

**HAWAII**  
**Advance Directive**  
**Planning for Important Healthcare Decisions**

***Caring Connections***  
*1731 King St., Suite 100, Alexandria, VA 22314*  
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**CARING CONNECTIONS**

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

**It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts

## Using these Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
  - 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.

### ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. 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.
6. Once the form is completed and signed, photocopy 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.

## 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.

1. 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 you can no longer understand the benefits, risks and alternatives to proposed healthcare, or make and communicate healthcare 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.

2. 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.

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

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

*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 under the age of 18 who is totally self-supporting.*

## **Introduction to Your Hawaii Advance Health-care Directive (continued)**

### **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 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,
- be a healthcare provider, or an employee of a healthcare 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 either under your last will and testament or by operation of law.

OR

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

### **Are there any important facts that I should know?**

A copy of your Hawaii Advance Health-care Directive has the same effect as the original.

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.

**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.

INSTRUCTIONS

**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

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ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR 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.)

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(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.

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

(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.

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**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: **(Check 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.

(9) **OTHER WISHES:** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

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

ADDITIONAL  
INSTRUCTIONS  
(IF ANY)

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(Add additional sheets if needed.)

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

---

(c) 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)

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

(13) **SIGNATURES:** Sign and date the form here:

\_\_\_\_\_ (sign and date)

\_\_\_\_\_ (print your name)

\_\_\_\_\_ (address)

\_\_\_\_\_ (city) (state) (zip code)

SIGN AND DATE  
THE DOCUMENT

PRINT YOUR NAME  
AND ADDRESS

ALTERNATIVE NO. 1  
WITNESS

WITNESSING  
PROCEDURE

(14) **WITNESSES:** This power of attorney will not be valid for making health-care decisions unless it is either:

- (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature: or
- (b) acknowledged before a notary public in the state.

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.

WITNESS #1

\_\_\_\_\_  
(signature of witness and date)

\_\_\_\_\_  
(printed name of witness)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city)

\_\_\_\_\_  
(state)

\_\_\_\_\_  
(zip code)

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

**HAWAII ADVANCE HEALTH-CARE DIRECTIVE — PAGE 8 OF 8**

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.

WITNESS #2

\_\_\_\_\_  
(sign name and date)

\_\_\_\_\_  
(printed name of witness)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

**ALTERNATIVE NO. 2**

OR

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)

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*Courtesy of Caring Connections  
1731 King St, Suite 100, Alexandria, VA 22314  
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## You Have Filled Out Your Advance 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(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. 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 and alternate 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. If you want to make changes to your document after it has been signed and witnessed, you should complete a new document.
5. Remember, you can always revoke one or both sections of your Hawaii Advance Health-Care Directive.
6. Be aware that your Hawaii document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance 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 for more information. **Caring Connections does not distribute these forms.**