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.
This page is left intentionally blank
# HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE

My name is:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle initial</th>
<th>Date of Birth</th>
<th>Date</th>
</tr>
</thead>
</table>

**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:

<table>
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<tr>
<th>Name and relationship of individual designated as health care agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
</tr>
<tr>
<td>Home Phone</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name and relationship of individual designated as health care agent</th>
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<tbody>
<tr>
<td>Street Address</td>
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<tr>
<td>Home Phone</td>
</tr>
</tbody>
</table>

**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.

**PEPA IN KALLIMUR IKIJEN AO BUKI WAWEN TAKTŌ KO ILIJU IM JAKLAJ ILO HAWAI‘I**

**HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE**

Eta in:

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<tr>
<th>Laaj</th>
<th>Etam</th>
<th>Mitō</th>
<th>inijel</th>
<th>Raan in Lotak</th>
<th>Rainin</th>
</tr>
</thead>
</table>

**PAAT 1: POWER OF ATTORNEY IKIJEN AM TAKTŌ – KELET EO AM ŃAN EO EJ AGENT ŃAN EOK:**

Ij jitoñe armij ņe bwe en agent im kömmane kelet ko ikijen ao taktō ŋan na:

- Etan im teen armij eo emj jitone bwe en agent ikijen taktō

- Aterej in Jokwe Bukwon Eo State Zip

- Talboon in Kabijuknen Cell Boon E-mail

_Lelok melele im kenono ippan ro rekkar kan kallimur ko kwoy kebooje ikijen am naj bōk wawen taktōko iliju im jaklaj_
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.

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.

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.

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

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.

PAAT 2: MELELE KO AN KAJJOJO ARMĲ (Komaroň ukâe ak jolok jabdrewot men ko kwøj jab err ie. Jeiki injel ko maan ilo etam kab rainin aolep ien am kânman octal.)

A. BEBE KO IKIJEN JEMLOK IN MOUR
• ńe ewor ao naninmij rot en ejelok uno en emaroň e im iban mour jen e im kân meniin ebaik ien ao jako, AK
• ńe ejako ao maroň kenono kake kânaan ko ao ikijen ao taktôim emaroň jab bar maroň rooltok jela in, AK
• ńe jonon kauwatata im drolol eo kwøj enjaake jen am taktôelap jen jonon am ejmouj lok.

Lelok melele im kenono ippân ro rekkar kân kallimur ko kwøj kebojoj ikijen am naj bök wawen taktôko iliju im jaklaj
INNEM ba ṇan taktō ro am im ro jet rej lale eok bwe ren lewaj, ak debiji, ak kabojrak jabdrewot kakolkol ko ekkar ṇan kelet ko emōj I kallikkari ijin lal: kōkalleiki juůn wot naan box kein imaan. Komaroň bar inijele kelet eo am.

☐ Ikōnaan kabojrak ak debiji waven taktōko renaj kaetok lok ao mour.

☐ Ikōnaan bōk waven taktōko renaj kaetok lok ao mour ak ren jet waven ko ekka aer kōmmani iumwin kakien ko an jikin taktōko.

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. OON IM DREN KO KWOJ JAB KANGI AK ILIMI - MONA KAB DREN KO:
Ekkar ṇan kelet ko ikar kōmnani ilo melele ko lok imaan ilo paragrap A, renaj aikuij letok, debiji ak kabojrak jen aer letok Oon im dren ijelokin wot ņe inaj kōkalleiki box in maan.

☐ Ne Minaj kollaiki box in, renaj aikuij letok oon im dren jabdrewot ien men eo dreo ej aikuij in bedded ioon karōk im kakien ko an taktōekka aer loori.

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. BOBRAE JEN METAK

☐ Ne inaj kōkolleiki box in, inaj kelet waven taktōko renaj bobrae metak ak apponono jekdron ņe emaroň kōmakaj lok ao jako.

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. KO JET

☐ Ne inaj kōkolleiki box in, aolep karōk im melele ko ikar kōlaajraki renaj aikuij in bar drelon ie bwe en bloomed ao taktō. (Jain im je rainin ilo kajjojo peij im kakobaiki ippān pepa in.)

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. TA KO REAURÔK IPPA: (Men ko jet komaroñ ak komaroñ jab kôaajraki. Kakkobaba pepa ñe men in aikuij.) Men ko reaurk ippa im rej unin ao kônaan wol mour ej: (ñan warn jonok: ekkar out ak mona, keetetale men in mour eo nejd, kaikukuj, bôk konao îlo koba ko an baamle, etal im jar ak kabuñ)

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):

Lomnak ko ao kôn ien en naj jab kônaan retook lok mour e ao kôn wawen taktoîlô bôk ko (Ñan warn jonok ewor: Ñe ejako ao moroñ kolmenlokjen im kômmon bebe ikijio make, ñe emô an jako ao maroñ kwalok lômnak ko ao, ñe ejako ao maroñ kadrelep, im men ko jet):

Lelok melele im kenono ippan taktôeo am, ro rejitenburo ippam, kab agent eo am kôn kallimur ko kwoj kebooje ikijen am naj bôk wawen taktôko iliju im jaklaj
YOUR NAME: (Please sign in front of witnesses or notary public)

<table>
<thead>
<tr>
<th>Print Your Full Name</th>
<th>Your Signature</th>
<th>Date of Birth</th>
<th>Date</th>
</tr>
</thead>
</table>

YOUR NAME: (Jouj im jaini imaan mejen rikamool ak notari)

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<tr>
<th>Jeiki Aolepen Etam kōn Capital Leta</th>
<th>kākalle In Jain In Etam</th>
<th>Raan In Lotak</th>
<th>Rainin</th>
</tr>
</thead>
</table>

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.

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<thead>
<tr>
<th>Witness #1 Print Name</th>
<th>Witness Signature</th>
<th>Date</th>
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<table>
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<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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RIKAMOOL RO: KELET ŅE EJ KEIN 1 AK 2, EN JAB AOLEPEOR.

Men In Aorůk: Rikamool Ro ejjab aikuij in agent eo am, ak juān taktōak juān rjerbal in jikin taktō jūn rikamool ejjab aikuij in juān nukum ak juān eo ewor an men in jolet jen eok.

KELET EO KEIN 1: RIKAMOOL RO:

Na (Rikamool 1) ij kamool ke armij in ej kōmmane kallimur kein einwot ke ej keboooje ikijen an naj buki wawen taktō ko iliju im jakljel ap jela kajien, im emǒj an jaini ak kwalok an kawepene kallimur in imaan meja kab ilak lale einwot emmon an kolmenlokjen im ejelok en ej pooje bwe en kōmmane. Ejjab nuku ilo botǒktōk, kaajiriri, ak ejjab nukan armij eo pālele im ilo ao jela, ijjab pad ilo laajrak in ro renaj wor aer jolet jen e ne enaj jako jen mour in. Ejjab na armij eo ej an agent ilo ao pad ilo pepa in, im ejjab na taktō eo an, ak rjerbal in jikin taktō.

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<th>Rikamool #1 Jeiki Etam</th>
<th>Kākalle in Etan Rikamool</th>
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<th>Aterej in Kabijuknen Eo</th>
<th>Bukōn Eo</th>
<th>State Eo</th>
<th>Zip</th>
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</table>
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.

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<tr>
<th>Witness #2 Print Name</th>
<th>Witness Signature</th>
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Na (Rikamool 2) ij kamool ke armij in ej kömmane kallimur kein einwot ke ej keboojie ikijen an naj buki wawen taktō ko iliju im jaklaj elap ao jela kajien, im emōj an jaini ak kwalok an kaweppe ke kallimur in imaan mejaj kab ilak lale einwot emmon an kolmenlokjen im ejelok en ej pooje bwe en kömmane. Ejjab na armij co ej an agent ilo ao pad ilo pepa in, im ejjab na taktō eo an, ak rijerbal in jikin taktō.

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<tr>
<th>Rikamool #2 Jeiki Etam</th>
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**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 - A Movement to Improve Care

Place Notary Seal or Stamp Above

December 2015
KELET EO KEIN 2: NOTARY PUBLIC AK RIKAMOOLE KÔKALLE IN ETAM

State in Hawai‘i,
(Evan Bukūn eo im) County eo __________________________ ss.

Ilo __________ raan in_____________________, ilo yiio in ________________, imaan meja,
__________________________________________________________, (likuti etan notary public ak rikamoole kākkalle in team eo) ekar jade tok ________________, ej juēn eo elap ao jela kajien (ak emō kamool ŋan na son jet kein kamool ko epo buruo kāk) ke etan in edrelon ilo peij ___ - ilo Kallimur kein ikijen an Buki Wawen taktō Ko Iliju im Jaklaj Ilo Hawai‘i emō jitaamwe ilo raan in __________________, ilo ___________________Judicial Circuit of the State of Hawai‘i, im kallikkar ke ej kōnmame meniin einwot ke ej an make kelet im ewor an maroñ ioon.

kākkalle in Etan Notary Public Eo ak Rikamoole kākkalle in Etam

Ao Eddo Ioon Jerbal In Enaj Jemlok Kutien Ilo: ________________

Kabe im original jonon wot juōn.

www.kokuamau.org/resources/advance-directives
Ekar jino ejaak jen Opiij En Elap An Old Age im
Kōkua Mau - A Movement to Improve Care

Jikin Notary Seal ak Jitaam Eo ņe Iloñ in Ijin

December 2015