

## 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.

# PEPA IN KALLIMUR IKIJEN AO BUKI WAWEN TAKTŌ KO ILIJU IM JAKLAJ ILO HAWAI‘I HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE

Eta in:

\_\_\_\_\_  
 Laaj Etam Mitḍ inijel Raan in Lotak Rainin

## PAAT 1: POWER OF ATTORNEY IKIJEN AM TAKTŌ – KELET EO AM ÑAN EO EJ AGENT ÑAN EOK:

Ij jitoñe armij ñe bwe en agent im kōmmāne kelet ko ikijen ao taktō ñan na:

\_\_\_\_\_  
 Etan im teen armij eo emḡ jitone bwe en agent ikijen taktō

\_\_\_\_\_  
 Aterej in Jokwe Bukwon Eo State Zip

\_\_\_\_\_  
 Talboon in Kabijuknen Cell Boon E-mail

Ñe inaj kabojrak malim in an agent eo ao bĕk kōnaan ak ñe agent eo ejjab kōnaan, maroñ, ak wor an ien ñan an common bebe ikijio, armij e juñ enaj bĕk jikin:

Etan im teen	armij eo emĵ jitone bwe en agent ikijen taktō		
Aterej in Jokwe	Bukwon Eo	State	Zip
Talboon in Kabijuknen	Cell Boon	E-mail	

### MAROÑ IM EDDO KO AN AGENT EO:

Agent eo ao enaj kwalok bebe ko einwot ao kōmeleleiki ilo Paat 2 ilo pepa in ak einwot ao maroñ naj make kōmeleleiki ak ilo jeje. Ne ewor bebe ko me ijjanin kar lelok melele kaki ñan ie, ikōnaan bwe agent eo ao en kōmmani kelet ko ekkar ñan ao naj kar kelet ie, bedbed ion an jela kōn kōnaan, kōobar, im tomak ko ao im ejjab ko an agent eo make. Ne court enaj aikuiji juñ eo ej eddo son na, ij jitone kadredre agent eo ao.

### NAAT EN ENAJ WEPPEN MALIM IN AN AGENT EN AO :

Enaj jino weppen an agent en ao jino bĕk eddoin jermal in an ñe lukkun taktōen ao ej kile ke ijjab maroñ make kolmenlokjen kake im kātĉlok bebe kōn wawen ao taktō ijelokin wot ñe inaj kĕkalleiki box ñe maan:

- Ne inaj kĕkalleiki box in, melelein bwe agent eo ao enaj jino bĕk eddoin jermal in an ien eo emakaj tata. Botaab, I irkuni jimwe im moroñ ko ao ñan ao maroñ make kōmmani kelet ko ij lo ke rekkar ikijen ao taktō Imaroñ kabojrak malim in ilo jabdrewot ien ñe ej emmon wot ao kolmenlokjen.

## 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.

## PAAT 2: MELELE KO AN KAJJOJO ARMIJ (Komaroñ ukĉe ak jolok jabdrewot men ko kwoj jab err ie. Jeiki inijel ko maan ilo etam kab rainin aolep ien am kōmman octal.)

### A. BEBE KO IKIJEN JEMLOK IN MOUR

- Ñe ewor ao naninmij rot en ejelok uno en emaroñ e im iban mour jen e im kōn meniin ebaak ien ao jako, AK
- Ñe ejako ao maroñ kenono kake kōnaan ko ao ikijen ao taktōim emaroñ jab bar maroñ rooltok jela in, AK
- Ñe jonon kauwatata im drolol eo kwoj enjaake jen am taktōelap jen jonon am ejmour lok.

**INNEM** ba ñan taktō ro am im ro jet rej lale eok bwe ren lewaj, ak debiji, ak kabojrak jabdrewot kakolkol ko ekkar ñan kelet ko emōj I kallikkari ijin lal: k̄kalleiki juōn wot naan box kein imaan. Komaroñ bar inijele kelet eo am.

Ikōnaan kabojrak ak debiji wawen taktōko renaj kaetok lok ao mour.

**AK**

Ikōnaan b̄k wawen taktōko renaj kaetok lok ao mour ak ren jet wawen ko ekka aer kōmmani iumwin kakien ko an jikin taktōko.

**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. OON IM DREN KO KWOJ JAB KANGI AK ILIMI - MONA KAB DREN KO:**

Ekkar ñan kelet ko ikar kōmmani ilo melele ko lok imaan ilo paragrap A, renaj aikuuj letok, debiji ak kabojrak jen aer letok Oon im dren ijelokin wot ñe inaj k̄kalleiki box in maan.

Ne Minaj kollaiki box in, renaj aikuuj letok oon im dren jabdrewot ien men eo dreo ej aikuuj in bedded ion kar̄k im kakien ko an taktōekka aer loori.

**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. BOBRAE JEN METAK**

Ne inaj k̄kalleiki box in, inaj kelet wawen taktōko renaj bobrae metak ak apponono jekdron ñe emaroñ kōmakaj lok ao jako.

**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. KO JET**

Ne inaj kōkalleiki box in, aolep karōk im melele ko ikar kōlaajraki renaj aikuuj in bar drelon ie bwe en bloomed ao taktō. (Jain im je rainin ilo kajjojo peij im kakobaiki ippān pepa in.)

**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):

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I have attached \_\_\_\_\_ additional sheet/s

**E. TA KO REAURŌK IPPA:** (Men ko jet komaroñ ak komaroñ jab kċaajraki. Kakkobaba pepa ñe men in aikuij.) Men ko reaurċ ippa im rej unin ao kċnaan wot mour ej: (ñan warn jonok: ekkat out ak mona, keetetale men in mour eo nejd, kaikujkuj, bċk kono ilo koba ko an baamle, etal im jar ak kabuñ)

Emċ ao kakobaiki \_\_\_\_\_ bar jet pepa ko

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 sheet/s

Lomnak ko ao kċn ien en naij jab kċnaan retook lok mour e ao kċn wawen taktŌlŌlŌ ko (Ñan warn jonok ewor: Ñe ejako ao moroñ kolmenlokjen im kċmmon bebe ikijio make, ñe emċ an jako ao maroñ kwalok lċnnak ko ao, ñe ejako ao maroñ kadrelep, im men ko jet):

Emċ ao kakobaiki bar \_\_\_\_\_ peij ko

**YOUR NAME:** (Please sign in front of witnesses or notary public)

Print Your Full Name	Your Signature	Date of Birth	Date
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**YOUR NAME:** (Jouj im jaini imaan mejen rikamool ak notari)

Jeiki Aolepen Etam k̄n Capital Leta	k̄kalle In Jain In Etam	Raan In Lotak	Rainin
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**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

**RIKAMOOL RO: KELET ŅE EJ KEIN 1 AK 2, EN JAB AOLEPEOR.**

**Men In Aor̄k: Rikamool Ro** ejjab aikuij in agent eo am, ak jūn taktōak jūn rijerbal in jikin taktō jūn rikamool ejjab aikuij in jūn nukum ak jūn eo ewor an men in jolet jen eok .

**KELET EO KEIN 1: RIKAMOOL RO:**

Na (Rikamool 1) ij kamool ke armij in ej kōmmane kallimur kein einwot ke ej kebooje ikijen an naj buki wawen taktō ko iliju im jaklaj elap ao jela kajien, im emōj an jaini ak kwalok an kawepene kallimur in imaan meja kab ilak lale einwot emmon an kolmenlokjen im ejelok en ej pooje bwe en kōmmane. Ejjab nuku ilo botōktōk, kaajiriri, ak ejjab nukun armij eo pālele im ilo ao jela, ijjab pad ilo laajrak in ro renaj wor aer jolet jen e ñe enaj jako jen mour in. Ejjab na armij eo ej an agent ilo ao pad ilo pepa in, im ejjab na taktō eo an, ak rijerbal in jikin taktō.

Rikamool #1 Jeiki Etam	K̄kalle in Etan Rikamool	Rainin
Aterej in Kabijuknen Eo	Buk̄n Eo	State Eo    Zip

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

Na (Rikamool 2) ij kamool ke armij in ej kōmmāne kallimur kein einwot ke ej kebooje ikijen an naj buki wāwen taktō ko iliju im jaklaj elap ao jela kajien, im emōj an jaini ak kwalok an kawēppene kallimur in imaan meja kab ilak lale einwot emmon an kolmenlokjen im ejelok en ej pooje bwe en kōmmāne. Ejjab na armij eo ej an agent ilo ao pad ilo pepa in, im ejjab na taktō eo an, ak rijerbal in jikin taktō.

\_\_\_\_\_  
Rikamool #2 Jeiki Etam    ██████████    kōkalle in Etam Rikamool    Rainin  
\_\_\_\_\_  
Aterej in Kabujuknen Eo    Bukān Eo    State Eo    Zip

**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](http://www.kokuamau.org/resources/advance-directives)  
Developed by the Executive Office on Aging and  
Kōkua Mau - A Movement to Improve Care

Place Notary Seal or Stamp Above

December 2015



**KELET EO KEIN 2: NOTARY PUBLIC AK RIKAMOOLE KŌKALLE IN ETAM**

State in Hawai'i,  
(Evan Bukān eo im) County eo \_\_\_\_\_ } ss.

Ilo \_\_\_\_\_ raan in \_\_\_\_\_, ilo yiio in \_\_\_\_\_, imaan meja,  
\_\_\_\_\_, (likuti etan notary public ak rikamoole  
kōkalle in team eo) ekar jade tok \_\_\_\_\_, ej  
juōn eo elap ao jela kajien (ak emā kamool ñan na son jet kein kamool ko epo buruo kaki) ke etan in  
edrelon ilo peij \_\_\_ - ilo Kallimur kein ikijen an Buki Wawen taktōKo Iliju im Jaklaj Ilo Hawai'i emā  
jitaamwe ilo raan in \_\_\_\_\_, ilo \_\_\_\_\_ Judicial Circuit of the State of Hawai'i,  
im kallikkar ke ej kōmmane meniin einwot ke ej an make kelet im ewor an maroñ ioon.

\_\_\_\_\_  
kōkalle in Etan Notary Public Eo ak Rikamoole kōkalle in Etam

Ao Eddo Ioon Jerbal In Enaj Jemlok Kutien Ilo: \_\_\_\_\_

**Kabe im original jonon wot juōn.**  
[www.kokuamau.org/resources/advance-directives](http://www.kokuamau.org/resources/advance-directives)  
Ekar jino ejaak jen Opiij En Elap An Old Age im  
Kōkua Mau - A Movement to Improve Care

Jikin Notary Seal ak Jitaam Eo ñe Iloñ in Ijin

December 2015