______________________________

Address of second agent: ______________________________

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Telephone contact of second agent: ______________________________

Section 2. If you have appointed more than one agent in Section 1 above, mark 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.

- You can can limit the power(s) that you choose to share with your agent(s)
  - Check each box for each power you would like to share

Section 3. Mark the boxes below to indicate the powers you want to give your agent or agents. MARK the box for "YES" that is opposite a category below to give your agent or agents the power in that category. If you do not mark the "YES" box opposite a category, your agent or agents will NOT have the power in that category.

	YES
(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) Retirement plans	( )
(I) Claims and litigation	( )
(J) Personal relationships and affairs	( )
(K) Benefits from government programs and civil or military service	( )
(L) Records, reports, and statements	( )
(M) Voter registration and absentee ballot requests	( )
(N) All other matters	( )
(O) Only these powers specified below:	( )

Section 4. Grant of Specific Authority (optional)

The agent or agents you have appointed WILL NOT have the power to do any of the following acts UNLESS you MARK the box opposite that category:

( ) create, amend, revoke, or terminate an inter vivos trust;
( ) make a gift, subject to the limitations of AS 13.26.665(q) and any special instructions in this power of attorney;
( ) create or change a beneficiary designation;
( ) revoke a transfer on death deed made under AS 13.48;
( ) create or change rights of survivorship;
( ) delegate authority granted under the power of attorney;
( ) waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan;
( ) exercise fiduciary powers that the principal has the authority to delegate

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A.S. 13.26.645

Power of Attorney - Agent’s duties

- act in good faith
- act only with the shared authority in the POA document
- act not to create conflict of interest
- act with care, competence, diligence for best interest of beneficiary
- should keep record of receipts, disbursements, transactions
- cooperate with person who has authority to make health care decisions

- Need to say WHEN you want the Power of Attorney to go into effect

DURABLE POWER OF ATTORNEY OPTIONS

Sections 5, 6, and 7 allow you to choose when you want your agent's powers to go into effect and whether or not you want this to be a durable power of attorney. *Note: If you want this to be a durable power of attorney, do not limit the term of this document in the sections below.*

Section 5. To indicate when this document becomes effective, mark 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 incapacity and shall not otherwise be affected by my incapacity.

Section 6. If you have indicated that this document becomes effective on the date of your signature, mark one of the following:

______ This document shall not be affected by my subsequent incapacity.

______ This document shall be revoked by my subsequent incapacity.

Section 7. If you have indicated that this document becomes effective upon the date of your signature and want to limit the duration of this document, complete the following:

This document shall only continue in effect until ____________________, 20___.
(Month/Day) (Year)

Power of Attorney - Incapacity

"Incapacity" means inability of an individual to manage property or business affairs bc the individual

(A) has an impairment in the ability to receive and evaluate information or make or communicate decisions even with the use of technological assistance OR

(B) i. is missing

ii. detained (incl. incarcerated in penal system) or

iii. outside the US and unable to return

(A) must be established by affidavit (AS 13.26.680, AS 13.26.695(3))

Section 8. Notice of revocation of the powers granted in this document.

You may revoke all of the powers granted in this document, or just specific powers. You may revoke all the powers granted in this power of attorney by notifying your agent in writing of the revocation or by completing a subsequent power of attorney. 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.

Section 9. Notice to Third Parties

A third party who relies on the reasonable representations of an agent as to a matter relating to a power granted by a properly executed statutory form 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 agent 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 agent, the principal's heirs, assigns, or estate for 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 incapacity of the principal, the incapacity of the principal is established by an affidavit, as required by law.

Optional Provisions

Section 10. You may designate an alternate agent. 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, 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:

Alternate or successor agent ______________________________________
(Name and address of alternate)

Section 11. You may nominate a guardian or conservator. If you wish to nominate a guardian or conservator, complete the following:

In the event that a court decides that it is necessary to appoint a guardian or conservator for me, I hereby nominate the following person to be considered by the court for appointment to serve as my guardian or conservator, or in any similar representative capacity.

Person nominated as guardian or conservator: ______________________________
(Name and address of guardian or conservator)

Section 13. Signatures.

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.

OPTIONAL: If a person other than the principal executes the signature for the principal, the person may not be a person who is appointed an agent in the power of attorney and the following signature line and notary verification must also be completed:

IN WITNESS WHEREOF, I have hereunto signed my name this ____ day of _______________, 20__.

Name of the principal: ____

Signature of the person signing at the request of the principal: ____

Printed name of person signing at the request of the principal: ____

Form of identification of person signing: ____

Acknowledged before me at______________________________________on the _____day of ___________, 20__.

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

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TRANSLATION CLAUSE (if needed)

A.S. 13.26.600

Power of Attorney - record keeping & revoking

- Want to have copy for self
- Copy to agent

- It can be revoked; a written statement to the Agent and any business or institutes stating you are removing this person from the shared authority

ALASKA REVOCATION OF POWER OF ATTORNEY

I, ________________________ (your name), of ____________________ (your town), Alaska, hereby **revoke** any and all Powers of Attorney and all authority to act as my Agent given to ______________________________ this date forward, my former Agent has **no authority** to handle my personal or financial affairs. Under **Alaska Law AS 13.26.001 - AS 13.26.410**, my former Agent must comply with this revocation. This document serves as notice of the revocation to the Agent and to all parties that receive it. A photocopy has the same effect as the original.

The foregoing Revocation was signed by _____________________________in our presence, and we, at her request and in her presence, and in the presence of each other, each of us being over the age of 18 years, have hereunto subscribed our names as Witnesses on this the __________ day of ____________________, 20_____.

____

Principal Signature

______________________________	______________________________
Witness	**Witness**
______________________________	______________________________
Street Address	Street Address
______________________________	______________________________
City, State, and ZIP	City, State, and ZIP

Questions?

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Alaska Advance Health Care Directive

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Advance Health Care Directive

Also called a ‘living will’ or ‘medical power of attorney’

Deals with health related decisions.

Advance Health Care Directive

- Allows you to appoint an agent(s) to make healthcare decisions for you.
  - You can limit your agents authority / ability to make decisions.

- Allows you to decide how you want to be kept alive or not, if you want to donate your organs, and other medical decisions

- Can decide when you want this to go into effect

- Can revoke at any time

Advance Health Care Directive

Must be 18 years old.

Must be ‘mentally competent’.

Must be signed in front of 2 witnesses AND notarized.

PART 1
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

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

____

(name of individual you choose as agent)

____

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

____

(telephone contact)

DESIGNATION OF FIRST ALTERNATE (OPTIONAL): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent

____

(name of individual you choose as first alternate agent)

____

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

(2) AGENT'S AUTHORITY. My agent is authorized and directed to follow my individual instructions and my other wishes to the extent known to the agent in making all health care decisions for me. If these are not known, my agent is authorized to make these decisions in accordance with my best interest, including decisions to provide, withhold, or withdraw artificial hydration and nutrition and other forms of health care to keep me alive, except as I state here:

____

____

____

(Add additional sheets if needed.)

Under this authority, "*best interest*" means that the benefits to you resulting from a treatment outweigh the burdens to you resulting from that treatment after assessing

(A) the effect of the treatment on your physical, emotional, and cognitive functions;

(B) the degree of physical pain or discomfort caused to you by the treatment or the withholding or withdrawal of the treatment;

(C) the degree to which your medical condition, the treatment, or the withholding or withdrawal of treatment, results in a severe and continuing impairment;

(D) the effect of the treatment on your life expectancy;

(E) your prognosis for recovery, with and without the treatment;

(F) the risks, side effects, and benefits of the treatment or the withholding of treatment; and

(G) your religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

(3) WHEN 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.

(4) AGENT'S OBLIGATION. 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

Attached is a PFD fillable Power of Attorney packet, but I can confirm the POA packet you have is still up to date.

PART 2
INSTRUCTIONS FOR HEALTH CARE

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.

(6) END-OF-LIFE DECISIONS. Except to the extent prohibited by law, I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: *(Check only one box.)*

[ ] (A) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards; OR

[ ] (B) Choice Not To Prolong Life

I want comfort care only and I do not want my life to be prolonged with medical treatment if, in the judgment of my physician, I have *(check all choices that represent your wishes)*

[ ] (i) a condition of permanent unconsciousness: a condition that, to a high degree of medical certainty, will last permanently without improvement; in which, to a high degree of medical certainty, thought, sensation, purposeful action, social interaction, and awareness of myself and the environment

(C) Artificial Nutrition and Hydration. If I am unable to safely take nutrition, fluids, or nutrition and fluids *(check your choices or write your instructions)*,

[ ] I wish to receive artificial nutrition and hydration indefinitely;

[ ] 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 in (6)(B) above, I do not wish to receive artificial nutrition and hydration.

[ ] Other instructions:________________________________
____

(D) Relief from Pain.

[ ] I direct that adequate treatment be provided at all times for the sole purpose of the alleviation of pain or discomfort; or

[ ] I give these instructions:
____

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.

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

[ ] (A) I give any needed organs, tissues, or other body parts,

OR

[ ] (B) I give the following organs, tissues, or other body parts only ____

____

[ ] (C) My gift is for the following purposes *(mark any of the following you want)*:

[ ] (i) transplant;

[ ] (ii) therapy;

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.

(9) PSYCHOTROPIC MEDICATIONS. If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

________ I consent to the administration of the following medications:

____

________ I do not consent to the administration of the following medications:

____

Conditions or limitations:____

____.

PART 5
PRIMARY PHYSICIAN
(Optional)

(12) I designate the following physician as my primary physician:

____
(name of physician)

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

____
(telephone)

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)

(14) SIGNATURES. Sign and date the form here:

DATE ____________________ ____________________________
(sign your name)

BIRTHDATE _______________

____
(print your name)

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

(15) WITNESSES. This advance care health directive will not be valid for making health care decisions unless it is

(A) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature. The witnesses may not be a health care provider employed at the health care institution or health care facility where you are receiving health care, an employee of the health care provider who is providing health care to you, an employee of the health care institution or health care facility where you are receiving health care, or the person appointed as your agent by this document. At least one of the two witnesses may not be related to you by blood, marriage, or adoption or entitled to a portion of your estate upon your death under your will or codicil; **or**

(B) acknowledged before a notary public in the state.

Advanced Care Directive - record keeping & revoking

- Want to have copy for self
- Copy to agent
- Copy to medical provider

- It can be revoked; a written statement to the Agent and any business or institutes stating you are removing this person from the shared authority

ALASKA REVOCATION OF ADVANCED CARE DIRECTIVE

I, ______________________ (your name), of __________________ (your town), Alaska, hereby **revoke** any and all Powers of Attorney and all authority to act as my Agent given to ____________________________ this date forward, my former Agent has **no authority** to handle my health care decisions. My former Agent must comply with this revocation. This document serves as notice of the revocation to the Agent and to all parties that receive it. A photocopy has the same effect as the original.

The foregoing Revocation was signed by ___________________________in our presence, and we, at her request and in her presence, and in the presence of each other, each of us being over the age of 18 years, have hereunto subscribed our names as Witnesses on this the _________ day of __________________, 20_____.

____

Principal Signature

________________________________	________________________________
Witness	**Witness**
________________________________	________________________________
Street Address	Street Address
________________________________	________________________________
City, State, and ZIP	City, State, and ZIP

STATE OF ALASKA

CITY OF

Life Planning Documents: Recap

- Help you make decisions on your finances and your care while you’re still living
- Can be revoked
- Can provide peace of mind
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Questions on Advanced Care Directive or Power of Attorney?

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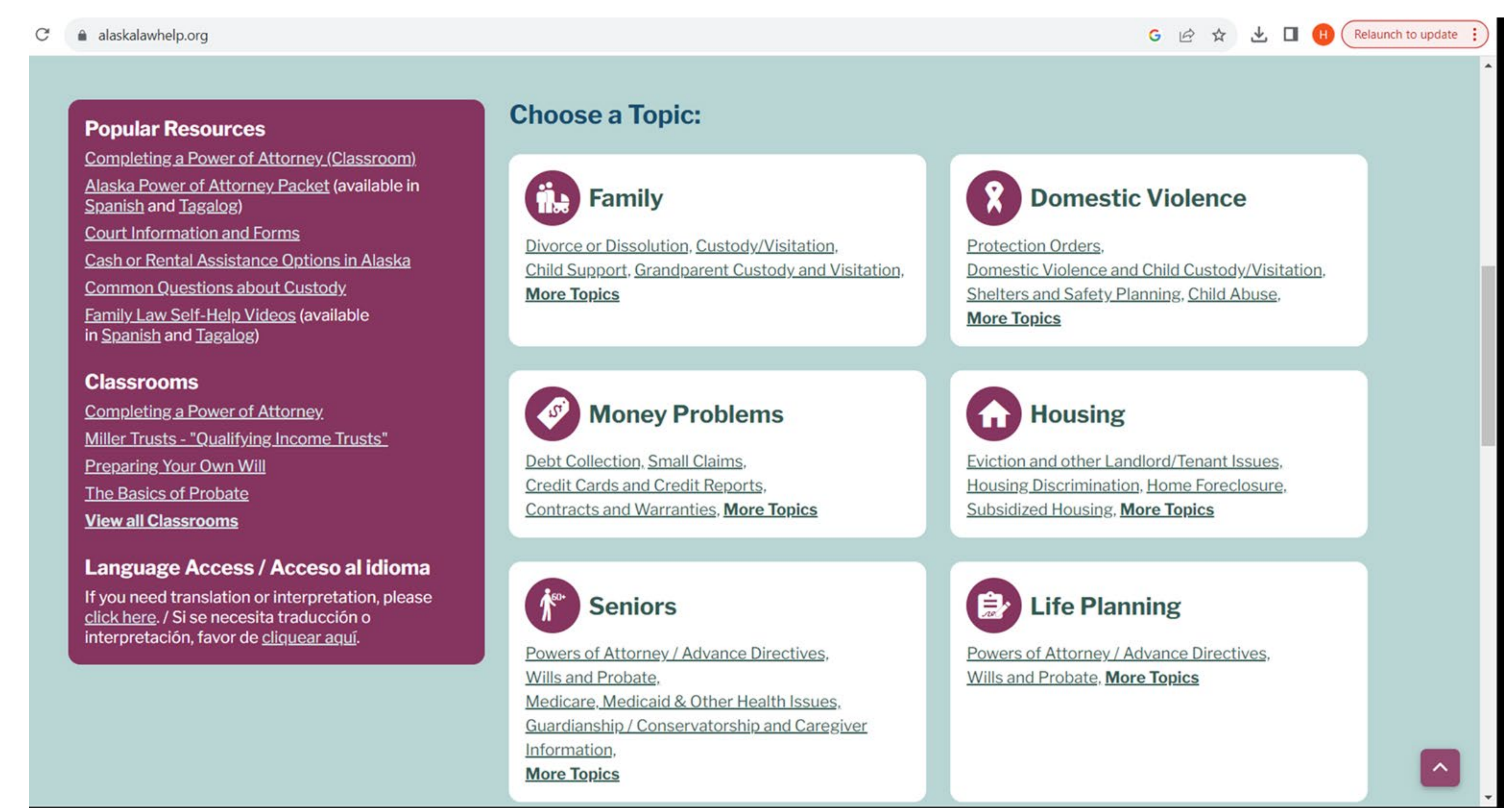
Final Thoughts

- All these documents allow you to make a choice:
  - your financial decisions
  - your health care decisions
  - distribution of your property
- Can provide peace of mind
- Can be useful to your family if something unexpected happens

AlaskaLawHelp.org

- FREE website, managed by Alaska Legal Services
- Easy to use
- Links to videos, forms, information



Thank you for your time!

-Heather Parker, hparker@alsc-law.org

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statewide online intake: *https://www.alsc-law.org/intake/*

New applications can be emailed to juneau@alsc-law.org