Triage Cancer Estate Planning Toolkit: Hawaii

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Hawaii probate courts accept written and holographic wills. To make a valid written will in Hawaii:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will or authorize someone to do so for you, in front of two witnesses who are not included in your will.
3. Your will does not need to be notarized to be legal in Hawaii, but you might want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, sign an affidavit in front of a notary to prove your identity and that all parties had knowledge of the will.

Due to the COVID-19 pandemic, Hawaii now allows you to execute your will remotely (e.g. sign an affidavit by teleconferencing with a notary). However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

A holographic will is one that is handwritten by you. To make a valid holographic will in Hawaii:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written and signed in your handwriting.

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove their validity in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Hawaii's statutory form for power of attorney allows you to appoint someone to manage your finances for you, including your property, taxes, and government benefits. You can also appoint a successor agent or co-agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. You can also use this document to nominate a conservator in advance, in case a court decides one is

necessary. Your agent is entitled to reasonable compensation for their help if you do not specify otherwise in the "special instructions" section. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it and will remain in effect until you die, unless you revoke your power of attorney.

Part III includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In Hawaii, this document includes two parts:

1. **Durable Power of Attorney for Health Care:** You can use this form to appoint someone (an agent) to make any and all decisions about your medical care for you, including life-sustaining care, if you become unable. You can also choose an alternate person if the first person you appoint is not available. This document takes effect when your primary physician determines you can no longer understand or communicate your preferences for health care, or immediately, if you would like.
2. **Instructions for Health Care:** Sometimes called a "living will," this document lets you indicate your preferences for end-of-life health care if you become unable to speak for yourself. You can provide instructions for specific situations, including administering or withholding cardiopulmonary resuscitation, artificial respiration, artificially administered nutrition (food offered through surgically-placed tubes), comfort or pain management therapy, and any other instructions you would like to include.
3. If you wish to make additional instructions, such as body and organ donation, you can sign, date, and witness or notarize additional pages indicating those wishes.

To make your AHCD valid, you can sign it and have it notarized, or sign in front of two adult witnesses. Your witnesses may not be the person you chose to make health care decisions for you or an employee of your health care provider. One of your witnesses may not be related to you by blood, adoption, or marriage, or entitled to any portion of your estate.

If you change your mind about the instructions in your AHCD, revoke the designation of your agent by writing a statement or telling your supervising health care provider. You can revoke any other part of your AHCD at any time and in any way that communicates your intent.

Part III of this toolkit includes a sample form.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance health care directive. You can complete a POLST form with your doctor. In Hawaii, this form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or food and hydration offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

Part III of this toolkit includes a sample form.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Hawaii does not have a funeral designation form. Hawaii does provide statutory authorization for you to provide instructions on what you would like to happen to your remains and designate an individual to carry out those wishes.

Part III of this toolkit includes a sample form.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Hawaii's Our Care, Our Choice Act has protected your right to control your end-of-life care since 2019. Qualified patients must:

- Be 18 years or older
- Be a Hawaii resident
- Be able to make and communicate medical decisions for yourself and take the medication on your own
- Be diagnosed with an incurable terminal illness with a prognosis six months or less to live, confirmed by three providers (your primary physician, a consulting physician, and a counseling provider)

If you would like to request aid-in-dying medication, start by talking to your physician. Your conversation could include discussing alternative and additional therapies (like comfort care or pain management), ways to involve loved ones, and the effects and process of taking an aid-in-dying medication. After this conversation, you must:

- Verbally ask for the medication twice, at least 20 days apart.
- Submit a written request for the medication using the required form. This request should come after your second verbal request.
- After receiving all three requests, your doctor will refer you to another doctor to verify your diagnosis and prognosis.

Taking aid-in-dying medications will not affect any life, health, or accident insurance policies you might have. If you pass away after taking an aid-in-dying medication, your death certificate will indicate that you died naturally from an underlying illness.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

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Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- Hawaii Sample Form for Disposition of Remains
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

PART III. STATUTORY FORMS

[§551E-51] Statutory form power of attorney. A document substantially in the following form may be used to create a statutory form power of attorney that has the meaning and effect prescribed by this chapter.

STATE OF HAWAII
STATUTORY FORM POWER OF ATTORNEY
IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property, including your money, whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney Act in chapter 551E, Hawaii Revised Statutes.

This power of attorney does not authorize the agent to make health care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent, you may name a co-agent in the Special Instructions. Co-agents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

DESIGNATION OF AGENT

I _____ name the following person
(Name of Principal)

as my agent:

Name of Agent:

Agent's Address:

_____

Agent's Telephone Number:

_____

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent:

_____

Successor Agent's Address:

_____

Successor Agent's Telephone Number:

_____

If my successor agent is unable or unwilling to act for me, I name as my second successor agent:

Name of Second Successor Agent:

_____

Second Successor Agent's Address:

_____

Second Successor Agent's Telephone Number:

_____

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act in chapter 551E, Hawaii Revised Statutes.

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

(_____) Real Property
(_____) Tangible Personal Property
(_____) Stocks and Bonds
(_____) Commodities and Options

(_____) Banks and Other Financial Institutions
(_____) Operation of Entity or Business
(_____) Insurance and Annuities
(_____) Estates, Trusts, and Other Beneficial Interests
(_____) Claims and Litigation
(_____) Personal and Family Maintenance
(_____) Benefits from Governmental Programs or Civil or Military Service
(_____) Retirement Plans
(_____) Taxes
(_____) All Preceding Subjects

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.)

(_____) Create, amend, revoke, or terminate an inter vivos trust
(_____) Make a gift, subject to the limitations of the Uniform Power of Attorney Act under section 551E-47, Hawaii Revised Statutes, and any special instructions in this power of attorney
(_____) Create or change rights of survivorship
(_____) Create or change a beneficiary designation
(_____) Authorize another person to exercise the authority granted under this power of attorney
(_____) Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
(_____) Exercise fiduciary powers that the principal has authority to delegate

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____

_____
_____
_____
_____
_____

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

NOMINATION OF CONSERVATOR OR GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a conservator or guardian of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for conservator or guardian of my estate:

_____

Nominee's Address:

_____

Nominee's Telephone Number:

_____

Name of Nominee for guardian of my person:

_____

Nominee's Address:

_____

Nominee's Telephone Number:

_____

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

_____
Your Signature Date

_____
Your Name Printed

_____
Your Address

_____
Your Telephone Number

State of _____

County of _____

This document was acknowledged before me on _____ ,
(Date)

by _____
(Name of Principal)

_____ (Seal, if any)

Signature of Notary

My commission expires: _____

This document prepared by:
_____

_____

IMPORTANT INFORMATION FOR AGENT
Agent's Duties
When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:

(1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;

(2) Act in good faith;

(3) Do nothing beyond the authority granted in this power of attorney; and

(4) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

(Principal's Name) by (Your Signature) as Agent
Unless the Special Instructions in this power of attorney state otherwise, you must also:

(1) Act loyally for the principal's benefit;

(2) Avoid conflicts that would impair your ability to act in the principal's best interest;

(3) Act with care, competence, and diligence;

(4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal;

(5) Cooperate with any person that has authority to make health care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and

(6) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

(1) Death of the principal;

(2) The principal's revocation of the power of attorney or your authority;

(3) The occurrence of a termination event stated in the power of attorney;

(4) The purpose of the power of attorney is fully accomplished; or

(5) If you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act, in chapter 551E, Hawaii Revised Statutes. If you violate the Uniform Power of Attorney Act in chapter 551E, Hawaii Revised Statutes, or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

[L 2014, c 22, pt of §1]

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

Advance Health Care Directive form

Date:

Your Name: Last First Middle initial

Street Address City State Zip

Part 1: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

The following statements only apply
• if I am close to death and life support would only postpone the moment of my death **OR**
• if I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is unlikely that I will ever become conscious **OR**
• if I have brain damage or a brain disease that makes me permanently unable to make and communicate health-care decisions about myself.

(INITIAL ONLY ONE (1) CHOICE IN EACH SECTION and CROSS OUT ALL THAT DO NOT APPLY.)

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.
OR
____ 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.
OR
____ NO, I do not want artificial nutrition and hydration.

C. Relief from Pain

____ YES, I do want treatment to relieve my pain or discomfort.
OR
____ NO, I do not want treatment to relieve my pain or discomfort.

D. Ethical, religious, or spiritual instructions (optional)

Is there a church, temple, spiritual group or a special person from whom you wish to receive spiritual care?

Name: Phone

Street Address City State Zip

E. do you want hospice care, if appropriate? ____ YES ____ NO

(Hospice provides physical, psychosocial, emotional, and spiritual support and counseling for the patient and his/her family. Hospice is available in home, hospital, hospice-unit, and nursing home settings.)

F. Primary care physician

Name: Phone

G. Other Wishes:

If you do not agree with any of the choices above or wish to add other instructions, including body and organ donation, you may add pages. If you are or could become pregnant, consult your doctor, and consider adding special instructions suspending or adding provisions. Remember to sign, date, witness or notarize additional pages. File a copy with:

☐ Doctor copy ☐ Family Copy ☐ Agent Copy ☐ www.myhealthdirective.com

PART 2: HEALTH-CARE POWER OF ATTORNEY AGENT'S AUTHORITY AND OBLIGATION

My agent shall make health-care decisions for me in accordance with my best interests and wishes so far as they are known. In determining my best interest, my agent shall consider my personal values. If a guardian of my person needs to be appointed for me by a court, I nominate my agent. I designate the following individual as my agent. He/she may make all health-care decisions for me if I am unable or unwilling to make them for myself unless I direct otherwise:

Name of Agent (Spouse, adult child, friend or other trusted person) Relationship

Street Address City State Zip

Home Phone Work Phone E-mail

If my agent is not available, I designate the following person as my alternative agent:

Name of Alternate Agent (Spouse, adult child, friend or other trusted person) Relationship

Street Address City State Zip

Home Phone Work Phone E-mail

____ My agent may make all health-care decisions for me. **OR**
____ My agent may make all health-care decisions for me except: _____

____ My agent's authority becomes effective when my primary physician determines that I am unable to make health-care decisions.**OR**
____ My agent's authority to make health-care decisions for me takes effect immediately.

YOUR NAME: Print Your Full Name Your Signature Date

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

Witness #1 Print Name Witness Signature Date

Address City State Zip Code

Witness #2 Print Name Witness Signature Date

Address City State Zip Code

OPTION 2: Notary Public

State of Hawai'i, _____ (County)
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 instrument and acknowledged that he or she executed it.

_____

My Commission Expires:_____

A copy has the same effect as the original.

Developed by the Executive Office on Aging, State of Hawai'i – Revised September 2003.

Checklist:

___ **Talk with your spouse, adult children, family, friends, spiritual advisors, and doctors** about what would be important to you.

___ **Ask someone you trust and can count on to be your health care agent.** Discuss your wishes with this person. Select an alternate health care agent in case your agent is unable to serve.

___ **Complete the enclosed optional Advance Health Care Directive** or make a document of your own. You can add more pages if needed.

___ **Have two qualified witnesses or a notary public witness your signature.**

___ **Inform family, friends, and doctors that you have an Advance Health Care Directive** and that you expect them to honor your wishes. Keep them informed about your current wishes.

___ **Give copies of the Advance Directive** to your health care agent, health care providers, family, close friends, spiritual advisors, and any other individuals who might be involved in your care. **Register your Advance Directive free of charge in Hawaii's own Document Bank at www.myhealthdirective.com.**

___ **Place copies in your medical files.**

___ **Keep a copy in any easy to find place in your home.** (Not in a safe deposit box!!) You could leave a note on the refrigerator to tell people where your important documents are so they can be found when they are needed.

___ You may **designate "Advance Directive" on your driver's license or state identification card** to indicate that you have completed an Advance Directive and wish it to be honored. Hawaii drivers' license stations do not file Advanced Directives.

___ **Review your Advance Directive regularly.** In case you make changes, inform people, create a new document, and replace the old one.

This brochure provides general information and does not constitute legal advice and may not apply to your individual situation.

Developed by the Executive Office on Aging, State of Hawai'i.
Checklist originally developed by UH Elder Law Program.
Revised April 2002.

Your Advance Directive for Future Health Care

It is a gift to family members and friends
so that they won't have to guess what you want
if you no longer can speak for yourself.

Kōkua Mau
"Continuous Care"

MYhealthDIRECTIVE.COM

Why do I need an Advance Directive?

Medical technology has given us many new options for sustaining life. This makes it important for you to discuss what kind of care you want before serious illness or accident occurs.

Now is the time to talk about these important issues while you can still make your own decisions and have time to talk about them with others.

If you don't have an Advance Directive and even one person interested in your care disagrees, your doctor may not honor your wishes for end-of-life care.

The Advance Directive takes the place of the former living will document and gives you more options. Review your existing forms to decide if an Advance Health Care Directive will better reflect your wishes.

What do I put in my Advance Directive?

The kind of health treatment you want or don't want.

You can say whether or not you want to be kept alive by machines that breathe for you or feed you even if there is no hope you will get better.

Your wishes for comfort care.

You can indicate whether you want medicine for pain or where you want to spend your last days. You can also give spiritual, ethical, and religious intructions.

The person or "agent" you want to make decisions for you when you cannot.

This agent does not have to be an attorney. Unless you limit your agent's authority, your agent has the right to accept or refuse any kind of medical care and testing, discharge or select doctors, and see all medical records.

How can I ensure my Advance Directive is honored?

Share copies and talk with people who will be involved in your care. Ask your doctor to insert your Advance Directive into your medical records. Register your Advance Directive free of charge at www.MyHealthDirective.com or call 587-4781.

Instructions for Advance Health Care Directive (in accordance with the Uniform Health Care Decisions Act, 1999)

Complete Part 1 and 2 on the enclosed form. You may add pages and make any changes you wish. You do not need an attorney to complete this form. If you need more help, consult the phone numbers included in this brochure. Complete the check list on the back page.

Part 1 – Individual Instruction

Give instructions to your doctor and others about any aspect of your health care. You will be given choices. Check only one box in each category and cross out all which do not apply.

Part 2 – Health Care Power of Attorney, your agent

Select one or more persons to be your agent and make health care decisions if you are unable. The person you appoint can be a spouse, adult child, friend, or any other trusted person. Your agent cannot be an owner or employee of a health care facility where you are receiving care unless they are related to you.

Ask two witnesses to sign and date the form

Both must be people you know. They cannot be health care providers, employees of a health care facility, or the person you choose as an agent. One person cannot be related to you or have inheritance rights.

Notary Public

If you do not have 2 witnesses, your Advance Directive must be notarized.

You have **the right to revoke or change your Advance Directive at any time** orally or in writing. Be sure to tell your agent and doctor.

Who can help me complete my Advance Directive?

Kauai: Seniors Law Program	**808-246-0573**
Maui, Molokai, Lanai: Legal Aid Society	**808-242-0724**
Oahu: UH Elder Law Program	**956-6544**
	www.hawaii.edu/uhelp
Big Island: Legal Aid Society (Hilo)	**808-934-0678**
(Kona)	**808-329-8331**

For further information contact:

Kokua Mau (Continuous Care) website at **www.kokuamau.org**.
Kokua Mau Speaker's Bureau: (800) 474-2113. Churches, Temples or Spiritual Groups can ask about the Complete Life Course.

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Physician Orders for Life Sustaining Treatment (POLST)

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person"s current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient „s Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A — Cardiopulmonary Resuscitation (CPR): *Person has no pulse and is not breathing.*

Check One

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)
(Section B: Full Treatment required)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B — Medical Interventions: *Person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure) ***Transfer*** to hospital if indicated. Avoid intensive care.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — Artificially Administered Nutrition: *Always offer food and liquid by mouth if feasible and desired.*

Check One

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.
Goal:_____

☐ Long-term artificial nutrition by tube.

Additional Orders:_____

D — Signatures and Summary of Medical Condition:

Discussed with:

☐ Patient ☐ Patient"s Surrogate (Health Care Decision-maker) ☐ Parent of Minor ☐ Guardian

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person"s medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Surrogate, Parent of Minor or Guardian

By signing this form, the legally recognized decision maker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and in the best interests of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)

Summary of Medical Condition	Office Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle)	Date of Birth	Gender: M F
Patient Current Address		

Contact Information

Patient"s Surrogate (Health Care Decisionmaker)	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional

Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/surrogate to be valid. Verbal orders are not acceptable.
- A surrogate may be designated by a patient or if the patient lacks capacity to consent to or refuse treatment, a non-designated surrogate may be appointed by consensus of the interested persons as per HRS §327E-5.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Section C:

- A surrogate who is not designated by the patient may make all health-care decisions for the patient except that artificial nutrition and hydration may be withheld or withdrawn only when the primary physician and a second independent physician certify in the medical records that the provision/continuation of nutrition/hydration prolongs the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327E-5.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person"s health status, or
- The person"s treatment preferences change.

Modifying and Voiding POLST

- A person with capacity or, if lacking capacity, the surrogate can request a different treatment plan and may revoke the POLST at any time and in any manner that communicates an intention as to this change.
- To void or modify a POLST form, draw a line through Sections A through D and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modifications.
- The patient"s physician may medically evaluate the patient and recommend new orders based on the patient"s current health status and goals of care.

Kokua Mau – *The Hawaii Hospice and Palliative Care Organization*

Kokua Mau is the lead agency for implementation of POLST in Hawaii. This form has been adopted by the Department of Health *(August 2009)*. For more information or to download a copy, visit www.kokuamau.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Triage Cancer Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Funeral Designation Form

WRITTEN INSTRUMENT
TO CONTROL DISPOSITION OF REMAINS

State of Hawai'i _____)
) SS
County of _____)

I, _____ do hereby designate _____

as the sole person who will have the right to determine and decide the disposition of my remains upon my death and the arrangements for funeral goods and services. I _____ have/ _____ have not attached specific directions concerning the disposition of my remains. If I have attached specific directions, the designee shall substantially comply with the specific directions, provided the directions are lawful and there are sufficient resources in my estate to carry out the directions.

SIGNATURE: Sign and date the form here:

_____ _____
(Sign Your Name) *(Date)*

_____
(Print Your Name)

DECLARATION OF NOTARY:

Subscribed and sworn before me, _____(insert name of notary public), on this _____ day of _____, in the year _____.

Notary Seal

_____
(Signature of Notary Public)

My Commission Expires: _____

(Notary certification appears on back of page)

Document Date _____ # Pages: _____

Name: _____, _____ Circuit

Doc. Description: _____

_____

Signature _____ Date _____

Notary Certification

Triage Cancer Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524