NEW HAMPSHIRE ADVANCE DIRECTIVE

Name (Principal's Name): _____

DOB: _____

Address: _____

I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

The durable power of attorney for healthcare form names your agent(s) and, if you wish, sets limits on what your agent can decide.

I choose the following person(s) as agent(s) if I have lost capacity to make health care decisions (cannot make health care decisions for myself).
(If you choose more than one person, they will become your agent in the order written, unless you indicate otherwise.)

A. Choosing Your Agent:

Agent: I appoint _____ of _____, _____, whose telephone number is (____) _____-_____, to be my agent to make health care decisions for me.

Alternate Agent: If the person above is not able, willing or available, I appoint _____ of _____, _____, whose telephone number is (____) _____-_____, to be my alternate agent.

If no one listed above can make decisions for you, a surrogate will be assigned in the order written in law (spouse, adult child, parent, sibling, etc.), and will have the same powers as an agent. If there is no surrogate, a court appointed guardian may be assigned.

B. Limiting Your Agent's Authority or Providing Additional Instructions

When you can no longer make your own health care decisions, your agent will be able to make decisions for you. Please review the Disclosure Statement that is attached to this advance directive for examples of how you may want to advise your agent. You may write in limits or additional instructions below or attach additional pages.

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.

_____

_____

I have attached ___ additional pages titled "Additional wishes for my Durable Power of Attorney for Health Care" to express my wishes.

II. LIVING WILL

If you would like to provide written guidance to your agent, surrogate, and/or medical practitioners in making decisions about life sustaining medical treatment if you cannot make your own decisions, you may complete the options below.

CHOOSE ITEM A OR B. Initial your choice:

If I suffer from an advanced life-limiting, incurable and progressive condition:

_____ A. I wish to have all attempts at life-sustaining treatment (within the limits of generally accepted health care standards) to try to extend my life as long as possible, no matter what burdens, costs or complications may occur.

OR

_____ B. I do NOT wish to have any life-sustaining treatment attempted that I would consider to be excessively burdensome or that would not have a reasonable hope of benefit for me. I wish to receive only those forms of life-sustaining treatment that I would not consider to be excessively burdensome AND that have a reasonable hope of benefit for me. The following are situations that I would consider excessively burdensome except those that I have crossed out and initialed: (Cross out and initial any of the below statements # 1-3 if you **disagree**.)

1. I do not wish to have life-sustaining treatment attempted if I am actively dying (medical treatment will only prolong my dying).

2. I do not wish to have life-sustaining treatment attempted if I become permanently unconscious with no reasonable hope of recovery.

3. I do not wish to have life-sustaining treatment attempted if I suffer from an advanced life-limiting, incurable and progressive condition and if the likely risks and burdens of treatment would outweigh the expected benefits.

Other situations that I would consider excessively burdensome if I suffer from an advanced life-limiting, incurable and progressive condition include the following:

_____

_____

(I have attached __ additional pages titled "Living Will Burdens")

In these situations, I wish for comfort care only. I understand that stopping or starting treatments to achieve my comfort, including stopping medically-administered nutrition and hydration, may be a way to allow me to die when the treatments would be excessively burdensome for me.

III. SIGNATURE

I have received, reviewed, and understood the disclosure statement, and I have completed the durable power of attorney for health care and/or living will consistent with my wishes. I have attached __ pages to better express my wishes.

Signed this _____ day of _____, 2021.

Principal's Signature: _____

(If you are physically unable to sign, this advance directive may be signed by someone else writing your name in your physical presence at your direction.)

THIS ADVANCE 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 this advance directive is signed and that the principal affirms that the principal 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 advance directive was acknowledged before me this _____ day of _____, 2021, by _____ (the "Principal").

_____

Notary Public/Justice of the Peace

My Commission Expires:

(Seal)

AN ADVANCE DIRECTIVE IS A LEGAL DOCUMENT. YOU SHOULD KNOW THESE FACTS BEFORE SIGNING IT.

• This form allows you to choose who you want to make decisions about your health care when you cannot make decisions for yourself. This person is called your "agent". You should consider choosing an alternate in case your agent is unable to act.

• Agents must be 18 years old or older. They should be someone you know and trust. They cannot be anyone who is caring for you in a health care or residential care setting.

• This form is an "advance directive" that defines a way to make medical decisions in the future, when you are not able to make decisions for yourself. It is not a medical order (e.g., it is not in and of itself a DNR (do not resuscitate order or (POLST)).

• You will always make your own decisions until your medical practitioner examines you and certifies that you can no longer understand or make a decision for yourself. At that point, your "agent" becomes the person who can make decisions for you. If you get better, you will make your own healthcare decisions again.

• With few exceptions(*), when you are unable to make your own medical decisions, your agent will make them for you, unless you limit your agent's authority in Part I.B of the durable power of attorney form. Your agent can agree to start or stop medical treatment, including near the end of your life. Some people do not want to allow their agent to make some decisions. Examples of what you might write in include: "I do NOT want my agent . . .

- to ask for or agree to stop life-sustaining treatment (such as breathing machines, medically administered nutrition and/or hydration (tube feeding), kidney dialysis, other mechanical devices, blood transfusions, and certain drugs)."
- to ask for or to agree to a Do Not Resuscitate Order (DNR order)."
- to agree to treatment even if I object to it in the moment, after I have lost the ability to make health care decisions for myself."

• The law allows your agent to put you in a clinical trial (medical study) or to agree to new or experimental treatment that is meant to benefit you if you have a disease or condition that is immediately life-threatening or if untreated, may cause a serious disability or impairment (for example new treatment for a pandemic infection that is not yet proven). You may change this by writing in the durable power of attorney for health care form:

- "I want my agent to be able to agree to medical studies or experimental treatment in any situation." or
- "I don't want to participate in medical studies or experimental treatment even if the treatment may help me or I will likely die without it."

• Your agent must try to make the best decisions for you, based on what you have said or written in the past. Tell your agent that you have appointed them as your healthcare decision maker. Talk to your agent about your wishes.

• In the "living will" section of the form, you can write down wishes, values, or goals as guidance for your agent, surrogate, and/or medical practitioners in making decisions about your medical treatment.

• You do not need a lawyer to complete this form, but feel free to talk to a lawyer if you have questions about it.

• You must sign this form in the physical presence of 2 witnesses or a notary or justice of the peace for it to be valid. The witnesses cannot be your agent, spouse, heir, or anyone named in your will, trust or who may otherwise receive your property at your death, or your attending medical practitioner or anyone who works directly under them. Only one witness can be employed by your health or residential care provider.

• Give copies of the completed form to your agent, your medical providers, and your lawyer.

* Exceptions: Your agent may not stop you from eating or drinking as you want. They also cannot agree to voluntary admission to a state institution; voluntary sterilization; withholding life-sustaining treatment if you are pregnant, unless it will severely harm you; or psychosurgery.