

HAWAII

Advance Directive

Planning for Important Healthcare Decisions

Courtesy of CaringInfo

www.caringinfo.org

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or 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.

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 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 you have an incurable and irreversible condition that will result in death within a relatively short time, or you become unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or 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.

How do I make my Hawaii Advance Health Care Directive legal?

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

Option 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, or
- 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

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

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare 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 healthcare decisions for you.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

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. You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent will be bound by the current laws of Hawaii as they regard pregnancy and termination of pregnancies.

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.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health-care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health-care institution where you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (b) Select or discharge health-care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

EXPLANATION
CONTINUED

Part 3 of this form allows you to give instructions about your wishes for organ donation.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility. You have the right to revoke this advance health-care directive or replace this form at any time.

**PART 1
DURABLE POWER OF ATTORNEY FOR HEALTH-CARE DECISIONS**

(1) **DESIGNATION OF AGENT:** I designate the following individual as my agent to make health-care decisions for me:

(Name of individual you choose as agent)

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

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

(Name of individual you choose as first alternate agent)

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

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

(Name of individual you choose as second alternate agent)

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

(home phone) (work phone)

PRINT THE NAME,
HOME ADDRESS
AND HOME AND
WORK TELEPHONE
NUMBERS OF YOUR
PRIMARY AGENT

PRINT THE NAME,
HOME ADDRESS
AND HOME AND
WORK TELEPHONE
NUMBERS OF YOUR
FIRST ALTERNATE
AGENT

PRINT THE NAME,
HOME ADDRESS
AND HOME AND
WORK TELEPHONE
NUMBERS OF YOUR
SECOND
ALTERNATE
AGENT

(2) **AGENT'S AUTHORITY:** My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, **except** as I state here:

(Add additional sheets if needed.)

(3) **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.

(4) **AGENT'S OBLIGATION:** My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

ADD PERSONAL INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

YOU MAY ADD INSTRUCTIONS THAT DO NOT LIMIT YOUR AGENT'S POWER IN PARAGRAPH (9), BELOW

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY, OTHERWISE YOUR AGENT WILL ONLY HAVE AUTHORITY IF YOU ARE DETERMINED TO BE UNABLE TO MAKE YOUR OWN DECISIONS

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4 OR 5 THAT DO NOT REFLECT YOUR WISHES

PART 2: INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) **END-OF-LIFE DECISIONS:** 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: **(Initial only one box)**

[] (a) **Choice NOT To Prolong Life**

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, **OR**

[] (b) **Choice To Prolong Life**

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) **ARTIFICIAL NUTRITION AND HYDRATION:** Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) **RELIEF FROM PAIN:** If I mark this box [], I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

INITIAL THE BOX ONLY IF YOU WANT ARTIFICIAL NUTRITION AND HYDRATION REGARDLESS OF YOUR MEDICAL CONDITION

INITIAL THE BOX ONLY IF YOU WANT TREATMENT FOR PAIN AND TO PROVIDE COMFORT, EVEN IF IT MEANS YOU MAY DIE MORE QUICKLY

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)

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**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

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 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. 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)

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, 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.

(signature of witness and date)

(printed name of witness)

(address)

(city)

(state)

(zip code)

WITNESS #2

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

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)

SIGN AND DATE
YOUR DOCUMENT
HERE

THIS PORTION
MUST BE FILLED
OUT BY A NOTARY
PUBLIC