HAWAII
Advance Directive
Planning for Important Health-Care Decisions

CaringInfo
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CARINGINFO

CaringInfo, 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.

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:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health-care providers
Engage in personal or community efforts

Disclaimer

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health-care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

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

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 the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health-care providers and/or faith leaders so that the form is available in the event of an emergency.

5. 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.

6. 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.

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.

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:

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

_____
(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:

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

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

_____
(Name of individual you choose as second alternate agent)

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

_____
(home phone) (work phone)

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

(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, OTHERWISE YOUR AGENT WILL ONLY HAVE AUTHORITY IF YOU ARE DETERMINED TO BE UNABLE TO MAKE YOUR OWN DECISIONS

(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.

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**)

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

[☐] (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.

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

(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).

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

(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:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH-CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(Add additional sheets if needed.)

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.)

YOU MAY EITHER HAVE YOUR FORM WITNESSED OR NOTARIZED

OR

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

ALTERNATIVE NO. 1 (Sign with Two Witnesses)

SIGN AND DATE YOUR DOCUMENT HERE

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

_____
(Signature of Principal)

WITNESS #1

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

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

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.

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)

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.

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.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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OR donate online today: www.NationalHospiceFoundation.org/donate