ADVANCE HEALTH CARE DIRECTIVES
Under Hawai'i Law

Checklist—How to Start and What to Do

Information about Advance Health Care Directives

Sample Advance Directive Forms—Including:
Individual Instructions for Health Care
Durable Power of Attorney for Health Care

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Caution: This brochure is not intended to provide legal advice. It presents general information about the law and may not necessarily apply to your situation.

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CHECKLIST:

- ☐ Talk with family members, friends, spiritual advisors, physicians, other health-care providers and other trusted persons about what would be important to you if you become terminally or irreversibly ill or injured and you can no longer communicate your health-care decisions or other wishes.

- ☐ Ask someone you trust and whom you can count on to be your health-care agent and discuss your wishes with this person. Select an alternate health-care agent in case your agent is unable to serve.

- ☐ Complete either one of the enclosed simplified forms, change or cross out provisions or make an entirely different document. Add pages if you like.

- ☐ Have two qualified witnesses or a notary witness your signature.

- ☐ Inform family members, spouse, parents, children, siblings, friends, physicians and othe rhealth-care providers that you have executed an advance health-care directive and that you expect them to honor your instructions. Keep them informed about your current wishes.

- ☐ Give copies of the document to your health-care agent, health-care providers, family, close friends, clergy or any other individuals who might be involved in caring for you.

- ☐ Place the executed document in your medical files.

- ☐ When you renew your driver's license or state I.D, you may designate that you have an advance directive by putting (AHCD) on it.

- ☐ Make plans to review the document on a regular basis—make a new document, if necessary, and keep people informed of any changes.

- ☐ Do it today!

INFORMATION ABOUT ADVANCE HEALTH CARE DIRECTIVES

Under the law, 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. These forms let you do either or both of these things. They also let you express your wishes regarding the designation of your primary physician. If you use one of these forms, you may complete or modify all or any part of it. You are free to use a different form.

Long 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 residential long-term health care institution at which 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 long 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. You may also add provisions relating to mental illness. Space is provided for you to add to the choices you have made or for you to write in any additional wishes.

Part 3 of this long form gives you options relating to the disposition of your organs/ body. Part 4 lets you designate a physician/facility to have primary responsibility for your health care. Part 5 pertains to religious or spiritual information you may wish to provide.

Short Form: The short form may be used if you do not desire to complete the long form. It dies not provide the detail found in the long form and may not address all your needs.

After completing either the long or short form, sign and date it at the end and have it witnessed by one of the two alternative methods indicated. 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 have the right to revoke or replace this document at any time.

SAMPLE LONG FORM

ADVANCE HEALTH CARE DIRECTIVE

MY NAME IS _____

MY ADDRESS IS:_____
(Address) (City) (State) (Zip code)

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) (E-Mail or other means of contact)

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) (E-Mail or other means of contact)

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) (E-Mail or other means to contact)

(2) AGENT'S AUTHORITY: **(Strike through any of the following provisions you do not want. You can add provisions on the form or attach additional pages.)**
My agent is authorized to make all of the following health care decisions for me:

- To consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including admission to or discharge from a health care facility or program, approval or disapproval of diagnostic tests, medical or surgical procedures, programs of medication, the use of alternative or complementary therapies as well as decisions to participate in education, research and experimental programs.
- To make decisions regarding orders not to resuscitate, including out-of-hospital "Comfort Care Only" documents, as well as decisions to provide, withhold, or withdraw nutrition and hydration, and all other forms of health care to keep me alive.
- To request, receive, examine, copy, and consent to the disclosure of medical or any other health care information, including medical files and records. This includes my delegated authority for my agent to act as my personal representative for release of all individually identifiable health information concerning me by both covered and non-covered entities under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and/or other Federal and State laws pertaining to healthcare and healthcare information.
- To communicate with, select and discharge health care providers, organizations, institutions and programs, including hospice programs and to make and change health care choices and options relating to plans, services, and benefits.
- To apply for public or private health care programs and benefits, to include Medicare, Medicaid, Med-Quest or other federal, state, local or private programs without my agent incurring any personal financial liability.
- To make all other health care decisions for me, except as I state here:

_____

(Consult with a mental health professional and/or attorney for appropriate language if you wish to give your agent additional information or instructions about decisions regarding mental illness. You may make a separate mental illness advance directive or include such provisions in this advance directive. Use 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. However, I always retain the right to make my own decisions about my health care and to revoke this authority as long as I am mentally capacitated.

(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. My agent shall not be obligated to assume any personal financial responsibility when making decisions in accordance with this document.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate my agent. If another person is appointed as guardian and my agent is willing and able to act, I would prefer my agent to have precedence in making health care decisions for me.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied with allowing 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 through 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 of the two following boxes. You may cross out any unwanted provisions.)**

____ ☐ (a) Choice **Not To** Prolong Life

I do not want my life to be prolonged if

- I am close to death and life support would only postpone the moment of my death or I have an incurable and irreversible condition that will result in my death within a relatively short time; or
- I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is unlikely that I will ever become conscious again; or
- I have brain damage or a brain disease that makes me permanently unable to interact and make and communicate health care decisions about myself and 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 the following 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. Examples of additional instructions include preferences to receive Hospice Care and/or to die at home.) I direct that:

_____

_____

PART 3

DONATION OF ORGANS/BODY AT DEATH (OPTIONAL)

(10) Upon my death: (Mark applicable box(es).

____ ☐ (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 through any of the following you do not want)

- Transplant
- Therapy
- Research
- Education

____ ☐ (d) I give my body to the John A. Burns School of Medicine for its research and education purposes. **(Obtain information/forms from the medical school Department of Anatomy)**

PART 4
PRIMARY PHYSICIAN/HEALTH -CARE FACILITY (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) I have the following preference of hospitals and/or nursing homes if I require such care:

_____
(You may name a facility, or you may indicate a preference for hospice care administered at home or in a hospice facility, a preference not to be institutionalized, a preference to remain at home, etc.)

PART 5

RELIGIOUS OR SPIRITUAL INFORMATION (OPTIONAL)

(13) I identify with the following church, temple, or other spiritual group:

_____

(14) I would like to receive my spiritual care from:

_____
(Name of individual or group)

_____
(Address) (City) (State) (Zip code)
(Phone)

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

SIGNATURE: **Sign and date the form here**:

_____ _____
(Sign Your Name) (Date)

_____
(Print Your Name)

WITNESSES: The power of attorney portion of this document 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; or (b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

First Witness

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) (Date)

_____ _____
(Printed Name of Witness) (Address of Witness)

Second Witness

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) (Date)

_____ _____
(Printed Name of Witness) (Address of Witness)

ALTERNATIVE NO. 2

State of Hawai'i
City and County of Honolulu

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)

My Commission Expires:_____

SAMPLE SHORT FORM

ADVANCE HEALTH CARE DIRECTIVE

MY NAME IS_____.

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:

_____

(Name and relationship of individual designated as health care agent)

_____

(Address) (City) (State) (Zip code) (Home phone) (Work 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:

_____

(Name and relationship of individual designated as alternate health care agent)

_____

(Address) City) (State) (Zip code) (Home phone) (Work phone) (E-Mail)

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 and to revoke this authority as long as I am mentally capacitated.

AGENT'S AUTHORITY AND OBLIGATION:

I intend my agent's authority to be as broad as possible subject only to any instructions and limitations I may state in Part 2 of this form or as I may otherwise provide orally or in writing. 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. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

PART 2: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

A. END-OF-LIFE DECISIONS:

I wish to provide instructions regarding end-of-life decisions based on different possible situations I may face in the future.
(Strike through any of the following provisions you do not want)

- If I am close to death and life support would only postpone the moment of my death, **OR**
- If I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is unlikely that I will ever become conscious again, **OR**
- If I have brain damage or a brain disease that makes me permanently unable to interact and to make and communicate health care decisions about myself and the likely risks and burdens of treatment would outweigh the expected benefits:

THEN

(Check only <u>one</u> of the three following boxes. You may also initial your selection)

____ ☐ (a) Choice <u>Not</u> To Prolong Life--I do not want my life to be prolonged.

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. **OR**

____ ☐ (c) Choice To Be Made By Health Care Agent--I want my agent who is designated in Part 1 of this document or in a separate document to make end-of-life decisions for me.

B. <u>ARTIFICIAL NUTRITION AND HYDRATION -- FOOD AND FLUIDS</u>:

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 regardless of my condition and regardless of the choice I have made in paragraph A.

C. <u>RELIEF FROM PAIN</u>:

____ ☐ 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.

D. <u>OTHER MATTERS</u>:

A copy of this form has the same effect as the original.

My agent shall not be obligated to assume any personal financial responsibility when making decisions in accordance with this document. My agent has the authority to request, receive, examine, copy and consent to the disclosure of medical or any other healthcare information, including medical files and records. This includes my delegated authority for my agent to act as my personal representative for release of all individually identifiable health information concerning me by both covered and non-covered entities under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and/or other Federal and State laws pertaining to healthcare and healthcare information.

X_____ _____

(My Signature) (Date)

_____ _____

(My Printed Name) (My Address)

WITNESSES:
This document must either be signed by two qualified adult witnesses who witness or acknowledge the signature; or be acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

First Witness*

*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) (Date)

_____ _____
(My Printed Name) (Address of Witness)

Second Witness**

**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.

_____ _____
(Signature of Witness) (Date)

_____ _____
(Printed Name of Witness) (Address of Witness)

ALTERNATIVE NO. 2

State of Hawai'i)
City and County of Honolulu)

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

_____