ADVANCE HEALTH-CARE DIRECTIVE

(DURABLE POWER OF ATTORNEY FOR HEALTH-CARE DECISIONS)

PART I. APPOINTMENT OF HEALTH-CARE AGENT

I, _____
a resident of the State of Hawai'i, (hereinafter known as the "Principal") hereby appoint, _____,my _____, a resident of the State of _____ (hereinafter known as the "Agent") as my Agent with all of the powers set forth herein below.
My Agent can be reached at:
Phone: _____ E-Mail: _____

APPOINTMENT OF ALTERNATE AGENT(S)
If my Agent appointed above is unable or unwilling to serve, I appoint the following person(s) to serve as Agent(s) in the order set forth below with the authority to make health-care decisions on my behalf as provided herein:

1st Alternate Agent

_____ a resident of the State of _____
Phone: _____ E-Mail: _____

2nd Alternate Agent

_____ a resident of the State of _____
Phone: _____ E-Mail: _____

EFFECTIVE IMMEDIATELY
My Agent's authority becomes effective immediately to make health-care decisions on my behalf.

DURATION
Unless stated otherwise herein, this document shall remain in effect until I revoke it. It is durable. I understand that I cannot revoke this document during the time I am considered incompetent to make my own decisions. This document shall not have an end date and shall terminate upon revocation, or if I create a new advance health-care directive and/or medical power of attorney.

POWERS OF MY AGENT
My Agent shall act for me and in my name in any way that I could act in person, to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health-care, including without limitation, to request, require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue.

My Agent's authority includes but is not limited to:

(a) to make **end-of-life decisions** such as whether to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health-care, in my Agent's sole and absolute discretion, including whether to provide treatment to alleviate pain or discomfort, even if it hastens the moment of my death. In exercising such powers, my Agent should follow my instructions herein, oral or written, that I may give to my Agent while I am competent;

(b) to talk with health-care providers and institutions and access my medical records, sign authorizations for release of my medical records and other necessary forms, as further discussed in the HIPAA release herein below;

(c) to consent to and arrange for or to refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including approval or disapproval of health examinations, diagnostic tests, medical or surgical procedures, programs of medication, the use of alternative or complementary therapies and to decide whether to participate in education, research and experimental programs;

(d) to authorize my admission to or discharge from any medical, nursing, residential or similar facility;

(e) to select and discharge health-care providers, organizations, institutions and programs and to make and change health-care choices and options relating to plans, services, and benefits; and

(f) to apply for public or private health-care programs, including Medicare, Medicaid, and Hawai'i Quest benefits, without my Agent incurring any financial liability.

I agree to the above provisions; Initial_____

AGENT'S OBLIGATION

My Agent shall make health-care decisions for me in accordance with this power of attorney for health-care, any instructions I give in Part II of this form, and my other wishes to the extent known to my Agent. To the extent my wishes are unknown, my Agent shall make health-care 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.

RELEASE OF HEALTH CARE INFORMATION

My Agent shall be treated as I would with respect to my rights regarding the use and disclosure of my individually identifiable health information or medical records. My Agent shall be immediately authorized to request and receive all of my individually identifiable health information and other medical records. This release authority applies to information governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 USC 1320d, 45 CFR 160-164, as now or may hereafter be amended, or any other similar law at the State or Federal level. I authorize any physician, health-care professional, dentist, health plan, hospital,

clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc., or other health-care clearinghouse to give, disclose and release to my Agent, without restriction, all of my health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

AGENT'S POST DEATH AUTHORITY

My Agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains.

PRIOR MEDICAL POWER OF ATTORNEY

By signing this document, I hereby revoke any and all prior medical powers of attorney that I may have previously executed.

PART II. LIVING WILL

I, _____, declare to include this Living Will as part of my Advance Health-Care Directive and Medical Power of Attorney Form.

END-OF-LIFE DECISIONS

Initial One

_____ **PROLONG MY LIFE** I want medical treatment that will prolong my life as long as possible within the limits of generally accepted health-care standards.

_____ **DO NOT PROLONG MY DEATH**

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to prolong the process of my dying if continued health-care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life and my death is likely to occur within several months, or if I require life support as the result of an irreversible condition, even if that life support might prolong my life for a sustained period.

Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued (1) if I have an injury, disease, illness or other condition which is incurable, terminal and expected to result in my death; or (2) if I am in a coma or vegetative state and there is no reasonable possibility of my regaining consciousness or normal brain function; or (3) if my consciousness is irrevocably impaired such that I am so severely demented that I am unable to respond to commands or requests, unable to recognize or meaningfully interact with family or other loved ones, or unable to convey the attributes that I associate with personhood, such as the ability to experience joy, desire, pleasure, and consciousness of myself as a continuing entity; or (4) under any other circumstances in which

my Agent believes that I would not desire further treatment given the available information about the treatment, its possible benefits, and its potential risks.

If I am in such a state and am unable to eat by swallowing my food, I specifically do not want any artificial means of nutrition and hydration. In making decisions about life-sustaining treatment under the provisions above, I want my Agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. My Agent is specifically authorized to direct and consent to the writing of a "do not resuscitate" or "no code" order (aka "POLST," if I haven't signed one already). I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

If I am at the end of life as described above, whether at home or in a long-term care facility, I request that my Agent avoid contacting 911 if possible. If I require transportation to a medical facility I request that it be accomplished privately through my healthcare providers or facility. I request that my Agent follow this direction to avoid the possibility of unwanted treatment and/or resuscitation.

_____ Initial here

I also recognize that certain health-care establishments (HMOs in particular) may be structured with financial incentives to provide its patients with as few services as possible. Although I do not want to have life-sustaining treatment or procedures under the above-mentioned circumstances, I do not wish treatment to be withdrawn prematurely on the basis of the provider's economic considerations. Thus I empower my Agent to require treatment and procedures if my Agent, in my Agent's sole discretion, determines that such treatment would be desired by me, and/or in my best interest. My Agent is authorized to compel treatment, and to take whatever steps, including resort to the courts, to compel treatment and reimbursement or payment for that treatment. I am a member of an HMO or similar establishment, and if I am refused treatment that my Agent believes I would benefit from, then my Agent is encouraged to instruct the establishment to put their refusal to provide care "in writing."

(ADD-ON OPTION) <u>ALTERNATIVE END-OF-LIFE OPTIONS</u> If I have been diagnosed by my attending physician with a terminal disease (likely to result in death within six months) and I want to avoid experiencing a lengthy or painful death process, I request that my Agent take all steps necessary to assist me in exercising any legal right to end my life with dignity. With The Our Care Our Choice Act in Hawaii, Hawaii has legally allowed to obtain an "medical aid-in-dying drug" from a physician if I am terminally ill and have 6 months or less to live. If I choose this alternative, I can self-administer to die peacefully in my sleep. If I choose to do so, my Agent is requested to support me in making this decision.

<u>RELIEF FROM PAIN & PALLIATIVE CARE AND SEDATION</u>

I direct that treatment for alleviation of pain or discomfort to be provided at all times, even if it may lead to physical damage, addiction, or even hasten the moment of my death. I wish to receive any other forms of palliative care and sedation that may ease my suffering. However, if

a decision (to preserve my lucidity and ability to communicate treatment for pain) is necessary, I wish treatment for pain to prevail. The use of palliative care, which may require intravenous administration, is not intended to counteract the directives regarding artificial means of nutrition and hydration.

HOSPICE

I desire the services of Hospice, if appropriate, as determined by my Agent and my primary, attending or supervising physician.

ALZHEIMER'S/DEMENTIA

If I develop dementia, I would like all life-prolonging treatments, such as artificial nutrition, fluids and antibiotics, as long as I have the ability to interact meaningfully with my family and friends. If I lose the capacity for meaningful interaction, I then want only treatments that would make me more comfortable and free from pain. I would then want care and treatment pursuant to END OF LIFE DECISIONS above.

PART III. PERSONAL CARE

INDEPENDENT LIVING

I wish to live in my home for as long as that is reasonably possible without endangering my physical or mental health and safety and to receive whatever assistance from household employees or personal care givers may be necessary to permit me to do so; provided, however, that in the event my Agent determines that appropriate household employees or personal care givers are not available without putting my financial position or physical or mental health or safety at risk, then I wish to live in the least restrictive and most home-like setting deemed appropriate by my Agent. I further request that I live as near as possible to my primary residence in order that I may visit with friends and neighbors to the degree my Agent believes that I will benefit from such relationships. I wish to return home as soon as reasonably possible after any hospitalization or transfer to convalescent care. If my Agent determines that I am no longer able to live in my home, I wish that my Agent consider alternatives to convalescent care which will permit me as much privacy and autonomy as possible, including such options as placing me in an assisted living facility or board and care facility.

INTENT TO RETURN HOME

If it should become necessary for me to enter a long-term care facility of any kind, or any other facility outside of my home, I hereby declare that it remains my express intent to return to my home at the earliest possible time.

VISITATION RIGHTS

In the event that any medical or care facility where I may be staying from time to time limits visitors to "close family members," I hereby state that I consider my health-care Agent to be a close family member and request that my Agent be allowed to visit me at any time. I also request that the facility where I am staying allow my then acting health-care Agent to provide the names of other individuals whom I consider close personal friends and that such people also be allowed to visit me freely.

I acknowledge that visitors are sometimes limited by a facility "in the best interests of a patient" to allow the patient quiet time to rest, etc. However, I would prefer visitors in any event, and in order to encourage the facility in which I may be staying to allow my friends to visit freely, I hereby expressly and without reservation provide that such facility shall incur no liability to me, my heirs, or successors in interest for allowing my friends to visit me freely.

SOCIAL INTERACTION
I wish to be encouraged to maintain my social relationships and to engage in social interaction even if I am no longer able to recognize my family and friends or to fully participate in social activities.

OUTDOOR ACTIVITIES I wish to spend time outdoors, and have exposure to sunlight and fresh air. If I can no longer travel on my own, I wish my Agent to arrange for trips to local parks and other areas where I may be outdoors in a natural setting.

DO NOT TRANSFER If I am in a nursing home, I desire a "Do Not Transfer" order to avoid the trauma and discomfort of transportation to a hospital. I direct any nursing home staff to consult with my Agent and physician for consent to transfer, before a transfer occurs.

CARE AND COMFORT I wish to have my mouth and lips kept moist so as to alleviate any possible sensation of dehydration. I desire hygienic grooming, care and comfort not inconsistent with any other provisions in this document.

PART IV. DISPOSITION OF REMAINS

I have executed a Declaration of Disposition of Last Remains and Appointment of Agent that specifically refers to this attachment in order that my wishes regarding my remains after my death shall be honored.

Initial if you want to include this provision.

_____ **AUTHORIZATION OF AUTOPSY** My Agent shall have the power and authority to authorize or refuse to authorize an autopsy for the purpose of resolving any issues related to my death or its cause in my Agent's sole and absolute discretion.

_____ **ANATOMICAL GIFTS/ORGAN DONATION** My Agent is authorized to make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act by informing the attending healthcare provider. Upon my death, my Agent has the power to consent to donation of _____ or _____any needed organs, tissues, or parts for the purposes of _____transplant, _____research and _____therapy.

The following paragraph gives your agent specific directions on your burial wishes.

DISPOSITION OF REMAINS My Agent shall have the power and authority to direct the disposition of my remains. I request that my remains be (please check the box)

___Traditional Burial (with embalming)
___Natural Burial (without embalming)
___Green Burial (on conservation land)
___Cremation
___Burial at Sea

ARRANGEMENTS FOR FUNERAL OR MEMORIAL SERVICE My Agent shall have the power and authority to arrange for my funeral or other memorial service.

PART V. GENERAL PROVISIONS

REIMBURSEMENT

My Agent is to be reimbursed for all out-of pocket costs while serving as my Agent.

EXCULPATION OF AGENT AND THIRD PARTIES

For the purpose of inducing any individual, organization or entity to act in accordance with the instructions of my Agent as authorized in this document, I hereby represent, warrant and agree that no person, organization or entity who relies in good faith upon the authority of my Agent under this document will incur any liability by me, my estate, my heirs, successors or assigns. My Agent is authorized to indemnify, on my behalf (or on behalf of my estate, heirs, successors or assigns) any person who relies in good faith upon the authority of my Agent for any loss or liability suffered as a result of such reliance. My Agent and my Agent's estate, heirs, successors and assigns are hereby released and forever discharged by me, my estate, my heirs, successors and assigns from all liability and from all claims or demands of all kinds arising out of the acts or omissions of any Agent, except for willful misconduct or gross negligence. My estate and/or trust shall indemnify my Agent and my Agent's estate, heirs, successors and assigns fro any loss suffered or liability incurred for all claims or demands of all kinds arising out of the acts or omissions of my Agent, except for willful misconduct or gross negligence.

RESIGNATION AND INCAPACITY

My Agent may resign by delivering written notice to me, or if I lack capacity to receive such notice, then upon delivery to the Agent's successor named herein. In addition, the incapacity of my Agent or successor Agent will be deemed a resignation by such individual without requirement of notice. My Agent shall be deemed incapacitated upon the Certification of 2 physicians that my Agent is incapable of managing his or her personal or financial affairs.

GOVERNING LAW

This document shall be governed by the laws in the State of Hawai'i, unless my Agent moves me to another jurisdiction, in which the laws of that new jurisdiction will then apply in the sole and absolute discretion of my Agent.

ADVICE OF LAWYER OBTAINED

My lawyer has advised me concerning my rights in connection with this advance directive and the applicable law and the consequences of signing or not signing this advance directive.

USE OF COPIES PERMITTED

Persons dealing with my Agent may rely fully on a photocopy of this document as though the photocopy was an original.

Date: _____ _____

NAME

THIS DOCUMENT MUST EITHER BE NOTARIZED **OR** SIGNED BY TWO WITNESSES.

HAWAII ACKNOWLEDGMENT
H.R.S. 502-41(G); H.A.R. 5-11-8

State of Hawai'i)
) ss.
County of Hawai'i)

On this _____ day of _____, 20_____, in the _____3rd_____ Circuit, State of
Day *Month* *Year* *Name of Circuit*

Hawai'i, before me personally appeared _____
Name of Signor

to me personally known (or satisfactorily proven) to be the person whose name is subscribed to this instrument, who, being by me duly sworn or affirmed, did say that such person executed the foregoing instrument identified or described as Advance Health-Care Directive
Type of Document

as the free act and deed of such person, and if applicable, in the capacity shown having been duly authorized to execute such instrument in such capacity. The foregoing instrument is dated

_____ and contained __8__ pages at the time of this acknowledgment /certification.
Date of Document *No. of pages*

Witness my hand and seal.

_____
(Printed Name of Notary Public)
Notary Public – STATE OF HAWAII

My commission expires: _____

_____
(Signature of Notary Public)

(Place Notary Seal or Stamp Above)

WITNESS STATEMENTS

I am not the person appointed as Agent or successor Agent in this medical power of attorney. I am not related to (your name in each of these blank areas)_____ by blood or marriage. I am not entitled to any portion of the _____ estate, nor do I have any claim against their estate. I am not the attending physician of _____ or an employee of the attending physician. I am not involved in providing direct patient care to _____ and not an officer, director, partner, or business office employee of the health-care facility or of any parent organization of the healthcare facility.

SIGNATURE OF THE FIRST WITNESS

Signature: _____

Print Name: _____ Date: _____

Address: _____

SIGNATURE OF THE SECOND WITNESS

Signature: _____

Print Name: _____ Date: _____

Address: _____