KŌKUA MAU
Continuous Care
A Movement to Improve Care

Background Information about the Multilingual Hawaii Advance Directive

The **Hawaii Advance Health Care Directive** (HI AD) or 'Advance Directive' (AD) as it is commonly known, is a written statement about your future medical care. Starting May 2016 the HI AD is available in 10 languages. To facilitate the discussion for providers and loved ones, the HI AD is a bilingual document translated content block by content block.

Please keep in mind that **most providers speak English only**. To ensure that your wishes and instructions are understood and can be honored, please fill out your HI AD in **English**. In order to complete an advance directive you need to either have two witnesses or a notary public for it to be valid.

Important limitation: If you choose to complete the English portion of a bilingual HI AD, State of Hawaii regulations require a **bilingual Notary** to notarize your bilingual version of the advance directive.

"The notarization of a document that has been written in a foreign language should only be performed by a notary who has a thorough understanding of the foreign language in which the document and/or notarial certificate are written." [...] *Similarly, a notary should not notarize a document written in English if the parties to the document who appear before the notary do not appear to speak, read, or understand English."* Page 5, Notary Manual 2010.

Call the Notary Public Program (808) 586-1216 for a **bilingual notary**, or go to their website https://notary.ehawaii.gov/notary/public/publicsearch.html ('Search Category': choose 'Language' in the fold down menu and in 'Search Terms' type in the language you want).

Please call the notary public office if you have more questions regarding using a bilingual notary.

Two recommendations for completing your bilingual AD:

1) Use **two witnesses** to complete a bilingual HI AD. Witnesses cannot be health care providers (like a doctor, nurse or social worker), employees of a health care facility, or the person you choose as an agent. One of the two persons cannot be related to you or have inheritance rights.

OR

2) Use a **bilingual notary**.

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HAWAIʻI ADVANCE HEALTH CARE DIRECTIVE

My name is:

Last First Middle initial Date of Birth Date

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

Street Address City State Zip

Home Phone Cell 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 health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

AGENT'S AUTHORITY AND OBLIGATION:

My health care agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

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. I can revoke this authority at any time as long as I have mental capacity.

夏威夷州醫療照護事前指示 HAWAIʻI ADVANCE HEALTH CARE DIRECTIVE

我的姓名: 姓氏 名字 中間名字縮寫 出生日期 日期

第一部分: 醫療照護授權 - 指定代理人:
我指定下者做我的醫療照護授權代理人，為我做有關醫療照護方面的決定：

姓名 關係

街道地址 城市 州 郵遞區號

住家電話號碼 行動電話號碼 電子信箱

如果我取消以上代理人之職權, 或該代理人不願意、不能、或有合理原因無法為我做有關醫療照護方面的決定時，我指定的候補代理人如下:

_____

姓名　　關係

_____

街道地址　　城市　　州　　郵遞區號

_____

住家電話號碼　　行動電話號碼　　電子信箱

代理人的職權和責任:
我的醫療代理人應按我在此表格之第二部分所指示，或我另外口頭或手書的指示，為我做醫療照護上的決定。如有我未曾指示過的事宜，我要我的代理人，就像我會做的選擇一樣, 根據我的價值觀、目標及偏好，而不是代理人自身的，來做決定。如果法庭必需替我指定一位監護人，我提名我的代理人。

代理人的職權何時生效:
除非我在下面的小格內勾選，否則當我的主治醫師宣判我不能自我做決定時，我的代理人的職權才開始生效。
___ 如果我在此小格內勾選， 我的代理人為我做醫療照護的職權立即生效。但是，我永遠保留為我自己做醫療照護的決定的權力。 只要我有精神自主能力，隨時可取消代理人的職權。

PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

A. END OF LIFE DECISIONS

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

THEN 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 following boxes. You may also initial your selection.

__ ☐ I want to stop or withhold medical treatment that would prolong my life.

OR

__ ☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

第二部分: 分項指示 (您可以更改或劃掉任何您不同意的地方，並請在修改處簽上姓名縮寫和日期)

A. 生命末期的決定

- 假如我的疾病無法治癒，而且病況無法好轉，在相當短的時日內，我將因此死亡，或
- 假如我已失去表達自己醫療照護上意願的能力，而此能力永遠無法再恢復，或
- 治療所可能承受的危險和負擔，超過期望的療效。

這時，我的醫護提供人員及其他與我的醫護有關的人員，應該依照我下列的指示, 提供、拒絕、或停止治療:
下面各項中只勾選一項。您也可縮寫簽名。
__ ☐ 我要停止或拒絕會延長我壽命的醫療處置。或
__ ☐ 我要可使我壽命延得越長越好的，在一般公認之醫療標準範圍內的醫療處置。

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.
__ ☐ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

B. 人工營養與補液 - 食物與液體:
應該依照我在前面A段做的選擇，提供、拒絕、或停止人工營養與補液，除非我在下面小格內勾選。
___☐ 如果我勾選此小格，只要是在一般公認之醫療標準範圍內，不論任何情況, 都必須提供人工營養與補液給我。

C. RELIEF FROM PAIN:
__ ☐ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

C. 疼痛的控制:
__☐如果我勾選此小格， 我選擇使用減除疼痛或不適的治療，即使這些治療會加速我的死亡。

D. OTHER
__ ☐ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

D. 其他:
__ ☐ 如果我勾選此小格，我附加的額外指示和資訊，都屬於我醫療照護指示的一部分。(附加的每一頁上都要簽名，寫日期，並與此表格訂在一起。)

E. WHAT IS IMPORTANT TO ME: (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

_____

_____

_____

_____

_____

_____

☐ I have attached ____ additional sheets

對我重要的事：(自由填寫。如有需要，可加附紙張。) 我很重視會令我活得很有意義的事，如下所列: (例如: 種花、帶寵物散步、購物、參加家庭聚會、去教堂或佛堂)

_____

_____

_____ 我附加了 ___頁紙

My thoughts about when I would not want my life prolonged by medical treatment (examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

_____

_____

_____

_____

_____

_____

_____

☐ I have attached ____ additional sheets

我對在何種情況下不要使用醫療處置來延長我的壽命的看法 (例如: 如果我失去心智能力而無法替自己做決定時，如果我無法與人溝通時，如果我無法享受用口進食)：

_____

_____

_____ 我附加了 ___頁紙

YOUR NAME: (Please sign in front of witnesses or notary public) [top of page 3 English version]

Print Your Full Name | Your Signature | Date of Birth | Date

您的姓名: (請於見證人或公證人在場時簽名)

正楷全名: _____ 簽名:[redacted]生日: _____ 日期:_____

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.

Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1: WITNESSES

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/ he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. 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.

Witness #1 Print Name | Witness Signature | Date

Street Address | City | State | Zip

見證人: 兩項中只選一項，不可兩項皆選。

請注意：見證人不能是您的醫療決定代理人、醫療照護人員或在醫療照護機構任職的人員。見證人之一， 不能是您的親屬，或有繼承權。

選擇一： 見證人

我 (第一位見證人) 我宣誓我認識簽署或承認此份醫療照護事前指示文件的人；此人在我的面前簽署或承認此份醫療照護事前指示；此人心智良好，沒有被強逼，被欺騙或受人影響；我與此人沒有任何不論是血親、姻親或領養的親屬關係, 而且就我所知，我沒有任何繼承此人遺產的權力；我不是此份醫療照護事前指示中指定的代理人；我不是醫療照護人員，或在醫療照護機構任職的人員。

[redacted]

第一位見證人正楷姓名 | 見證人簽名 | 日期

街道地址 | 城市 | 州 | 郵遞區號

I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. 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.

Witness #2 Print Name	Witness Signature	Date

Street Address	City	State	Zip

我 (第二位見證人) 我宣誓我認識簽署或承認此份醫療照護事前指示文件的人；此人在我的面前簽署或承認此份醫療照護事前指示；此人心智良好，沒有被強逼，被欺騙或受人影響；我不是此份醫療照護事前指示中指定的代理人；我不是醫療照護人員，或在醫療照護機構任職的人員。

第二位見證人正楷姓名	見證人簽名	日期

街道地址	城市	州	郵遞區號

OPTION 2: NOTARY PUBLIC

State of Hawai'i,
(City and) County of_____} ss.

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 ___ -page Hawai'i Advance Health Care Directive dated on _____, in the _____Judicial Circuit of the State of Hawai'i, and acknowledged that he/she executed the same as his/her free act and deed.

_____
Signature of Notary Public

My Commission Expires:_____

A copy has the same effect as the original.
www.kokuamau.org/resources/advance-directives
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Kōkua Mau - A Movement to Improve Care
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Place Notary Seal or Stamp Above

選擇二: 公證人

夏威夷州_____郡。於_____(年、月、日)，
在我 _____ 的面前，
(寫上公證人的名字)
親自到場夏威夷州巡迴法庭的

_____
(寫上授權人的名字)
確實(或有可信的證據證明)是於_____(年、月、日)簽署本份夏威夷州醫療照護事前指示共__頁的授權人本人，並已向我證明授權是依自己的意願訂立此授權書。

[redacted]
(公證人簽名)

我的公證職權有效至:_____

影印本與原本具相同效力。
www.kokuamau.org/resources/advance-directives
由Executive Office on Aging 及
Kōkua Mau – A Movement to Improve Care 共同製作
2015年12月

在此蓋章證明

This translation is accurate and complete to the best of the CACCC translation team's knowledge and ability. It also uses CACCC's Chinese translations of medical terms that have been accepted by major health organizations throughout the U.S.

相關中文資訊及服務，請聯絡：
美華慈心關懷聯盟
www.caccc-usa.org
電郵： info@caccc-usa.org
電話：1-866-661-5687

美華慈心關懷聯盟
Chinese American Coalition *for* Compassionate Care
www.caccc-usa.org