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.

夏威夷州医疗照护事前指示 HAWAIʻI ADVANCE HEALTH CARE DIRECTIVE

我的姓名: 姓氏 名字 中间名字缩写 出生日期 日期

第一部分: 医疗照护授权 - 指定代理人:
我指定下者做我的医疗照护授权代理人，为我做有关医疗照护方面的决定：

姓名 关系

街道地址 城市 州 邮递区号

住家电话号码 行动电话号码 电子信箱

如果我取消以上代理人之职权, 或该代理人不愿意、不能、或有合理原因无法为我做有关医疗照护方面的决定时，我指定的候补代理人如下:

_____

姓名　　关系

_____

街道地址　　城市　　州　　邮递区号

_____

住家电话号码　　行动电话号码　　电子信箱

代理人的职权和责任:
我的医疗代理人应按我在此表格之第二部分所指示，或我另外口头或手书的指示，为我做医疗照护上的决定。如有我未曾指示过的事宜，我要我的代理人，就像我会做的选择一样, 根据我的价值观、目标及偏好，而不是代理人自身的，来做决定。如果法庭必需替我指定一位监护人，我提名我的代理人。

代理人的职权何时生效:
除非我在下面的小格内勾选，否则当我的主治医师宣判我不能自我做决定时，我的代理人的职权才开始生效。
___ 如果我在此小格内勾选， 我的代理人为我做医疗照护的职权立即生效。但是，我永远保留为我自己做医疗照护的决定的权力。 只要我有精神自主能力，随时可取消代理人的职权。

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: 分项指示 (您可以更改或划掉任何您不同意的地方，并请在修改处签上姓名缩写和日期)

A. 生命末期的决定

- 假如我的疾病无法治癒，而且病况无法好转，在相当短的时日内，我将因此死亡，或
- 假如我已失去表达自己医疗照护上意愿的能力，而此能力永远无法再恢复，或
- 治疗所可能承受的危险和负担，超过期望的疗效。

这时，我的医护提供人员及其他与我的医护有关的人员，应该依照我下列的指示, 提供、拒绝、或停止治疗:
下面各项中只勾选一项。您也可缩写签名。

__ □ 我要停止或拒绝会延长我寿命的医疗处置。或

__ ☐ 我要可使我寿命延得越长越好的，在一般公认之医疗标准范围内的医疗处置。

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. 人工营养与补液 - 食物与液体:
应该依照我在前面A段做的选择，提供、拒绝、或停止人工营养与补液，除非我在下面小格内勾选。

___☐ 如果我勾选此小格，只要是在一般公认之医疗标准范围内，不论任何情况, 都必须提供人工营养与补液给我。

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:

__ ☐ 如果我勾选此小格， 我选择使用减除疼痛或不适的治疗，即使这些治疗会加速我的死亡。

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:

__ ☐ 如果我勾选此小格，我附加的额外指示和资讯，都属于我医疗照护指示的一部分。(附加的每一页上都要签名，写日期，并与此表格订在一起。)

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

对我重要的事：(自由填写。如有需要，可加附纸张。) 我很重视会令我活得很有意义的事，如下所列: (例如: 种花、带宠物散步、购物、参加家庭聚会、去教堂或佛堂)

我附加了 ___页紙

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

我对在何种情况下不要使用医疗处置来延长我的寿命的看法 (例如: 如果我失去心智能力而无法替自己做决定时，如果我无法与人沟通时，如果我无法享受用口进食)：

我附加了 ___页紙

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: (请于见证人或公证人在场时签名)

正楷全名: _____ 签名:[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

见证人: 两项中只选一项，不可两项皆选。

请注意：见证人不能是您的医疗决定代理人、医疗照护人员或在医疗照护机构任职的人员。见证人之一， 不能是您的亲属，或有继承权。

选择一： 见证人

我 (第一位见证人) 我宣誓我认识签署或承认此份医疗照护事前指示文件的人；此人在我的面前签署或承认此份医疗照护事前指示；此人心智良好，没有被强逼，被欺骗或受人影响；我与此人没有任何不论是血亲、姻亲或领养的亲属关系, 而且就我所知，我没有任何继承此人遗产的权力；我不是此份医疗照护事前指示中指定的代理人；我不是医疗照护人员，或在医疗照护机构任职的人员。

[redacted]

第一位见证人正楷姓名 | 见证人签名 | 日期

街道地址 | 城市 | 州 | 邮递区号

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 (第二位见证人) 我宣誓我认识签署或承认此份医疗照护事前指示文件的人；此人在我的面前签署或承认此份医疗照护事前指示；此人心智良好，没有被强逼，被欺骗或受人影响；我不是此份医疗照护事前指示中指定的代理人；我不是医疗照护人员，或在医疗照护机构任职的人员。

[redacted]

第一位见证人正楷姓名	见证人签名	日期

街道地址	城市	州	邮递区号

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
Developed by the Executive Office on Aging and
Kōkua Mau - A Movement to Improve Care
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Place Notary Seal or Stamp Above

选择二: 公证人

夏威夷州_____郡。於_____(年、月、日)，
在我 _____ 的面前，
(写上公证人的名字)
亲自到场夏威夷州巡迴法庭的

_____
(写上授权人的名字)
确实(或有可信的证据证明)是于_____(年、月、日) 签署本份夏威夷州医疗照护事前指示共__页的授权人本人，并已向我证明授权是依自己的意愿订立此授权书。

[redacted]
_____
(公证人签名)

我的公证职权有效至:_____

影印本与原本具相同效力。
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

在此盖章证明

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