

HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE

My name is:

Last

First

Middle initial

Date of Birth

Date

PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:

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

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

AGENT’S AUTHORITY AND OBLIGATION:

My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:

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.

- ☐ If I mark this box, my agent’s authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care. I can revoke this authority at any time as long as I have mental capacity.

PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

A. END OF LIFE DECISIONS

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

THEN 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 of the following boxes. You may also initial your selection.

☐ I want to stop or withhold medical treatment that would prolong my life.

OR

☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

YOUR NAME:

Print Your Full Name

Date of Birth

Date

PART 2: INDIVIDUAL INSTRUCTIONS (CONTINUED) (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

☐ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. RELIEF FROM PAIN:

☐ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER

☐ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

E. WHAT IS IMPORTANT TO ME: (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

☐ I have attached _____ additional sheet/s

My thoughts about when I would not want my life prolonged by medical treatment (examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

☐ I have attached _____ additional sheet/s

YOUR NAME: (Please sign in front of witnesses or notary public)

Print Your Full Name Your Signature Date of Birth Date

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.

Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1: WITNESSES

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

Witness #1 Print Name Witness Signature Date

Street Address City State Zip

I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

Witness #2 Print Name Witness Signature Date

Street Address City State Zip

OPTION 2: NOTARY PUBLIC

State of Hawai'i,
(City and) County of _____ } ss.

On this _____ day of _____, in the year _____, before me,
_____, (insert name of notary public) 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 ____ -page Hawai'i
Advance Health Care Directive dated on _____, in the _____ Judicial Circuit of
the State of Hawai'i, and acknowledged that he/she executed the same as his/her free act and deed.

Signature of Notary Public

My Commission Expires: _____

A copy has the same effect as the original.
www.kokuamau.org/resources/advance-directives
Developed by the Executive Office on Aging and
Kōkua Mau - A Movement to Improve Care

December 2015

Place Notary Seal or Stamp Above

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent

CHECKLIST:

- **Talk with your spouse, partner, adult children, family, friends, spiritual advisors, and doctors** about what would be important to you.
- **Ask someone you trust and can count on to be your health care agent.** Discuss your wishes with this person. Select an alternate health care agent in case your agent is unable to serve.
- **Complete the enclosed optional Advance Directive.** You can add more pages if needed to outline your wishes.
- **Have two qualified witnesses or a notary public** witness your signature.
- **Inform family, friends, and doctors that you have an Advance Directive** and that you expect them to honor your wishes. Keep them informed about your current wishes.
- **Give copies of the Advance Directive** to your health care agent, health care providers, family, close friends, spiritual advisors, and any other individuals who might be involved in your care.
- **Place copies in your medical files.**
- **Keep a copy in any easy to find place in your home.** (Not in a safe deposit box!!) You could leave a note on the refrigerator to tell people where your important documents are so they can be found when they are needed.
- You may designate **“Advance Directive” on your driver’s license or state identification card** to indicate that you have completed an Advance Directive and wish it to be honored. Hawai‘i drivers’ license stations do not file Advanced Directives.
- **Review your Advance Directive regularly.** In case you make changes, inform people, create a new document, and replace the old one.
- **Learn about POLST:** Do you need POLST (Provider Orders for Life Sustaining Treatment) in addition to an Advance Directive? Talk with your doctor or advanced practice registered nurse (APRN) about POLST and visit www.kokuamau.org/polst for more information for you and for your provider as well as the POLST form.

This brochure provides general information and does not constitute legal advice and may not apply to your individual situation.

Developed by Kōkua Mau and the Executive Office on Aging, State of Hawai‘i. Checklist originally developed by UH Elder Law Program. *Revised: January 2016*

YOUR ADVANCE DIRECTIVE FOR FUTURE HEALTH CARE



It is your gift to loved ones, family members and friends
so that they won't have to guess what you want
if you no longer can speak for yourself



KŌKUA MAU
Continuous Care
A Movement to Improve Care



Executive Office on Aging
Department of Health

WHY DO I NEED AN ADVANCE HEALTH CARE DIRECTIVE?

Medical technology has given us many new options for sustaining life. This makes it important for you to discuss what kind of care you want before serious illness or accident occurs. Everyone over the age of 18 should have one.

Now is the time to talk about these important issues while you can still make your own decisions and have time to talk about them with others.

If you don't have an Advance Health Care Directive, (commonly known as 'Advance Directive'), and even one person interested in your care disagrees, your doctor may not honor your wishes for end-of-life care.

The Advance Directive takes the place of the former living will document and gives you more options. Review your existing forms and make sure your Advance Directive reflects your current wishes.

WHAT DO I PUT IN MY ADVANCE DIRECTIVE?

THE PERSON OR "AGENT" YOU WANT TO MAKE DECISIONS FOR YOU WHEN YOU CANNOT.

You should identify someone you trust to act as your agent as well as an alternate. This person does not have to be an attorney. Unless you limit this person's authority, this person has the right to accept or refuse any kind of medical care and testing, discharge or select doctors, and see all medical records.

THE KIND OF HEALTH TREATMENT YOU WANT OR DON'T WANT.

You can say whether or not you want to be kept alive by machines that breathe for you or be fed by a tube even if there is no hope you will get better.

YOUR WISHES FOR COMFORT CARE.

You can indicate whether you want medicine for pain or where you want to spend your last days. You can also give spiritual, ethical, and religious instructions.

HOW CAN I ENSURE MY ADVANCE DIRECTIVE IS HONORED?

Share copies and talk with your agent, loved ones, family, and others who will be involved in your care. Discuss it with all your doctors and ask all of them to insert your Advance Directive into your medical records. This document and resources in other languages, such as Advance Directives or POLST, are available from your healthcare provider, doctor, or health insurance company or on the Kōkua Mau website at www.kokuamau.org/languages.

INSTRUCTIONS FOR ADVANCE DIRECTIVE

(in accordance with the Uniform Health Care Decisions Act, 1999)

Complete Part 1 and 2 on the enclosed form. You may add pages and make any changes you wish. You do not need an attorney to complete this form. If you need more help, consult the phone numbers included in this brochure. Complete the check list on the back page.

PART 1 – HEALTH CARE POWER OF ATTORNEY, YOUR AGENT

Select one or more persons to be your agent and make health care decisions if you are unable. The person you appoint can be a spouse, adult child, friend, or any other trusted person. Your agent cannot be an owner or employee of a health care facility where you are receiving care unless they are related to you.

PART 2 – INDIVIDUAL INSTRUCTION

Give instructions to your doctor and others about any aspect of your health care. You will be given choices. Check only one box in each category and cross out all which do not apply. You can also add more about your wishes and goals for care.

Ask two witnesses to sign and date the form

Both must be people you know. They cannot be health care providers, employees of a health care facility, or the person you choose as an agent. One person cannot be related to you or have inheritance rights.

Notary Public

If you do not have 2 witnesses, your Advance Directive must be notarized.

You have the **right to revoke or change your Advance Directive at any time** orally or in writing. Be sure to tell your agent and doctor.

WHO CAN HELP ME COMPLETE MY ADVANCE DIRECTIVE?

Talk with your health care provider and your health plan representative.

Legal Aid Senior Hotline: 1-888-536-0011

O'ahu: UH Elder Law Program, **808-956-6544**, www.hawaii.edu/uhelp

For further information contact:

Kōkua Mau - A Movement to Improve Care

- For Advance Directives (also as a writable pdf) please visit: www.kokuamau.org/resources/advance-directives.
- Kōkua Mau Speaker's Bureau can provide speakers about Advance Care Planning (Advance Directives and POLST).

www.kokuamau.org • info@kokuamau.org • (808) 585-9977
Kōkua Mau • P.O. Box 62155 • Honolulu HI 96839