



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

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.

TU‘UTU‘UNI MAKEHE ‘A HAUAI‘I FEKAU‘AKI MO E TOKANGAEKINA E MO‘UI LELEÍ. HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE

Ko hoku hingoá ko:

Hingoa Fakaiku Hingoa ‘Uluaki Hingoa Loto ‘ Aho fá‘ele‘i ‘Aho

KONGA 1 - MAFAI ‘O E LOEÁ KI HE MO‘UI LELEÍ – FILI ‘O E FAKAFOFONGÁ:

‘Oku ou fili ‘a e tokotaha ko ení ke hoko ko hoku fakafofonga ke ne faitu‘utu‘uni ki hono tokangaekina ‘eku mo‘uí:

Hingoa mo e fekau‘aki ‘a e tokotaha kuo fili ke hoko ko e fakafofonga tokangaekina mo‘ui

Hingoa e Hala Kolo Vahefonua Zip

Telefoni ‘i ‘api Telefoni to‘oto‘o ‘Imeili

Kapau te u fakangata ‘a e mafai hoku fakafongá, pē kapau ‘oku fakafisi, pē ‘ikai lava, pē ‘ata‘ataa mo‘oni ke faitu‘utu‘uni ma‘aku, ‘oku ou fili ‘a e tokotaha ko ení ke hoko ko hoku fakafongá talifaki:

| | | | |
|-----------------------|---|---------------|--|
| Hingoa mo e fekau‘aki | ‘a e tokotaha kuo fili ke hoko ko e fakafongá tokangekina mo‘ui | | |
| Hingoa e Hala | Kolo | Vahefonua Zip | |
| Telefoni ‘i ‘api | Telefoni to‘oto‘o | ‘Imeili | |

KO E MAFAI MO E FATONGIA ‘O E FAKAFOFONGÁ:

‘Oku tukuange ki hoku fakafongá ki hono tokangaekina ‘eku mo‘uí, ke faitu‘utu‘uni fakatatau ki hoku loto ‘oku hā he Konga 2 ‘o e foomú ni, pē ko ia kuo u to e tu‘utu‘uni ngutu pē tohí. Kapu ‘oku ‘i ai ha ngaahi fiema‘u tu‘utu‘uni kuo ‘ikai kau he‘eku fai tu‘utu‘uni, ‘oku ou fiema‘u hoku fakafongá ke ne muimui ki he ngaahi fili ko ia na‘aku mei faí, ‘o fakatatau ki he ngaahi me‘a ‘oku ou mahu‘inga‘ia ai, ‘a ‘eku ngaahi taumu‘a mo e ngaahi me‘a ‘oku ou manako ai, ‘o ‘ikai makatu‘unga he ngaahi me‘a ko ia ‘oku fiema‘u ‘e hoku fakafongá. Kapau ‘oku fiema‘u ki ha fakamaau‘anga lao ke fili ha tokotaha ke ne tokanga‘i au, pea ‘oku ou fokotu‘u atu hoku fakafongá.

KO E TAIMI ‘OKU LAU AI ‘A E MAFAI ‘O E FAKAFOFONGÁ:

‘Oku lau e mafai hoku fakafongá ‘i he taimi ko ia kuo pehee ‘e he‘eku tefito‘i toketaa, kuo ‘ikai ke u kei lava ke faitu‘utu‘uni fekau‘aki mo hoku tokangaekina, tukukehe kapau ‘oku ou fili ‘a e puha ko ení.

Kapau kuo u fili e puha ko ‘ení, ko e ‘oange ia e mafai ki hoku fakafongá ke faitu‘utu‘uni fekau‘aki mo hoku tokangaekina. Kā neongo ia, ‘oku ou kei ma‘u pē ‘a e totonu ke u faitu‘utu‘uni fekau‘aki mo hoku tauhí. ‘Oku ngofua ke u fakangata ‘a e mafai ko ení ‘i ha taimi pē ‘oku kei ma‘u ai ‘eku fakakauká.

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.

KONGA 2: FAKAHINOHINO TAAUTAHA (‘E lava ke ke fakalelei pē kohi‘i e ngaahi me‘a ‘oku ‘ikai ke ke tui ki aí Fakamo‘oni fakakonga pea faka‘aho e ngaahi liliú.)

A. TU‘UTU‘UNI FELĀVE‘I MO E FAKANGATA E MO‘UÍ

- Kapau ‘oku ‘i ai haku mahaki ‘oku ‘ikai ala faito‘o, pē mahaki ‘oku ‘ikai lava ke fakangata ‘ene tupú, pea ‘oku mahino ‘e iku vave mai pē ngata ‘o e mo‘uí, PĒ
- Kapau kuo ‘ikai ke u to e malava ke u fetu‘utaki atu ‘eku fiema‘u fakatauhí, pea ngalingali he‘ikai ha to e taufonua ‘a e fetu‘utakí, PĒ
- Kapau kuo hulu atu e me‘a ‘e ala hoko mo mafatukituku e ngaahi feinga faito‘ó fakahoa ki he lelei ‘e ala ma‘u aí.

PEA ‘Oku ou fekau hoku ngaahi ‘api tauhi mahaki mo e ni‘ihi kehe ‘oku nau kau hoku tauhi ke nau fakahoko, ta‘ofi, pē tuku ‘aupito e faito‘ó ‘o fakatatau ki he fili kuo u faka‘ilonga ‘i laló : Faka‘ilonga‘i e puha pē ‘e taha ‘i lalo: Fakamo‘oni fakakonga ho‘o fili.

___ ‘Oku ou loto ke tuku ‘aupito pē ta‘ofi e faito‘o ke fakalōloa ‘eku mo‘uí.

PĒ

___ ‘Oku ou loto ke fakahoko kiate au ‘a e faito‘o ke fakalōloa ki he lahi taha ‘eku mo‘uí, ka e fakatatau ki he fakangatangata ‘o e tauhi mahaki anga mahení.

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. FAFANGA MO FAKAINU MAKEHE - ME‘AKAI MO E VAI:

Kuo pau ke ‘oange, ta‘ofi pe tuku ‘aupito e fafanga mo e fakainu makehé, ‘o fakatatau ki he fili kuo u fai ‘i he palakalafi kimu‘á A tukukehe kapau kuo u fili ‘e au ‘a e puha ko ení.

___ Kapau kuo u fili ‘a e puha ko ení. kuo pau ke ‘oange ‘a e fafanga mo e fakainu makehé, ‘i ha tūkunga pē ‘o fakatatau ki he fakangatangata ‘o e tauhi mahaki anga mahení.

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. FAKANONGA MEI HE MAMAHÍ PĒ LANGÁ:

___ Kapau kuo u fili ‘a e puha ko ení, ko ‘eku fili ia e faito‘o ke tokoni ki he fakasi‘isi‘i e langá pē faingata‘a‘iá neongo ai pē ‘e ala vave ai e maté.

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. NGAahi ME‘A KEHE

___ Kapau kuo u fili ‘a e puha ko ení, ‘oku ‘uhinga ia ko ‘eku ngaahi fakahinohino pe fakamatala tānaki atú, ‘oku fiema‘u ia ke kau ‘i hoku tauhi. (Fakamo‘oni hingoa pea faka‘aho e peesi tānaki kotoa pea fakapipiki ki he foomu ko ení.)

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. KO E ME‘A ‘OKU MAHU‘INGA KIATE AÚ: (Tānaki mai ha ngaahi peesi kapau ‘e fiema‘u.) Ko e ngaahi me‘a ‘oku ou mahu‘inga‘ia ai, pē ‘oku makatu‘unga ai e mahu‘inga ai e mo‘uí kiate au: (Ngaahi sīpinga, Ngaohi ngoue, lue mo ‘eku ki‘i manu tauhi, ‘alu ki falekoloa, kau he ngaahi fakataha faka-fāfili, ‘alu ki he lotú pē tempalé):

Kuo u fakapipiki e la‘ipepa pe ngaahi la‘ipepa _____

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

Ko ‘eku fakakaukau ki he taimi he‘ikai te u to e fiema‘u ai ke fakatolonga fakafaito‘o ‘ata‘ataa pē ‘eku mo‘uí. (‘Oku kau ai e ngaahi sīpinga ko eni: Kapau kuo ‘ikai ke u kei malava ‘o faitu‘utu‘uni ma‘aku, kapau kuo mole kotoa ‘eku malava ke fetu‘utaki, kapau kuo ‘ikai ke u malava ke folo lelei ha me‘a pē ngaahi me‘a pehee):

Kuo u fakakau atu e la‘ipepa pē ngaahi la‘ipepa tānaki.

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

Print Your Full Name

Your Signature

Date of Birth

Date

HOHINGOA: (Kātaki ‘o fakamo‘oni he ‘ao ‘o e kau fakapapau‘i fakamo‘oní pē tokotaha falala‘anga he fonuá)

Hikinima ho Hingoa Kakató

Ko ho‘o fakamo‘oní ‘Aho fā‘ele‘í

‘Aho

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

KAU FAKAMO‘ONI: FILI E 1 PĒ 2, ‘OUA ‘E FILI LŌUA.

Mahu‘inga: ‘Oku ‘ikai ngofua ki he Kau Fakamo‘oní ke kau ai ho fakafongā tokangaekina mo‘uí, pē tokotaha ‘oku ‘i ai hano ‘api mahaki, pē tokotaha ngāue ‘api mahaki. He‘ikai ngofua ke fakamo‘oni ha kāinga pē ha taha ‘oku ‘i ai ha‘ane totonu ki ha koloa ‘a e mahakí.

FILI 1: FAKAMO‘ONI

‘Oku ou (Fakapapau Fakamo‘oni 1) fakahā heni ‘oku ou ‘ilo‘i lelei ‘a e tokotaha ko eni na‘a ne fakakakato ‘a e fakafonu ‘o e Tu‘utu‘u Fakafaito‘o Makehé, pea na‘a ne fakamo‘oni hingoa pē fakapapau‘i e mafai kuo tuku ki ai ‘e he laó ‘i hoku ‘aó, pea ‘oku hā ‘atamai lelei pē pea na‘e ‘ikai fakamalohi‘i. ‘Oku ‘ikai ke ma felāve‘i toto, mali pē pusiaki pea ‘oku mahino kiate au ‘oku ‘ikai ke u tu‘u ke ma‘u ha kongā ‘ene koloá. ‘Oku ‘ikai ko e fakafongā au kuo fili pea hā he tohí ni, pea ‘oku ‘ikai haku ‘api tauhi mahaki, pē ko ha tokotaha au ‘oku ou ngāue ha ‘api pehee.

Fakapapau Fakamo‘oni #1 Tohinima ho Hingoa

Fakamo‘oni Hingoa

‘Aho

Tu‘asila e Halá

Kolo

Vahefonua 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 |

‘Oku ou (Fakapapau Fakamo‘oni 2) fakahā heni ‘oku ou ‘ilo‘i lelei ‘a e tokotaha ko eni na‘a ne fakakakato ‘a e fakafonu ‘o e Tu‘utu‘uni Fakafaito‘o Makehé, pea na‘a ne fakamo‘oni hingoa pē fakapapau‘i e mafai kuo tuku ki ai ‘e he laó ‘i hoku ‘aó, pea ‘oku hā ‘atamai lelei pē pea na‘e ‘ikai fakamalohi‘i. ‘Oku ‘ikai ko e fakafongā au kuo fili pea hā he tohí ni, pea ‘oku ‘ikai haku ‘api tauhi mahaki, pē tokotaha ngāue ha ‘api pehee.

| | | |
|--|-------------------|---------------|
| Fakapapau Fakamo‘oni #2 Tohinima ho Hingoá | Fakamo‘oni Hingoa | ‘Aho |
| Tu‘asila e Halá | Kolo | Vahefonua Zip |

OPTION 2: NOTARY PUBLIC

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

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

FILI 2: TOKOTAHA FALALA‘ANGA HE FONUÁ

Vahefonua Hauai‘i
(Kolo mo e) Vahe ‘o _____ } ss.

‘I he ‘aho _____ ‘o _____, ‘i he ta‘u _____, ‘i hoku ‘ao,
_____, (Fakahū e hingoa ‘o e tokotaha falala‘anga
he fonuá) na‘e hā ‘a _____, ‘a ia ‘oku ou ‘ilo‘i
lelei (pē ko e fakamahino pau kiate au makatu‘unga he ngaahi fakamo‘oni taau) ko ia ‘a e tokotaha ‘oku hā hení _____
peesi ko e Tu‘utu‘uni Tokangekina Mo‘ui Makehe ‘a Hauai‘i ‘aho _____, ‘i he _____
Fakamaau‘anga e Vahefonua Hauai‘i pea fakapapau‘i ‘oku ne fai eni ‘i he loto tau‘atāina.

Fakamo‘oni hingoa ‘a e tokotaha falala‘anga he fonuá

‘Oku ‘osi hoku mafai he: _____

Fokotu‘u e Sila pē Sitapa ‘a e Tokotaha
Falala‘angá ‘i ‘olunga

‘Oku mahu‘inga tatau pē tataú mo e mu‘aki tohi.
www.kokuamau.org/resources/advance-directives
Ko e fa‘u ‘e he ‘Ōfisi Pule ki he Kau Hoholo Vaivaí mo e
Kōkua Mau - Hawai‘i Hospice and Palliative Care Organization
Sanuali 2016