NEW HAMPSHIRE ADVANCE DIRECTIVE

NOTE: This form has two sections.
You may complete both sections, or only one section.

I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, of _____, New Hampshire, born on
(your name) *(your city of residence)*

_____, hereby appoint _____ of _____,
(your date of birth) *(agent 1's name)* *(agent 1's city)*

_____, whose telephone numbers on this date are _____ (home/cell)
(agent 1's state) *(agent 1's phone #)*

and _____ (work/cell), as my agent to make any and all health care decisions
(agent 1's phone #)

for me, except to the extent I state otherwise in this directive or as prohibited by law. **This durable power of attorney for health care shall take effect in the event I lack the capacity to make my own health care decisions.**

In the event that _____ is unable, unwilling or unavailable, or
(agent 1's name)

ineligible to act as my health care agent, I hereby appoint _____
(agent 2's name)

of _____, _____, whose telephone numbers on this date are
(agent 2's city) *(agent 2's state)*

_____ (home/cell) and _____ (work/cell), as my alternate agent.
(agent 2's phone #) *(agent 2's phone #)*

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE DECISIONS.

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: medically administered nutrition and hydration, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish, you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

A. LIFE-SUSTAINING TREATMENT.

1. If I am near death and lack the capacity to make health care decisions, I authorize my agent to direct that:
(initial beside your choice of (a) or (b))

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

2. Whether near death or not, if I become permanently unconscious I authorize my agent to direct that:
(initial beside your choice of (a) or (b))

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

B. ADDITIONAL INSTRUCTIONS.

Here you may include any specific desires or limitations you deem appropriate, such as your preference concerning medically administered nutrition and hydration, when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or are unacceptable to you for any other reason. You may leave these questions blank if you desire.

_____
(initial here if you agree) If I am incapacitated and I object to treatment, treatment may be given to me against my objection. (This option is intended to grant your agent additional authority, if for example you have dementia, and you try to change the treatment being recommended by your agent and health provider.) (initial beside this statement if you agree)

_____
(initial here if you agree) I grant my agent authority to request or agree to a DNR order. (initial beside this statement if you agree)

I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d and 45 CFR 160-164. I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or any other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver such revocation to my health care provider.
(attach additional pages as necessary)

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this directive. I have read and understand the information contained in the disclosure statement.

The original of this directive will be kept at _____, and the following persons and institutions will have signed copies:

_____

_____

_____

Signed this _____ day of _____, 20_____.
(day) *(month)* *(year)*

Principal's Signature: _____
(your signature)

THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness:_____ Address:_____

Witness:_____ Address:_____

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Durable Power of Attorney for Health Care was acknowledged before me this _____ day of _____, 20____.

_____
Notary Public/Justice of the Peace

My Commission Expires:

(Seal)

II. LIVING WILL

Declaration made this _____ day of _____, 20_____.
(day) *(month)* *(year)*

I, _____, of _____, County of _____,
(your name) *(your city of residence)* *(your county of residence)*

State of New Hampshire, born on _____, being of sound mind, willfully
(*your date of birth)*

and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness and I am certified to be near death or in a permanently unconscious condition by two (2) physicians or a physician and an APRN (Advanced Practice Registered Nurse), and two (2) physicians or a physician and an APRN have determined that my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or that I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the natural ingestion of food or fluids by eating and drinking, or the performance of any medical procedure deemed necessary to provide me with comfort care.

(Initial below if it is your choice)

In carrying out any instruction I have given under this section, I authorize that even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.
_____

In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and health care providers as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed this _____ day of _____, 20____.
(day) *(month)* *(year)*

Principal's Signature: _____
(your signature)

THIS LIVING WILL DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time the living will is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness:_____ Address:_____

Witness:_____ Address:_____

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Living Will was acknowledged before me this _____ day of _____, 20____.

_____
Notary Public/Justice of the Peace

My Commission Expires:

(Seal)

INFORMATION CONCERNING THE DURABLE

POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING IT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except if you say otherwise in the directive, this directive gives the person you name as your health care agent the power to make any and all health care decisions for you when you lack the capacity to make health care decisions for yourself (in other words, you no longer have the ability to understand and appreciate generally the nature and consequences of a health care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care). "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your health care agent, therefore, will have the power to make a wide range of health care decisions for you. Your health care agent may consent (in other words, give permission), refuse to consent, or withdraw consent to medical treatment, and may make decisions about withdrawing or withholding life-sustaining treatment. Your health care agent cannot consent to or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy, unless the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this directive any treatment you do not want, or any treatment you want to be sure you receive. Your health care agent's power will begin when your doctor certifies that you lack the capacity to make health care decisions (in other words, that you are not able to make health care decisions). If for moral or religious reasons you do not want to be treated by a doctor or to be examined by a doctor to certify that you lack capacity, you must say so in the directive and you must name someone who can certify your lack of capacity. That person cannot be your health care agent or alternate health care agent or any person who is not eligible to be your health care agent. You may attach additional pages to the document if you need more space to complete your statement.

Under no conditions will your health care agent be able to direct the withholding of food and drink that you are able to eat and drink normally.

Your agent shall be directed by your written instructions in this document when making decisions on your behalf, and as further guided by your medical condition or prognosis. Unless you state otherwise in the directive, your agent will have the same power to make decisions about your health care as you would have made, if those decisions by your health care agent are made consistent with state law.

It is important that you discuss this directive with your doctor or other health care providers before you sign it, to make sure that you understand the nature and range of decisions which could be made for you by your health care agent. If you do not have a health care provider, you should talk with someone else who is knowledgeable about these issues and can answer your questions. Check with your community hospital or hospice for trained staff. You do not need a lawyer's assistance to complete this directive, but if there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

The person you choose as your health care agent should be someone you know and trust, and he or she must be at least 18 years old. If you choose your health or residential care provider (such as your doctor, advanced practice registered nurse, or an employee of a hospital, nursing home, home health agency, or residential care home, other than a relative), that person will have to choose between acting as your health care agent or as your health or residential care provider, because the law does not allow a person to do both at the same time.

You should consider choosing an alternate health care agent, in case your health care agent is unwilling, unable, unavailable or not eligible to act as your health care agent. Any alternate health care agent you choose will then have the same authority to make health care decisions for you.

You should tell the person you choose that you want him or her to be your health care agent. You should talk about this directive with your health care agent and your doctor or advanced practice registered nurse and give each one a signed copy. You should write on the directive itself the people and institutions who will have signed copies. Your health care agent will not be liable for health care decisions made in good faith on your behalf.

EVEN AFTER YOU HAVE SIGNED THIS DIRECTIVE, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AS LONG AS YOU ARE ABLE TO DO SO, AND TREATMENT CANNOT BE GIVEN TO YOU OR STOPPED OVER YOUR CLEAR OBJECTION. You have the right to revoke the power given to your health care agent by telling him or her, or by telling your health care provider, orally or in writing, that you no longer want that person to be your health care agent.

YOU HAVE THE RIGHT TO EXCLUDE OR STRIKE REFERENCES TO APRN'S IN YOUR ADVANCE DIRECTIVE AND IF YOU DO SO, YOUR ADVANCE DIRECTIVE SHALL STILL BE VALID AND ENFORCEABLE.

Once this directive is executed it cannot be changed or modified. If you want to make changes, you must make an entirely new directive.

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR JUSTICE OF THE PEACE OR TWO (2) OR MORE QUALIFIED WITNESSES, WHO MUST BOTH BE PRESENT WHEN YOU SIGN AND WHO WILL ACKNOWLEDGE YOUR SIGNATURE ON THE DOCUMENT. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

- the person you have designated as your health care agent;
- your spouse or heir at law;
- your attending physician or APRN, or person acting under the direction or control of the attending physician or APRN;

ONLY ONE OF THE TWO WITNESSES MAY BE YOUR HEALTH OR RESIDENTIAL CARE PROVIDER OR ONE OF YOUR PROVIDER'S EMPLOYEES.

Definitions

In executing this form, you may authorize your health care agent to direct whether or not life-sustaining treatment may be started and/or discontinued for you when you are near death or permanently unconscious.

"Near death" is defined as "an incurable condition caused by injury, disease, or illness which is such that death is imminent and the application of life-sustaining treatment would, to a reasonable degree of medical certainty, as determined by 2 physicians or a physician and an APRN, only postpone the moment of death."

"Permanently unconscious" is defined as "a lasting condition, indefinitely without improvement, in which thought, awareness of self and environment, and other indicators of consciousness are absent as determined by an appropriate neurological assessment by a physician in consultation with the attending physician or an appropriate neurological assessment by a physician in consultation with an APRN."

INSTRUCTIONS FOR SIGNING
NEW HAMPSHIRE ADVANCE DIRECTIVE

The New Hampshire Advance Directive has been designed to be easy for people to sign. This document has two parts: a Durable Power of Attorney for Health Care and a Living Will. You may choose to sign either or both parts of this document.

When you sign the Advance Directive, you will need either two independent witnesses or a notary public or justice of the peace. Before you sign the Durable Power of Attorney for Health Care, please review the informational pages also enclosed. When you execute the Durable Power of Attorney for Health Care, you will need to initial on the line to the left of your response to each of the two questions raised on the second page relating to the termination of artificial life support. On the second page, there is also a statement which would permit your agent to make decisions for you if you are incapacitated and object to treatment. We recommend that you consider granting this authority to your agent by initialing on the line beside the statement. There is also a statement on the second page which would allow your agent to have the authority to agree to a DNR order. If you would like your agent to have this authority to agree to a DNR, you should initial on the line beside this statement.

The Living Will also includes a statement relating to the termination of medically administered nutrition and hydration. When you execute this part of the document, you will need to initial on the line below this statement only if you want medically administered nutrition and hydration to continue to be given to you even if all other forms of life-sustaining treatment have been withdrawn.

At the time of signing, please assemble either a notary public, justice of the peace, or two witnesses. The witnesses must not be related to you, a person designated as your agent, or your physician. Insert all requested information about yourself and your agents in the blank spaces. You will initial your answers to the questions as discussed above, complete the date and sign as the “Principal” in each place indicated. You will notice that the Living Will includes the date on both pages. Witnesses must sign on the lines indicated and include the town and state of residence on the line indicated for the address.