Introduction to Your Hawaii Advance Health-Care Directive

This packet contains a legal document, the **Hawaii Advance Health-Care Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Part 1, Durable Power of Attorney for Health-Care Decisions, lets you name someone to make decisions about your medical care, including decisions about life support. The Durable Power of Attorney for Health-Care Decisions becomes effective (a) when your doctor determines that you can no longer understand the benefits, risks, and alternatives to proposed health care, or make and communicate health-care decisions yourself, or (b) immediately if you designate this on the document. The Durable Power of Attorney for Health-Care Decisions is especially useful because it appoints someone to speak for you any time you cannot or do not choose to make your own medical decisions, not only at the end of life.

Part 2, Instructions for Health care, functions as your state's living will. It lets you state your wishes about medical care in the event that you can no longer speak for yourself and:

a) you have an incurable and irreversible condition that will result in death within a relatively short time, or
b) you become unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or
c) the likely risks and burdens of treatment would outweigh the expected benefits.

Part 3, Donation of Organs, this is an optional section that allows you to record your wishes regarding organ donation.

Part 4, Primary Physician, this is an optional section that allows you to designate your primary physician.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: This document will be legally binding only if the person completing it is a competent adult who is 18 years of age or older or an emancipated minor.

Completing Your Hawaii Advance Health-Care Directive

How do I make my advance health-care directive legal?

In order to make your advance health-care directive legally binding you have two options:

1. Sign your document or acknowledge your signature in the presence of two witnesses, who must also sign the document to show that they personally know you and believe you to be of sound mind and under no duress, fraud, or undue influence. Neither of your witnesses can be:

- the person you appointed as your agent,
- a health-care provider or an employee of a health-care provider or facility.

In addition, one of your witnesses cannot be:

- related to you by blood, marriage, or adoption, or
- entitled to any part of your estate.

OR

2. Sign your document or acknowledge your signature in the presence of a notary public in Hawaii.

Who should I pick to be my Agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second and third person as your alternate agents. The alternates will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Should I add instructions to my advance health-care directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke the designation of your agent only by a signed writing or by personally informing your supervising health-care provider. You may revoke all or part of an advance health-care directive (other than designating a new agent), at any time and in any manner that communicates your intent to revoke.
A new advance directive revokes a previous advance directive to the extent that they conflict with each other.

Unless you expressly instruct otherwise in your Durable Power of Attorney for Health-Care Decisions, your designation of your spouse as your agent is automatically revoked upon annulment, divorce, or dissolution of your marriage, or if you are legally separated.

ORGAN DONATION (OPTIONAL)

INITIAL THE BOX THAT BEST REFLECTS YOUR WISHES

STRIKE ANY PURPOSES YOU DO NOT WANT

PRIMARY PHYSICIAN (OPTIONAL) PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN (OPTIONAL)

PART 3: DONATION OF ORGANS AT DEATH (OPTIONAL)

(10) Upon my death: (mark applicable box)

[ ] (a) I give any needed organs, tissues, or parts,
OR

[ ] (b) I give the following organs, tissues, or parts only

_____

My gift is for the following purposes:
(strike any of the following you do not want)
(i) Transplant
(ii) Therapy
(iii) Research
(iv) Education

PART 4: PRIMARY PHYSICIAN (OPTIONAL)

(11) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

(12) **EFFECT OF COPY**: A copy of this form has the same effect as the original.

(13) **EXECUTION**

This advance health-care directive will not be valid for making health-care decisions unless it is EITHER:

(A) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; the witnesses may not be a health-care provider employed at the health-care institution or health-care facility where you are receiving health care, an employee of the health-care provider who is providing health care to you, an employee of the health-care institution or health-care facility where you are receiving health care, or the person appointed as your agent by this document; at least one of the two witnesses may not be related to you by blood, marriage, or adoption or entitled to a portion of your estate upon your death under your will or codicil. (Use Alternative 1, below, if you decide to have your signature witnessed.)

OR

(B) acknowledged before a notary public in the state. (Use Alternative 2, below, if you decide to have your signature notarized.)

YOU MAY EITHER HAVE YOUR FORM WITNESSED OR NOTARIZED

SIGN AND DATE YOUR DOCUMENT HERE

WITNESS #1

THIS WITNESS CANNOT BE RELATED TO YOU OR BE ENTITLED TO ANY PORTION OF YOUR ESTATE

HAVE YOUR WITNESS SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

ALTERNATIVE NO. 1 (Sign with Two Witnesses)

IN WITNESS WHEREOF, I have hereunto signed my name this _____day of _____, _____.
(Day) (Month) (Year)

_____
(Signature of Principal)

Witness Who is Not Related to or a Devisee of the Principal

I declare under penalty of false swearing pursuant to Section 710-1062, Hawaii Revised Statues, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____
(signature of witness and date)

_____
(printed name of witness)

_____
(address)

_____
(city) (state) (zip code)

WITNESS #2

ALTERNATIVE NO. 1 (Sign with Two Witnesses, continued)

Witness Who May be Related to or a Devisee of the Principal

I declare under penalty of false swearing pursuant to Section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

HAVE YOUR WITNESS SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

_____

(signature of witness and date)

_____

(printed name of witness)

_____

(address)

_____

(city) (state) (zip code)

SIGN AND DATE YOUR DOCUMENT HERE

THIS PORTION MUST BE FILLED OUT BY A NOTARY PUBLIC

ALTERNATIVE NO. 2 (Sign before a Notary)

IN WITNESS WHEREOF, I have hereunto signed my name this _____day of _____, _____.
(Day) (Month) (Year)

_____
(Signature of Principal)

State of Hawaii

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 instrument, and acknowledged that he or she executed it.

Notary Seal

_____
(Signature of Notary Public)

Courtesy of CaringInfo
1731 King St, Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800-658-8898

You Have Filled Out Your Health-Care Directive, Now What?

1. Your Hawaii Advance Health-Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. Hawaii allows you to note that you have completed an advance directive on your driver's license. You may want to have this notation made, so that your family, friends, and physicians will know that you have made an advance directive and would like for it to be found and honored.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your Hawaii document.

8. Be aware that your Hawaii document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

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YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

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Philadelphia, PA 19182-4401

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