DISCLAIMER
The Division of Senior and Disability Services cannot provide legal advice to any provider, or recipient, of PCA services.
If you have questions about the sufficiency of this form or something similar, the provider or the recipient should seek the advice of a private attorney.

LIMITED POWER OF ATTORNEY

I, _____, of _____
_____
(Name of Principal) (Address of Principal)

_____, Alaska, appoint _____ of ____
_____
(Name of Agent(s)) (Address of Agent(s))

_____ as my agent(s) for health care decisions related to a personal care assistant. I authorize my agent(s) to make any health care decision related to and including giving direction to a personal care assistant regarding services provided. I revoke all previous powers of attorney I have executed as they govern health care decisions related to and including giving direction to a personal care assistant.

If I have named more than one agent, and one or more agents cannot serve as agent, the remaining agents shall serve. If there are no remaining agents, I appoint _____ _____ of _____ as my alternate agent.

If I have appointed more than one agent:

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

This document shall become effective:

_____Upon the date of my signature
_____Upon the date of my incapacity and shall not otherwise be affected by my incapacity

If this document is effective upon the date of my signature:

_____This document shall not be affected by my subsequent incapacity
_____This document shall be revoked by my subsequent incapacity

If I have indicated that this document shall become effective upon the date of my signature, and I wish to limit the term of its effectiveness, the document shall be effective for _____ years from the date of my signature.

_____ _____
Principal Date

This health care power of attorney must be signed by two qualified witnesses or a notary public.

A qualified witness is one who is personally known to you and who is present when you sign or acknowledge your signature; a witness 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.

ALTERNATIVE NO. 1

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.

_____ _____

Date Signature of Witness

_____

Printed Name of Witness

_____

Address

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 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.

_____ _____

Date Signature of Witness

_____

Printed Name of Witness

_____

Address

ALTERNATIVE NO. 2

STATE OF ALASKA)
) ss.
FIRST JUDICIAL DISTRICT)

On this _____ day of _____, in the year _____, before me,

_____, appeared _____,
(Name of Notary Public) (Name of Principal)

personally known to me (or provided 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 Public, State of Alaska
My commission expires: _____