



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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HAWAI‘I 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 healthcare 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.

ハワイ州医療についての事前指示書

HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE

本人の氏名:

名

姓

ミドルネームのイニシャル

生年月日

記入日

パート1: 医療委任状 – 代理人の指名:

私は、下記の者を代理人に選任し、私に代わって医療に関する判断を行う権限を委任します。

 代理人の氏名 代理人と本人の関係

 住所 都市 州 郵便番号

 自宅電話番号 携帯電話番号 電子メール

私が代理人の権限を取り消した場合、または代理人が私の代わりに医療判断をすることが不能であるか、合理的な理由によって不可能であるか、拒否する場合は、下記の者を代わりに代理人として指名します。

代理人の氏名	代理人と本人の関係		
住所	都市	州	郵便番号
自宅電話番号	携帯電話番号	電子メール	

代理人の権限と義務:

私の医療代理人は、私が本文書のパート2に於いて指示した通り、また、私が口頭及び文書によって指示した通りに決定をするものとします。私が指定していない内容について判断を行う場合は、代理人ではなく私の価値観、目的、優先順位に基づいて、私が希望したであろう決定を代理人がすることを望みます。法廷において私の後見人が必要となった場合、本代理人を指名します。

代理人の権限が有効となる時期:

代理人の権限は、下記の選択肢にチェックが入っている場合を除き、私の医療についての判断能力が失われたと主治医が判断した時に有効になるものとします。

- この選択肢がチェックされている場合、代理人の医療判断の権限は直ちに有効となります。ただし、私は医療に関する自分自身の意思決定権利を常に留保します。また、私が意思能力を有する限り、何時でも代理人の権限を取り消すことができるものとします。

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.

パート2: 個別の指示 (同意できないものは修正するか抹消線を引いて削除してください。修正箇所にはイニシャルと日付を書き添えてください。)

A. 終末期の判断

- 治療不能かつ回復不能な状態に陥り、短期間のうちに死亡することがわかっている場合、または
- 医療に関する自分の希望を伝える意思疎通の能力を失い、かつその能力が回復する見込みのない場合、または
- 医療処置のリスクと負担が期待されるメリットを上回る場合。

上記条件に当てはまった場合、私は医療提供者およびその他医療関係者に対し、下記に選択した条件に従って医療処置を提供、差し控えまたは中止することを指示します。以下の選択肢のうち1つだけチェックを入れてください。選択肢にイニシャルを記入してもかまいません。

延命を目的とする医療基準の差し控えまたは中止を希望します。

または

一般的に受け入れられている医療水準の範囲内で延命を目的とする医療処置を希望します。

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. 人工栄養/水分補給 - 食べ物と飲料:

前記パラグラフAにおいて私が選択した条件に従って、栄養と水分の人工補給を提供、差し控えまたは中止してください。ただし、下記の選択肢にチェックを入れてある場合はこの限りではありません。

この選択肢にチェックを入れてある場合、一般的に受け入れられている医療基準の範囲内で、如何なる条件下においても人工栄養/水分補給を行ってください。

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. 痛みの緩和:

この選択肢にチェックを入れてある場合、たとえ死期を早めることになっても痛みの除去または緩和を希望します。

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. その他

この選択肢にチェックを入れてある場合、追加ページに記載された私の指示または情報に従って医療処置を行ってください。(本文書に追加した各ページに署名と日付を記入してください。)

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 sheet/s

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

私(証人2)は、本医療についての事前指示書作成者を個人的に知っており、彼女/彼が健全な精神を持ち、不当な威圧を受けずに、私の前で本委任状に署名または承認したことを宣言します。私は本文書において指名された代理人ではなく、医療提供者または医療提供者/施設の従業員でもありません。

証人2氏名(活字体)	証人の署名	記入日
住所	都市	州 郵便番号

OPTION 2: NOTARY PUBLIC

State Hawai'i, } ss.
(City and) 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 ___ -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
Kokua Mau - A Movement to Improve Care
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Place Notary Seal or Stamp Above

オプション2: 公証人

ハワイ州
(都市および)郡 _____ } ss.

_____年 _____月 _____日、_____ハワイ州巡回裁判所において、本職 _____(公証人の氏名)の面前に、_____ (日付)に作成された本ハワイ州医療についての事前指示書 _____ ページに記載されている、_____ 本人が出頭し(または十分な証拠を本職に提示し)、彼/彼女が自由意志による行為・行動において本文書を作成した旨を認めた。

公証人の署名

公証人の任期: _____

上に公証人の押印

本文書のコピーも原本と同じ効力を有します。
www.kokuamau.org/resources/advance-directives
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