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>
<thead>
<tr>
<th>Name and relationship of individual designated as health care agent</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>E-mail</th>
</tr>
</thead>
</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>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
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<table>
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<tr>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>E-mail</th>
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</thead>
</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:

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

**PAAT 1: POWER OF ATTORNEY IKIJEN AM TAKTŌ – KELET EO AM ŇAN EO EJ AGENT ŇAN EOK:**
Ij jitoñe armij Ňe bwe en agent im kömmme kelet ko ikijen ao taktō Ňan na:

<table>
<thead>
<tr>
<th>Etan im teen</th>
<th>armij eo emøj jitone bwe en agent ikijen taktō</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Aterej in Jokwe</th>
<th>Bukwon Eo</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tulboon in Kabijuknen</th>
<th>Cell Boon</th>
<th>E-mail</th>
</tr>
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</table>

*Lelok melele im kenono ippān ro rekkar kōn kallimur ko kwoj kebooje ikijen am naj bök wawen taktō ko iliju im jaklaj*
Etan im teen  armij eo emōj jitone bwe en agent ikijen taktō

Aterej in Jokwe  Bukwon Èo  State  Zip

Talboon in Kabiujuknen  Cell Boon  E-mail

MARAÑ IM EDDO KO AN AGENT EO:
Agent eo ao enaj kwalok bebe ko einwot ao kômeleleiki ilo Paat 2 ilo pepa in ak einwot ao maroñ naj make kômeleleiki ak ilo jeje. Ne ewor bebe ko me ijjanin kar lelol melele kaki ñan ie, ikônaan bwe agent eo ao en komman kelet ko ekkar ñan ao naj kar kelet ie, bedbed ioon an jela kôn kônaan, kôtobar, im tomak ko ao im ejjab ko an agent eo make. Ne court enaj aikuiji juōn eo ej eddo son na, ij jitone kadredre agent eo ao.

NAAT EN ENAJ WEPPEN MALIM IN AN AGENT EN AO :
Enaj jino weppen an agent en ao jino bôk eddoin jerbal in an ñe lukkun taktō en ao ej kile ke ijab maroñ make kolmenlokjen kake im kôttōllok bebe kôn wawen ao taktō, ijelokin wot ñe inaj kôkkalleiki box ñe mana:
__ □ Ne inaj kôkkalleiki box in, melelein bwe agent eo ao enaj jino bôk eddoin jerbal in an ien eo emakaj tata. Botaab, I irkuni jimwe im moroñ ko ao ñan ao maroñ make kômman kelet ko ij lo ke rekkar ikijen ao taktō. Imaroñ kabojarak malim in ilo jabdrewot ien ñe ej emmon wot ao kolmenlokjen.

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.

PAAT 2: MELELE KO AN KAJJOJO ARMIJ (Komaroñ ukôte ak jolok jabdrewot men ko kwoj jab err ie. Jeiki injel ko maan ilo etam kab rainin aolep ien am kômman octal.)

A. BEBE KO IKIJEN JEMLOK IN MOUR
• Ñe ewor ao naninjim rot en ejelok uno en emaroñ e im iban mour jen e im kôn meniin ebaak ien ao jako, AK
• Ñe ejako ao maroñ kenono kake kônnaan ko ao ikijen ao taktō im emaroñ jab bar maroñ rootlok jela in, AK
• Ñe jonon kauwatata im drolool eo kwoj enjaake jen am taktō elap jen jonon am ejmour lok.

Lelok melele im kenono ippān ro rekkar kôn kallimur ko kwoj kebooe ikijen am naj bôk wawen taktō ko iliju im jaklaj
INNEM ba ŋan taktō ro am ro jet rej lalé eok bwe ren lewaj, ak debiji, ak kabojrak jabdrewot kakolkol ko ekkar ŋan kelet ko emōj I kallikkari ijin lal: kōkalleiki juōn wot naan box kein imaan. Komaroñ bar inijele kelet eo am.

☐ Ikōnaan kabojrak ak debiji wawen taktō ko renaj kaetok lok ao mour.

☐ Ikōnaan bōk wawen taktō ko renaj kaetok lok ao mour ak ren jet wawen ko ekka aer kémmani iumwin kakien ko an jikin taktō ko.

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 ŋan kelet ko ikar kémmani 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 beded ioon karōk im kakien ko an taktō ekka 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 kōkalleiki box in, inaj kelet wawen taktō ko renaj bobrae metak ak apponono jekdron ņe emaroñ kémmakaj 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 REAURŌK IPPA:** (Men ko jet komaroŋ ak komaroŋ jab kōlaajraki. Kakkobaba pepa ſe men in aikuij.) Men ko reaurōk ippa im rej unin ao kōnaan wot mour ej: (ñañ warn jonok: ekkat out ak mona, keetetale men in mour eo nejd, kaikujkuj, bōk konao ilo koba ko an baamle, etal im jar ak kabuŋ)

□ Emōj ao kakobaiki _______ bar jet pepa ko

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

Lomnak ko ao kōn ien en naj jab kōnaan retook lok mour e ao kōn wawen taktō lōnlōŋ ko (ñañ warn jonok ewor: ſe ejako ao moroŋ kolmenlokjen im kōmmon bebe ikijio make, ſe emōj an jako ao maroŋ kwalok lōmnak ko ao, ſe ejako ao maroŋ kadrelep, im men ko jet):

□ Emōj ao kakobaiki bar ____ peij ko
YOUR NAME: (Please sign in front of witnesses or notary public)

Print Your Full Name  Your Signature  Date of Birth  Date

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

Jeiki Aolepen Etam kôn Capital Leta  kôkalle In Jain In Etam  Raan In Lotak  Rainin

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.

<table>
<thead>
<tr>
<th>Witness #1 Print Name</th>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

RIKAMOOL RO: KELET ŴE EJ KEIN 1 AK 2, EN JAB AOLEPEOR.

Men In Aorôk: Rikamool Ro ejjab aikuij in agent eo am, ak juôn taktô ak juôn rierbal in jikin taktô. juôn rikamool ejjab aikuij in juôn nukum ak juôn eo ewor an men in jolet jen eok .

KELET EO KEIN 1: RIKAMOOL RO:

Na (Rikamool 1) ij kamool ke armij in ej kômmane kallimur kein einwot ke ej keboooje ikijen an naj buki waven taktô ko iliju im jaklaj elap ao jela kajien, im emôj an jaini ak kwalok an kaweppe kallimur in imaan meja kab ilak lale einwot emmon an kolmenlokjen im ejelok en ej pooje bwe en kômmane. Ejjab nuku ilo botôktôk, kaajiriri, ak ejjab nukun armij eo pâlele 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 taktô eo an, ak rierbal in jikin taktô.

<table>
<thead>
<tr>
<th>Rikamool #1 Jeiki Etam</th>
<th>Kôkalle in Etan Rikamool</th>
<th>Rainin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aterej in Kabijuken Eo</td>
<td>Bukôn Eo</td>
<td>State Eo</td>
</tr>
</tbody>
</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.

<table>
<thead>
<tr>
<th>Witness #2 Print Name</th>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Na (Rikamool 2) ij kamool ke armij in ej kömmame kallimur kein einwot ke ej kebooje ikijen an naj buki wawen taktō ko iliju im jaklaj elap ao jela kajien, im emōj an jaini ak kwalok an kaweppeℓ kallimur in imaan mejā kab ilak lale einwot emmon an kolmenlokjen im ejelok en ej poojie 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.

<table>
<thead>
<tr>
<th>Rikamool #2 Jeiki Etam</th>
<th>kōkalle in Etam Rikamool</th>
<th>Rainin</th>
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</table>

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</tr>
</thead>
</table>

**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.

_______________________________________________________

My Commission Expires: __________________________

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

State in Hawai‘i,
(Evan Bukōn eo im) County eo ______________________  } ss.

Ilo __________ raan in____________________, ilo yiio in ______________, imaan meja,
_______________________________, (likuti etan notary public ak rikamoole
kōkkalle in team eo) ekar jade tok ________________________________, ej
juōn eo elap ao jela kajien (ak emōj kamool ŋan na son jet kein kamool ko epo buruo kaki) ke etan in
edrelon ilo peij ___ - ilo Kallimur kein ikijen an Buki Wawen taktō Ko Iliju im Jaklaj Ilo Hawai‘i emōj
jitaamwe ilo raan in __________________, ilo ______________ Judicial Circuit of the State of Hawai‘i,
im kallikkar ke ej kōmmane meniin einwot ke ej an make kelet im ewor an maroñ ıoon.

___________________________________________________________

kōkalle in Etan Notary Public Eo ak Rikamoole kōkalle 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 - Hawai‘i Hospice im Palliative Care Organization

Jokin Notary Seal ak Jitaam Eo ŋe Iloñ in Ijin

December 2015