HAWAII OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE FORMS EXPLANATION

Act 169 of the Hawaii Legislative Session (called the Uniform Health Care Decisions Act (Modified) or UHCDA) is found in Hawaii Revised Statutes Chapter 327E and was signed by the Governor on July 1, 1999. The UHCDA makes significant changes to the law pertaining to health-care decision-making, including advance health-care directives.

This **explanation** and **accompanying forms** can assist you in making an advance health-care directive to give instructions about your health-care and to name somebody else to make health-care decisions for you. Many people find it helpful to talk to family members, close friends, health care professionals and spiritual advisors about health care decisions and advance health care directives. It is important to let those people who are closest to you know your desires so that your wishes will be honored.

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. The forms which follow let you do either or both of these things.

The first (longer) form also lets you express your wishes regarding organ donations, the designation of your health care provider and information about your spiritual advisors. If you use this form, you may complete or modify all or any part of it. You are free to use a different form. The second (short) form is intended for individuals who have limited instructions or who are in a hurry or who may have difficulty with the long form.

These forms are different from the optional form found in the new law. You can make your own forms if you like. Give UHELP a call at (808) 956-6544 if you have questions about these forms.

FOR THE FIRST (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 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: Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition; Request, receive, examine, copy, and consent to the disclosure of medical or any other health-care information; Select or discharge health-care providers and institutions; Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and 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 lets you make decisions about donation of your organs and/or body at death and Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

Spaces are provided for you to initial ____wherever there are boxes to check options presented to you in the form. While it is not necessary to place your initials in these spaces, you may do so to indicate your choice more clearly. You may also wish to strike through the options you do not check.

FOR THE SECOND (SHORT) FORM

Part 1 of this form is a simplified 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.

Part 2 of this form provides basic options for instructions about 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. Limited space is provided for you to add to the choices you have made or for you to write out any additional wishes.

If you make a new advance health care directive you should locate any old ones and replace them. It is a good practice to safeguard the original and keep it with your other

important papers. Let people know where you keep this important document and how they can get it in an emergency.

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 may also wish to give copies to family members and friends. 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 advance health-care directives or replace them with other forms at any time.**

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

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 to 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 to 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)

☐ AGENT'S AUTHORITY: My agent is authorized to make all of the following health-care decisions for me**: (Strike through any of the following provisions you do not want—You may also initial the provisions or the strike-through or both.)**

- To consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including 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 request, receive, examine, copy, and consent to the disclosure of medical or any other health-care information.

- 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 artificial nutrition and hydration, and all other forms of health care to keep me alive.

- To 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, to include Medicare, Medicaid, and Hawaii Quest benefits without my agent incurring any personal financial liability.

- To make all other health-care decisions for me, except as I state here:

_____

_____

(Add additional sheets if needed. You may strike through any unused lines.)

(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.

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 through any wording you do not want.

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. Strike through any unwanted provisions)

- o 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,
  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.
  I have brain damage or a brain disease that makes me permanently unable to make and communicate health-care decisions about myself and the likely risks and burdens of treatment would outweigh the expected benefits.
  OR
- o 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.

- o 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,

- o 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:

_____

_____

(Add additional sheets if needed. You may strike through any unused lines)

PART 3 DONATION OF ORGANS/BODY AT DEATH (OPTIONAL)

(10) Upon my death: (Initial applicable lines).

_____(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)

(i) Transplant
(ii) Therapy
(iii) Research
(iv) 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 school**)

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—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)

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

SIGNATURES: **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) (City) (State) (Zip)

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)

_____

(City) (State) (Zip Code)

ALTERNATIVE NO. 2

State of Hawaii
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 executed it.

Notary Seal

_____

(Signature of Notary Public)

My Commission Expires:_____

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.

- o 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:

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 make and communicate health-care decisions about myself*:*

THEN

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

- o Choice Not To Prolong Life--I do not want my life to be prolonged. **OR**
- o 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**
- o 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. ARTIFICIAL NUTRITION AND HYDRATION—FOOD AND FLUIDS:

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.

- o 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. RELIEF FROM PAIN:

- o 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. OTHER MATTERS:
A copy of this form has the same effect as the original.

_____(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 _____ _____(Date)
(Signature of Witness)

_____
(Printed Name of Witness)

_____
(Address of 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.

Second Witness _____ _____(Date)
(Signature of Witness)

_____
(Printed Name of Witness)

_____
(Address of 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.

ALTERNATIVE NO. 2
State of Hawaii
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

_____
My Commission Expires:_____