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 (Short Form)—Including:
Individual Instructions for Health Care
Durable Power of Attorney for Health Care

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(Short Form)

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 the enclosed simplified form, 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. Make copies of the document and

- ☐ 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 ID, 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 as soon as possible—if you cannot, ask your doctor about designating a "Surrogate" ! Also talk to your doctor about Physician Orders for Life Sustaining Treatmetnt (POLST) and Comfort Care Only-Do-Not-Resuscitate (CCO-DNR) Documents.

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. This simplified form lets you do either or both of these things. You may complete or modify all or any part of it. There are many other forms and formats --you are free to use a different one or make your own.

Part 1 of this form is a power of attorney for health care. This part 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. If you choose not to limit the authority of your agent, your agent generally 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 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. If you wish to provide more detailed instructions, you may wish to add pages to this form, to look at one of the long sample forms available from UHELP or to use a different form.

After completing the 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.

Note on CCO-DNR and POLST Forms

Advance directives are not generally used to make emergency resuscitation decisions although they may be used as the basis to withhold cardio-pulmonary resuscitation attempts in cases where a person has been determined to be in a condition as stated in his or her advance directive. Accordingly, in addition to advance directives, you may wish to talk to your physician about the following forms:

Under Hawai`i law, individuals may sign a form to obtain a special bracelet or necklace through the Department of Health which would tell "first responders" not to resuscitate them in an emergency. This is referred to as a "Comfort Care Only-Do-Not-Resuscitate," (CCO-DNR) or "Rapid Identification Document."

Another law provides for a health care protocol called "Physician Orders for Life-Sustaining Treatment" (POLST). A special form containing information and directions about an individual's end of life decisions such as cardiopulmonary resuscitation (CPR) and tube feeding is used. Emergency medical personnel and other health care professionals are required to follow the provisions contained in the POLST. By law the POLST form is not an advance directive but a physician's order and, accordingly, is immediately actionable.

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 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. My agent shall have the authority to decide whether to execute Physician Orders for Life Sustaining Treatment (POLST) and/or Comfort Care Only-Do-Not-Resuscitate (CCO-DNR) documents, which may provide health care providers and first responders with additional information about specific immediately actionable treatment decisions for me.

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 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)
(My Printed Name)	(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)
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)

My Commission Expires: _____

Document Date _____ Number of Pages _____

Name: _____, _____ Circuit

Document Description _____

Signature _____ Date_____

Notary Certification