



KŌKUA MAU

“Continuous Care”

Hawai'i Hospice and Palliative Care Organization

Background Information about the Multilingual Hawaii Advance Directive

The **Hawaii Advance Health Care Directive** (HI AD) or ‘Advance Directive’ (AD) as it is commonly known, is a written statement about your future medical care. Starting May 2016 the HI AD is available in [10 languages](#). To facilitate the discussion for providers and loved ones, the HI AD is a bilingual document translated content block by content block.

Please keep in mind that **most providers speak English only**. To ensure that your wishes and instructions are understood and can be honored, please fill out your HI AD in **English**. In order to complete an advance directive you need to either have two witnesses or a notary public for it to be valid.

Important limitation: If you choose to complete the English portion of a bilingual HI AD, State of Hawaii regulations require a **bilingual Notary** to notarize your bilingual version of the advance directive.

“The notarization of a document that has been written in a foreign language should only be performed by a notary who has a thorough understanding of the foreign language in which the document and/or notarial certificate are written.” [...] Similarly, a notary should not notarize a document written in English if the parties to the document who appear before the notary do not appear to speak, read, or understand English.” Page 5, Notary Manual 2010.

Call the Notary Public Program (808) 586-1216 for a **bilingual notary**, or go to their website <https://notary.ehawaii.gov/notary/public/publicsearch.html> (‘Search Category’: choose ‘Language’ in the fold down menu and in ‘Search Terms’ type in the language you want).

Please call the notary public office if you have more questions regarding using a bilingual notary.

Two recommendations for completing your bilingual AD:

1) Use **two witnesses** to complete a bilingual HI AD. Witnesses cannot be health care providers (like a doctor, nurse or social worker), employees of a health care facility, or the person you choose as an agent. One of the two persons cannot be related to you or have inheritance rights.

OR

2) Use a **bilingual notary**.

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HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE Tagalog

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.

ADVANCE DIRECTIVE PARA SA PANGANGALAGA NG KALUSUGAN SA HAWAI‘I

HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE

Ako ay si:

Apelyido

Pangalan

Gitnang inisyal

Petsa ng Kapanganakan

Petsa

BAHAGI 1: HEALTH CARE POWER OF ATTORNEY – PAGTATALAGA NG AHENTE:

Itinatalaga ko ang sumusunod na indibidwal bilang aking ahente na gagawa ng mga desisyon sa pangangalaga ng kalusugan para sa akin:

Pangalan at kaugnayan sa indibidwal na itinalaga bilang ahente sa pangangalaga ng kalusugan

Address ng Kalye Lungsod Estado Zip

Telepono sa Bahay Cell Phone E-mail

Kung babawiin ko ang kapangyarihan ng aking ahente o kung ang aking ahente ay hindi pumapayag, hindi kaya, o hindi maaaring gumawa ng mga desisyon para sa akin, itinatalaga ko ang sumusunod na indibidwal bilang aking alternatibong ahente:

Pangalan		at kaugnayan sa indibidwal na itinalaga bilang ahente sa pangangalaga ng kalusugan		
Address ng Kalye	Lungsod	Estado	Zip	
Telepono sa Bahay	Cell Phone	E-mail		

KAPANGYARIHAN AT OBLIGASYON NG AHENTE:

Ang aking ahente sa pangangalaga ng kalusugan ay dapat gumawa ng mga desisyon tulad ng ibinilin ko sa Bahagi 2 ng form na ito o na maaari kong ibigay nang pasalita o pasulat. Kung may mga desisyon na hindi ko nabigyan ng mga tagubilin, gusto kong gawin ng aking ahente ang ganoong mga desisyon na tulad sana ng gagawin ko, na ibinabatay ang mga ito sa aking mga pinahahalagahan, layunin, at mga kagustuhan sa halip na sa mga pinahahalagahan, layunin at mga kagustuhan ng aking ahente. Kung ang tagapag-alaga ko ay kailangang italaga ng korte para sa akin, inonomina ko ang aking ahente.

KAILAN MAGKAKABISA ANG KAPANGYARIHAN NG AHENTE:

Magkakabisa ang kapangyarihan ng aking ahente sa pangangalaga ng kalusugan kapag ipinasya ng aking pangunahing doktor na hindi ko makayang gawin ang aking sariling mga desisyon sa pangangalaga ng kalusugan maliban kung mamarkahan ko ang sumusunod na kahon.

Kung mamarkahan ko ang kahong ito, magkakabisa kaagad ang kapangyarihan ng aking ahente na gumawa ng mga desisyon sa pangangalaga ng kalusugan para sa akin. Gayunpaman, palagi kong hawak ang karapatang gawin ang aking mga sariling desisyon tungkol sa pangangalaga ng aking kalusugan. Maaari kong bawiin ang kapangyarihang ito sa anumang oras basta't mayroon akong kakayahan sa pag-iisip.

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.

BAHAGI 2: MGA INDIBIDWAL NA TAGUBILIN (Maaari ninyong baguhin o burahin ang anumang bagay na hindi ninyo sinasang-ayunan. Lagyan ng inisyal at petsa ang anumang mga pagbabago.)

A. MGA DESISYON SA PAGWAWAKAS NG BUHAY

- Kung mayroon akong walang lunas na karamdaman at hindi na gagaling na kondisyon na magreresulta sa aking pagkamatay sa loob ng maikling panahon, **O**
- Kung nawala ko na ang aking kakayahang sabihin ang aking mga kagustuhan hinggil sa pangangalaga ng aking kalusugan at hindi malamang na mapapanumbalik ko ang kakayahang iyon, **O**
- Kung ang mga posibleng panganib at pasanin ng paggamot ay mas mabigat kaysa sa mga inaasahang benepisyo.

KUNG GAYON Ibinibilin ko na ipagkaloob, huwag ipagkaloob, o ihinto ng mga tagapagbigay ng pangangalaga ng kalusugan ko at mga iba pang sangkot sa aking pangangalaga ang paggamot alinsunod sa desisyong minarkahan ko sa ibaba: Lagyan ng tsek ang isa lamang sa mga sumusunod na kahon. Maaari din ninyong lagyan ng inisyal ang inyong pinili.

Gusto kong ihinto o huwag ipagkaloob ang medikal na paggamot na magpapahaba ng aking buhay.

O
 Gusto ko ng medikal na paggamot na magpapahaba ng aking buhay hangga't maaari sa loob ng mga limitasyon ng mga pamantayan ng pangangalaga ng kalusugan na tanggap ng kalahatan.

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.

B. ARTIPISYAL NA NUTRISYON AT PAGBIBIGAY NG TUBIG - PAGKAIN AT MGA INUMIN:

Ang artipisyal na nutrisyon at pagbibigay ng tubig ay kailangang ipagkaloob, hindi ipagkaloob o itigil alinsunod sa desisyong ginawa ko sa naunang talata A maliban kung mamarkahan ko ang sumusunod na kahon.

Kung mamarkahan ko ang kahong ito, kailangang maipagkaloob ang artipisyal na nutrisyon at pagbibigay ng tubig sa ilalim ng lahat ng pangyayari basta't ito ay nasa loob ng mga limitasyon ng mga pamantayan sa pangangalaga ng kalusugan na tanggap ng kalahatan.

C. RELIEF FROM PAIN:

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

C. GINHAWA MULA SA PANANAKIT:

Kung mamarkahan ko ang kahong ito, pinipili ko ang paggamot upang maibsan ang pananakit o kawalan ng ginhawa kahit pa pabibilisin nito ang aking pagkamatay.

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.)

D. IBA PA

Kung mamarkahan ko ang kahong ito, isasama sa aking pangangalaga ang mga karagdagang tagubilin o impormasyong inilakip ko. (Lagdaan at lagyan ng petsa ang bawat karagdagang pahina at ilakip sa form na ito.)

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

E. ANO ANG IMPORTANTE SA AKIN: (Opsyonal. Gumamit ng mga karagdagang papel kung kailangan.) Ang mga bagay na pinahahalagahan ko at dahilan upang gusto ko pang mabuhay ay: (mga halimbawa: paghahardin, paglalakad kasama ang aking alagang hayop, pamimili, pagsali sa mga pagsasalo-salo ng pamilya, pagpunta sa simbahan o templo):

Naglakip ako ng mga _____ na karagdagang piraso ng papel

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

Ang aking mga kaisipan tungkol sa kung kailan ko hindi gustong pahabain ang aking buhay sa pamamagitan ng medikal na paggamot (Kabilang sa mga halimbawa ang: Wala na akong kakayahang mag-isip upang gawin ang aking mga sariling desisyon, kung nawala ko na ang aking kakayahang makipag-usap, kung hindi na ako ligtas na nakakalunok, atbp.):

■ Naglakip ako ng mga _____ na karagdagang piraso ng papel

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

OPTION 2: NOTARY PUBLIC

State 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 - Hawai'i Hospice and Palliative Care Organization
December 2015

Place Notary Seal or Stamp Above

OPSYON 2: NOTARIO PUBLIKO

Estado ng Hawai'i, }
(Lungsod at) County ng _____ } ss.

Ngayong _____ araw ng _____, sa taong _____, sa harapan ko, si _____, (ilagay ang pangalan ng notario publiko) ay dumating si _____, personal kong kakilala (o pinatunayan ang pagkatao niya batay sa sapat na ebidensya) bilang ang taong pinangalanan sa ___ -pahinang Advance Directive para sa Pangangalaga ng Kalusugan sa Hawai'i na ito na napetsahang _____, sa _____ Judicial Circuit ng Estado ng Hawai'i, at pinatunayan niya na siya ang gumawa nito bilang kanyang malayang hakbang at gawain.

Lagda ng Notario Publiko

Ang Aking Komisyon ay Magpapaso sa: _____

Ang kopya ay may parehong bisa tulad ng orihinal.
www.kokuamau.org/resources/advance-directives
Ginawa ng Executive Office on Aging at ng
Kōkua Mau - Hawai'i Hospice and Palliative Care Organization
Enero 2016

Ilagay sa Itaas ang Selyo o Marka ng Notario