Alaska
MENTAL HEALTH ADVANCE HEALTH CARE DIRECTIVE

(Chapter 38 Session Laws of Alaska 2004)

EXPLANATION

This form pulls out the specific mental health care provisions (Part 4) contained in Alaska Statutes Title 13, Chapter 52 (AS 13.52) enacted in 2004, which becomes effective on January 1, 2005 and also includes the option to designate someone to make mental health care decisions for you (Agent) if it has been determined you are incompetent to do so. It is not required to designate an Agent, but if you have someone you trust completely, it can be a big help in preventing psychiatric procedures being forced upon you. The full form with the other parts (General Health Care Directives, Anatomical Gifts, and Designation of Primary Physician) can be found at http://psychrights.org/States/Alaska/Directives.htm. You may complete or modify all or any part of this form and are free to use a different form if the form complies with the requirements of AS 13.52.

After completing this form, sign and date the form at the end and have the form notarized or witnessed as provided below. Give a copy of the signed and completed form to your agent or surrogate, if any, 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 also might want to keep a copy handy in order to show it to a mental health facility in the event that becomes necessary. If you have named someone as your Agent you should talk to him/her/them to make sure they understands your wishes and are willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time, except that you may not revoke this declaration when you are determined not to be competent by a court, by two physicians, at least one of whom shall be a psychiatrist, or by both a physician and a professional mental health clinician. In this advance health care directive, "competent" means that you have the capacity

(1) to assimilate relevant facts and to appreciate and understand your situation with regard to those facts; and

(2) to participate in treatment decisions by means of a rational thought process.

DIRECTIONS REGARDING MENTAL HEALTH CARE

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 or otherwise change it to your liking.

(1) 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 do not consent to the administration of any psychotropic medications, except:

_____

Conditions or limitations: _____

_____

(2) 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 I do not consent to the administration of electroconvulsive treatment.

(3) ADMISSION TO AND RETENTION IN FACILITY. If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding admission to and retention in a mental health facility for mental health treatment are as follows:

☐ I consent to being admitted to a mental health facility for mental health treatment for up to _____ days. (The number of days not to exceed 17.)

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

Conditions or limitations: _____

_____

_____

OTHER WISHES OR INSTRUCTIONS

_____

_____

_____

(Add additional sheets if needed.)

OPTIONAL DURABLE POWER OF ATTORNEY FOR MENTAL 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)

_____

(home telephone) (work telephone)

ALTERNATE AGENT (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)

_____
(home telephone) (work telephone)

SECOND ALTERNATE AGENT (Optional) If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent

_____
(name of individual you choose as second alternate agent)

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

_____
(home telephone) (work telephone)

(2) AGENT'S AUTHORITY. My agent is authorized and directed to follow my individual instructions and my other wishes as expressed here or to the extent known to the agent in making mental health care decisions for me. If these are not known, my agent is authorized and directed to make these decisions based on:

☐ what I would choose if I were competent, or

☐ my best interests:

_____
_____
_____
(Add additional sheets if needed.)

Under this authority, "best interest" means that the potential benefits from a treatment outweigh the risks or detriments resulting from that treatment after assessing

(A) the effect of the treatment on physical, emotional, and cognitive functions;
(B) the degree of physical pain or discomfort caused by the treatment or the withholding or withdrawal of the treatment;
(C) the prognosis with and without the treatment;
(D) the quality of life with and without the treatment;
(E) the effect of the treatment on life expectancy with and without the treatment;
(F) the risks, side effects, and potential benefits of the treatment or the withholding of treatment; and
(G) religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE. 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.

NOMINATION OF GUARDIAN. If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named above, in the order designated.

SIGNATURE. Sign and date the form here:

_____ _____

(signature) (date)

_____

(print your name)

_____

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

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.

NOTARIZATION

State of Alaska)
)ss
_____ Judicial District)

On this _____ day of _____, in the year _____, before me appeared _____ , personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that the person executed it.

Notary Seal

_____

(signature of notary public)

My Commission Expires: _____

NOTICE: This form may also be authenticated by two witnesses on the next page. There are different rules for people who are relatives and those who are not.

WITNESSES (Total of Two Required)
Alternative to Notarization

Witness(es) Not Related to or a Devisee of the Principal

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider providing health care to the principal;

(3) an employee of the health care institution or health care facility where the principal is receiving health care;

(4) the person appointed as agent by this document;

(5) related to the principal by blood, marriage, or adoption; or

(6) entitled to a portion of the principal's estate upon the principal's death under a will or codicil.(date) (signature of witness)

_____	_____
(signature of witness) (date)	(signature of witness) (date)
_____	_____
(printed name of witness)	(printed name of witness)
_____	_____
(address) (city) (state) (zip code)	(address) (city) (state) (zip code)

Witness(es) Related to or a Devisee of the Principal

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider who is providing health care to the principal;

(3) an employee of the health care institution or health care facility where the principal is receiving health care; or

(4) the person appointed as agent by this document.

_____	_____
(signature of witness) (date)	(signature of witness) (date)
_____	_____
(printed name of witness)	(printed name of witness)
_____	_____
(address) (city) (state) (zip code)	(address) (city) (state) (zip code)