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
HAWA'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>
<tbody>
<tr>
<td>Street Address</td>
</tr>
</tbody>
</table>

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:

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

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 HAUA'I FEKAU‘AKI MO E TOKANGAEKINA E MO‘UI LELEÍ.
HAUA'I ADVANCE HEALTH CARE DIRECTIVE

Ko hoku hingoa ko:


KONGA 1 - MAFAI ‘O E LOEÁ KI HE MO‘UI LELEÍ – FILI ‘O E FAKAFOFONGÁ:
‘Ōku ou fili ‘a e tokotaha ko eni ke hoko ko hoku fakafofonga ke ne faitu‘utu‘uni ki hono tokangaekina ‘eku mo‘ui:

<table>
<thead>
<tr>
<th>Hingoa mo e fekau‘aki</th>
<th>‘a e tokotaha kuo fili ke hoko ko e fakafofonga tokangekina mo‘ui</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hingoa e Hala</td>
<td>Kolo</td>
</tr>
</tbody>
</table>

Telefoni ‘i ‘api | Telefoni to’oto’o | ‘Imeili |
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 TAAUTAHÁ ('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‘UI

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

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.

PEA ‘Oku ou fekau hoku ngaahi ‘api tauhí mahaki mo e ni’ihi kehe ‘oku nau kau hoku tauhí 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 tauhí 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 palakahafi kimu’á A tukuheke 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 tauhí 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 tauhí. (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 MEʻA ‘OKU MAHUʻINGA KIATE AʻU: (Tānaki mai ha ngaahi peesi kapau ‘e fiemaʻu.) Ko e ngaahi meʻa ‘oku ou mahuʻingaʻia ai, pē ‘oku makatuʻunga ai e mahuʻinga ai e moʻui kiate au: (Ngaahi sīpinga, Ngaohi ngoue, lue mo ‘eku kiʻi manu tauhī, ‘alu ki falekoloa, kau he ngaahi fakataha faka-fāmili, ‘alu ki he lotū pē temipalē):

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

Kuo u fakakau atu e laʻipepa pē ngaahi laʻipepa 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‘oni pē tokotaha falala‘anga he fonuá)

Hikinima ho Hingoa Kakató | Ko ho‘o fakamo‘oni ‘Aho fā’ele‘i | ‘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‘oni ke kau ai ho fakafonu tokangaekina mo’ui, 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 mahaki.

FILI 1: FAKAMO‘ONI


Fakapapau Fakamo‘oni #1 Tohinima ho Hingoa | Fakamo‘oni Hingoa | ‘Aho
---|---|---

Tu‘asila e Halá | Kolo | Vahefonua Zip

Peesi 5 mei he 7
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>
<tbody>
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<td></td>
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<td></td>
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</tbody>
</table>

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

‘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 lao ‘i hoku ‘aō, pea ‘oku hā ‘ata‘amai lelei pē pea na‘e ‘ikai fakamalo‘i‘i. ‘Oku ‘ikai ko e fakafononga au kuo fili pea hā he tohi ni, pea ‘oku ‘ikai haku ‘api tauhi mahaki, pē tokotaha ngāue ha ‘api pehee.

<table>
<thead>
<tr>
<th>Fakapapau Fakamo‘oni #2 Tohinima ho Hingoa</th>
<th>Fakamo‘oni Hingoa</th>
<th>‘Aho</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tu‘asila e Halá</td>
<td>Kolo</td>
<td>Vahefonua Zip</td>
</tr>
</tbody>
</table>

OPTION 2: NOTARY PUBLIC

State Hawai‘i,
(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:_____________________

Place Notary Seal or Stamp Above

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
FILI 2: TOKOTAHA FALALA‘ANGA HE FONUÁ
Vahefonua Hauai‘i
(Kolo mo e ) Vahe ‘o _____________________}

‘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 fakamahīno pau kiate au makatu‘unga he ngaahi fakamo‘oni taau) ko ia ‘a e tokotaha ‘oku hā henī _____
peesi ko e Tu‘utu‘uni Tokangekina Mo‘ui Makehe ‘a Hauai‘i ‘i ‘aho __________________, ‘i he __________________
Fakamaau‘anga e Vahefonua Hauai‘i pea fakapapa‘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: ______________________}

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

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

Vahevahe pea talatalanoa ki ho‘o toketaa, ngaahi ‘ofa‘angā mo ho fakafofonā fēkau‘aki mo ho‘o Tu‘utu‘uni
Tokangaekina Mo‘ui Makehe‘.  Peesi 7 mei he 7