healthy **living**

KAISER PERMANENTE®

Hawaii Advance Health Care Directive Step By Step Instructions

Advance Health Care Directive

At Kaiser Permanente, we support your right to make health care [physical and mental condition(s)] decisions. You also have the right to name someone else to make health care decisions for you. We encourage you to make these important decisions now, when you are healthy, by completing advance directives.

Discuss these important decisions with your family and doctor. By placing your wishes in writing, your family and health care providers will know what you want if you become unable to make decisions for yourself.

By clarifying your wishes at a time when you are able to think clearly about them, you free your family from making difficult decisions for you.

Your Health Care Wishes

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 [physical and mental condition(s)] decisions for you. This form lets you do either or both of these things. Discuss these important decisions with your family and doctor.

Make Decisions Now

The best time to discuss and complete an Advance Health Care Directive is before you are admitted to a hospital, or even better, now. This gives you time to think about your decisions, discuss them with your family, friends, and doctor, and make the necessary arrangements for witnesses or a notary public. Completing this Advance Health Care Directive will help your family by freeing them of the burden of having to make difficult decisions for you. Please be sure that any agent(s) you designate on the Advance Health Care Directive is informed and has agreed to be named as an agent on the directive.

Mail to:

Kaiser Permanente
c/o MRA Department
711 Kapiolani Boulevard
Honolulu, HI 96813

STEP BY STEP INSTRUCTIONS FOR COMPLETING THE HAWAII ADVANCE HEALTH CARE DIRECTIVE

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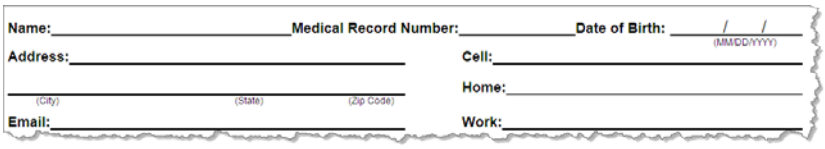
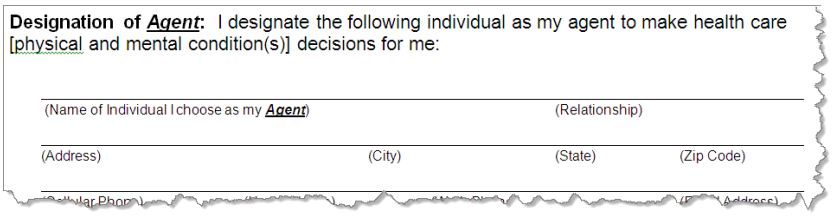
Hawaii Advance Health Care Directive

INSTRUCTIONS FOR PART I: DURABLE HEALTH CARE POWER OF ATTORNEY

Step 1:
Fill in your vital information on the Advance Health Care Directive form.


Name:_____ Medical Record Number:_____ Date of Birth: ___/___/___ (MM/DD/YYYY)
Address:_____ Cell:_____
_____ Home:_____
(City) (State) (Zip Code)
Email:_____ Work:_____

Step 2:
Choose your agent who will make health care [physical and mental condition(s)] decisions for you.


Designation of *Agent*: I designate the following individual as my agent to make health care [physical and mental condition(s)] decisions for me:

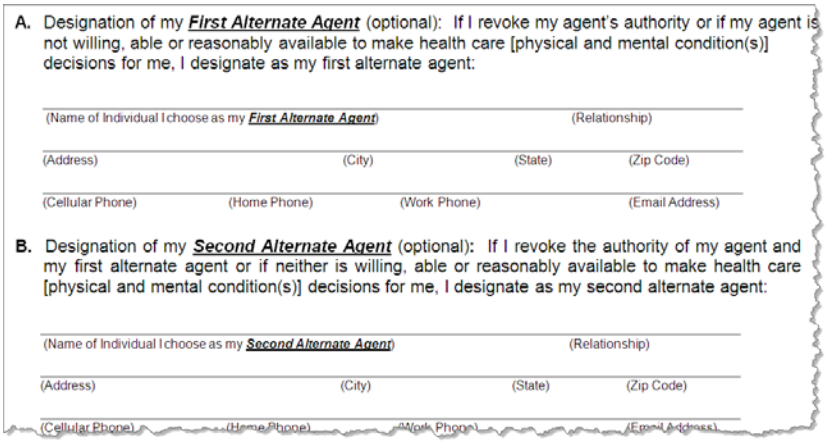
(Name of Individual I choose as my ***Agent***) (Relationship)

(Address) (City) (State) (Zip Code)

(Cellular Phone) (Home Phone) (Work Phone) (Email Address)

Do not exceed the number of designated agents allowed on this form.
***NOTE: Unless related to you, your agent may not be an owner, operator, or employee of any health care institution (for example, Kaiser Permanente).**

Step 3:
It is *OPTIONAL* to choose two *ALTERNATE* agents who can make health care [physical and mental condition(s)] decisions for you.


A. Designation of my ***First Alternate Agent*** (optional): If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make health care [physical and mental condition(s)] decisions for me, I designate as my first alternate agent:

(Name of Individual I choose as my ***First Alternate Agent***) (Relationship)

(Address) (City) (State) (Zip Code)

(Cellular Phone) (Home Phone) (Work Phone) (Email Address)

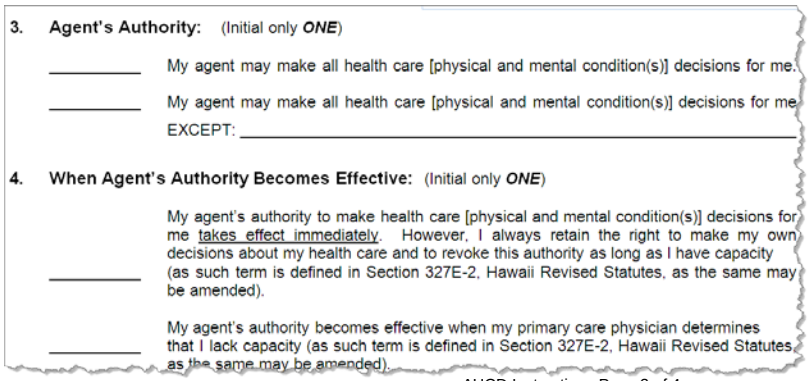
B. Designation of my ***Second Alternate Agent*** (optional): If I revoke the authority of my agent and my first alternate agent or if neither is willing, able or reasonably available to make health care [physical and mental condition(s)] decisions for me, I designate as my second alternate agent:

(Name of Individual I choose as my ***Second Alternate Agent***) (Relationship)

(Address) (City) (State) (Zip Code)

(Cellular Phone) (Home Phone) (Work Phone) (Email Address)

Step 4:
Choose whether your agent can make all, or some, health care [physical and mental condition(s)] decisions for you, and when the agent's authority becomes effective.


3. Agent's Authority: (Initial only ***ONE***)

_____ My agent may make all health care [physical and mental condition(s)] decisions for me.

_____ My agent may make all health care [physical and mental condition(s)] decisions for me EXCEPT: _____

4. When Agent's Authority Becomes Effective: (Initial only ***ONE***)

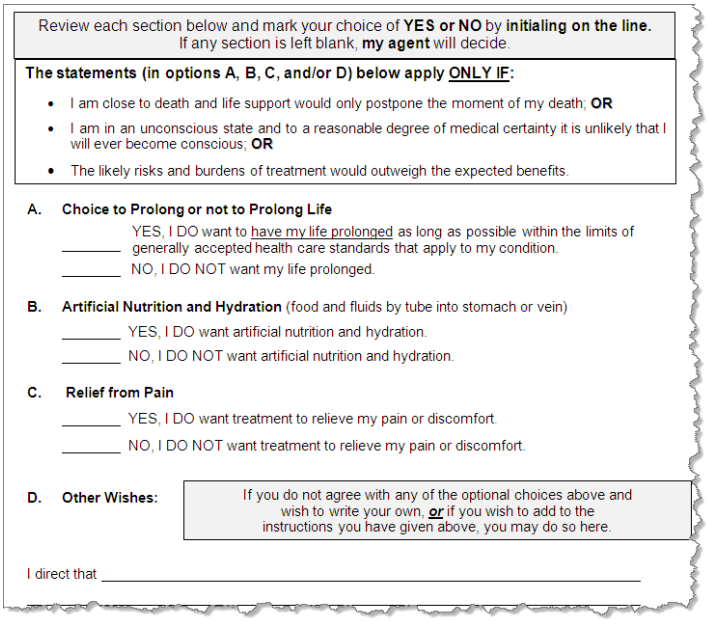
_____ My agent's authority to make health care [physical and mental condition(s)] decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care and to revoke this authority as long as I have capacity (as such term is defined in Section 327E-2, Hawaii Revised Statutes, as the same may be amended).

_____ My agent's authority becomes effective when my primary care physician determines that I lack capacity (as such term is defined in Section 327E-2, Hawaii Revised Statutes, as the same may be amended).

INSTRUCTIONS FOR PART II: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

Step 5:
Choose your individual instructions for your care.

You ***MUST*** initial on the line to indicate your preferences



Review each section below and mark your choice of **YES or NO** by **initialing on the line.** If any section is left blank, **my agent** will decide.

The statements (in options A, B, C, and/or D) below apply ONLY IF:

- I am close to death and life support would only postpone the moment of my death; **OR**
- I am in an unconscious state and to a reasonable degree of medical certainty it is unlikely that I will ever become conscious; **OR**
- The likely risks and burdens of treatment would outweigh the expected benefits.

A. Choice to Prolong or not to Prolong Life

_____ YES, I DO want to have my life prolonged as long as possible within the limits of generally accepted health care standards that apply to my condition.

_____ NO, I DO NOT want my life prolonged.

B. Artificial Nutrition and Hydration (food and fluids by tube into stomach or vein)

_____ YES, I DO want artificial nutrition and hydration.

_____ NO, I DO NOT want artificial nutrition and hydration.

C. Relief from Pain

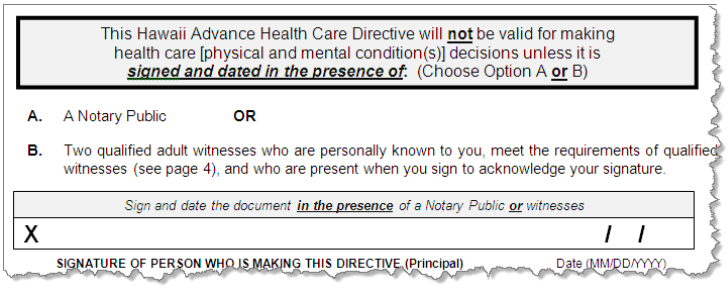
_____ YES, I DO want treatment to relieve my pain or discomfort.

_____ NO, I DO NOT want treatment to relieve my pain or discomfort.

D. Other Wishes: If you do not agree with any of the optional choices above and wish to write your own, ***or*** if you wish to add to the instructions you have given above, you may do so here.

I direct that _____

Step 6:
You ***MUST*** ***sign*** and ***date*** this Advance Health Care Directive in front of a notary public ***OR*** two witnesses.



This Hawaii Advance Health Care Directive will **not** be valid for making health care [physical and mental condition(s)] decisions unless it is ***signed and dated in the presence of***: (Choose Option A **or** B)

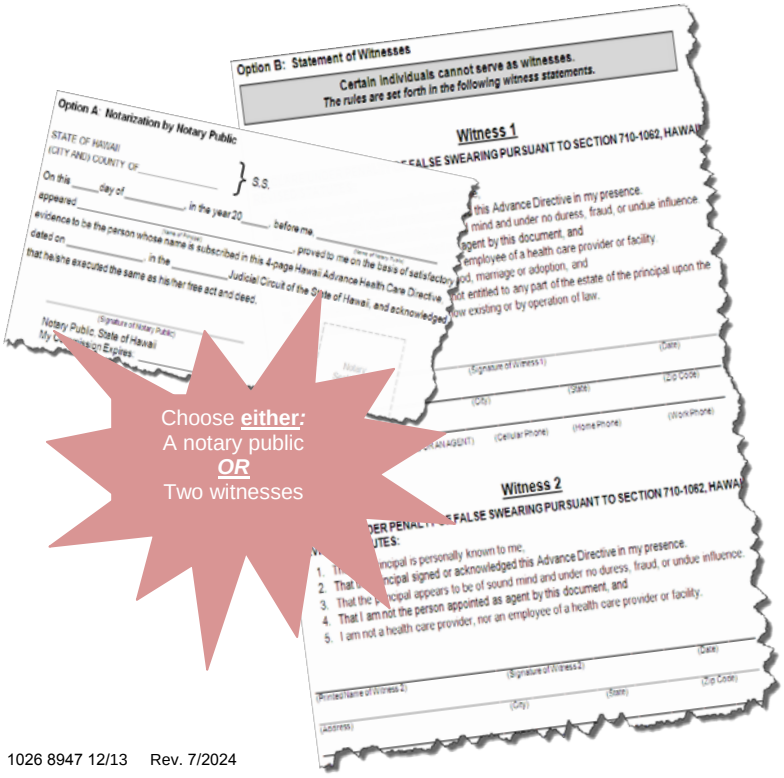
A. A Notary Public **OR**

B. Two qualified adult witnesses who are personally known to you, meet the requirements of qualified witnesses (see page 4), and who are present when you sign to acknowledge your signature.

*Sign and date the document **in the presence** of a Notary Public **or** witnesses*

X _____ / /

SIGNATURE OF PERSON WHO IS MAKING THIS DIRECTIVE (Principal) Date (MM/DD/YYYY)



Choose **either**:
A notary public
OR
Two witnesses

Ensure all dates on the form are the **same** so you don't have to re-do the form later

Step 7:
Turn your Advance Health Care Directive in to a Kaiser Permanente representative or mail a COPY to:

Kaiser Permanente
c/o MRA Department
711 Kapiolani Boulevard
Honolulu, HI 96813

Checklist

- ☐ Be sure to fill out the form accurately and completely, including your name and medical record number (MRN) on the top right corner of each page.
- ☐ Be sure you name appropriate agent(s): Unless related to you, your agent may not be an owner, operator, or employee of any health care institution (for example, Kaiser Permanente).
- ☐ Have two qualified witnesses **or** a notary public witness your signature. The form will not be valid if unqualified witnesses are used or if it is improperly notarized.
- ☐ Ensure all dates on the form are the same so you don't have to re-do the form later. (The form will be returned to you and you will need to complete a new form if any errors or discrepancies with dates and signatures are found.)
- ☐ Make a copy of your Advance Health Care Directive. You should also make a copy for your spouse, a close family member, and the agent(s) you have appointed to make decisions for you.
- ☐ Keep your original documents where you keep other important papers.
- ☐ Whenever you are admitted to a hospital, a skilled nursing facility or a home care agency, you will be asked if you have an Advance Health Care Directive. Please acknowledge that you have completed an Advance Health Care Directive at that time.

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Hawaii Advance Health Care Directive

MRN:

Name:

DOB:

For Kaiser Permanente Use Only

Name: _____ **Medical Record Number:** _____ **Date of Birth:** ____/____/____ (MM/DD/YYYY)

Address: _____ **Cell:** _____

_____ **Home:** _____

(City) (State) (Zip Code)

Email: _____ **Work:** _____

PART I: DURABLE HEALTH CARE POWER OF ATTORNEY

Note: You should discuss your wishes in detail with your designated agent(s).

1. Agent's Obligation: My agent shall make health care [physical and mental condition(s)] decisions for me in accordance with this Health Care Power of Attorney, any instructions I have in Part II of this form, and my other wishes to the extent known to my agent. To the extent that my wishes are unknown, my agent shall make health care [physical and mental condition(s)] 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. *See instructions for details on agent relationship.

2. Designation of *Agent*: I designate the following individual as my agent to make health care [physical and mental condition(s)] decisions for me:

_____

(Name of Individual I choose as my ***Agent***) (Relationship - *see instructions)

_____

(Address) (City) (State) (Zip Code)

_____

(Cellular Phone) (Home Phone) (Work Phone) (Email Address)

A. Designation of my ***First Alternate Agent*** (optional): If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make health care [physical and mental condition(s)] decisions for me, I designate as my first alternate agent:

_____

(Name of Individual I choose as my ***First Alternate Agent***) (Relationship - *see instructions)

_____

(Address) (City) (State) (Zip Code)

_____

(Cellular Phone) (Home Phone) (Work Phone) (Email Address)

B. Designation of my ***Second Alternate Agent*** (optional)**:** If I revoke the authority of my agent and my first alternate agent or if neither is willing, able or reasonably available to make health care [physical and mental condition(s)] decisions for me, I designate as my second alternate agent:

_____

(Name of Individual I choose as my ***Second Alternate Agent***) (Relationship - *see instructions)

_____

(Address) (City) (State) (Zip Code)

_____

(Cellular Phone) (Home Phone) (Work Phone) (Email Address)

KAISER PERMANENTE

Hawaii Advance Health Care Directive

MRN:

Name:

DOB:

For Kaiser Permanente Use Only

3. Agent's Authority: (Initial only ***ONE***)

_____ My agent may make all health care [physical and mental condition(s)] decisions for me.

_____ My agent may make all health care [physical and mental condition(s)] decisions for me EXCEPT: _____

4. When Agent's Authority Becomes Effective: (Initial only ***ONE***)

_____ My agent's authority to make health care [physical and mental condition(s)] 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 have capacity (as such term is defined in Section 327E-2, Hawaii Revised Statutes, as the same may be amended).

_____ My agent's authority becomes effective when my primary care physician determines that I lack capacity (as such term is defined in Section 327E-2, Hawaii Revised Statutes, as the same may be amended).

PART II: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

Review each section below and mark your choice of **YES or NO** by **initialing on the line.** If any section is left blank, **my agent** will decide.

The statements (in options A, B, C, and/or D) below apply ONLY IF:

- I am close to death and life support would only postpone the moment of my death; **OR**
- I am in an unconscious state and to a reasonable degree of medical certainty it is unlikely that I will ever become conscious; **OR**
- The likely risks and burdens of treatment would outweigh the expected benefits.

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_____ YES, I DO want to have my life prolonged as long as possible within the limits of generally accepted health care standards that apply to my condition.

_____ NO, I DO NOT want my life prolonged.

B. Artificial Nutrition and Hydration (food and fluids by tube into stomach or vein)

_____ YES, I DO want artificial nutrition and hydration.

_____ NO, I DO NOT want artificial nutrition and hydration.

C. Relief from Pain

_____ YES, I DO want treatment to relieve my pain or discomfort.

_____ NO, I DO NOT want treatment to relieve my pain or discomfort.

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Hawaii Advance Health Care Directive

MRN:
Name:
DOB:
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D. Other Wishes:

If you do not agree with any of the optional choices above and wish to write your own, ***or*** if you wish to add to the instructions you have given above, you may do so here.

I direct that _____

_____

Effect of Copy: A facsimile or copy of this form has the same effect as the original.

Revocation of All Prior Directives: By executing this Advance Health Care Directive, I hereby revoke any and all previously executed Advance Health Care Directives and instruments serving similar purposes, which I have signed or may have signed prior to the date of this Advance Health Care Directive.

This Hawaii Advance Health Care Directive will **not** be valid for making health care [physical and mental condition(s)] decisions unless it is ***signed and dated in the presence of*****:** (Choose Option A **or** B)

A. A Notary Public **OR**

B. Two qualified adult witnesses who are personally known to you, meet the requirements of qualified witnesses (see page 4), and who are present when you sign to acknowledge your signature.

*Sign and date the document **in the presence** of a Notary Public **or** witnesses*

X _____ **/ /**

SIGNATURE OF PERSON WHO IS MAKING THIS DIRECTIVE (Principal) Date (MM/DD/YYYY)

Option A: Notarization by Notary Public

STATE OF HAWAII
(CITY AND) COUNTY OF_____ } S.S.

On this _____day of _____, in the year 20_____, before me, _____
(Name of Notary Public)
appeared _____, proved to me on the basis of satisfactory
(Name of Principal)
evidence to be the person whose name is subscribed in this 4-page Hawaii Advance Health Care Directive, dated on _____, in the _____Judicial Circuit of the State of Hawaii, and acknowledged that he/she executed the same as his/her free act and deed.

_____
(Signature of Notary Public)
Notary Public, State of Hawaii
My Commission Expires: _____

Notary Seal/Stamp

KAISER PERMANENTE®

Hawaii Advance Health Care Directive

MRN:

Name:

DOB:

For Kaiser Permanente Use Only

Option B: Statement of Witnesses

Certain individuals cannot serve as witnesses.
The rules are set forth in the following witness statements.

Witness 1

I DECLARE UNDER PENALTY OF FALSE SWEARING PURSUANT TO SECTION 710-1062, HAWAII REVISED STATUTES:

1. That the principal is personally known to me,
2. That the principal signed or acknowledged this Advance Directive in my presence.
3. That the principal appears to be of sound mind and under no duress, fraud, or undue influence.
4. That I am not the person appointed as agent by this document, and
5. I am not a health care provider, nor an employee of a health care provider or facility.
6. I am not related to the principal by blood, marriage or adoption, and
7. 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.

(Printed Name of Witness 1) (Signature of Witness 1) (Date)

(Address) (City) (State) (Zip Code)

(Relationship – ***CANNOT*** BE A RELATIVE OR AN AGENT) (Cellular Phone) (Home Phone) (Work Phone)

Witness 2

I DECLARE UNDER PENALTY OF FALSE SWEARING PURSUANT TO SECTION 710-1062, HAWAII REVISED STATUTES:

1. That the principal is personally known to me,
2. That the principal signed or acknowledged this Advance Directive in my presence.
3. That the principal appears to be of sound mind and under no duress, fraud, or undue influence.
4. That I am not the person appointed as agent by this document, and
5. I am not a health care provider, nor an employee of a health care provider or facility.

(Printed Name of Witness 2) (Signature of Witness 2) (Date)

(Address) (City) (State) (Zip Code)

(Relationship – CAN BE A RELATIVE BUT ***NOT AN AGENT***) (Cellular Phone) (Home Phone) (Work Phone)