NEW HAMPSHIRE
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
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CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    1. Instructions for preparing your advance directive, please read all the instructions.
    2. Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your New Hampshire Advance Directive

This packet contains a legal document, a **New Hampshire Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may fill out Part I, Part II, or both, depending on your advance planning needs. You must complete Part III.

Part I is the **New Hampshire Durable Power of Attorney for Health Care.** This part lets you name an adult, called your agent, to make decisions about your health care— including decisions about life-sustaining treatments—if you can no longer speak for yourself. The power of attorney for health care is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life.

Part I also allows you to express your desires regarding your health care and other advance planning decisions, including your desires regarding life-sustaining treatments, in order to help guide your agent.

Part I goes into effect when your doctor certifies in writing that you are no longer able to understand and appreciate generally the nature and consequences of your health care decision.

Part II is a **New Hampshire Living Will**, which is your state's living will. The declaration in Part II is limited to a statement that you want life-sustaining treatment withheld or withdrawn if you are actively dying or permanently unconscious. If this is not your choice, you should not complete Part II. In addition, because Part II is limited in this way and Part I allows you to express a broader range of choices, if you plan to complete Part I, you may wish to leave Part II blank and record your advance planning wishes in Part I only.

Part II goes into effect when your doctor and one other doctor certify that you are permanently unconscious or actively dying.

Part III contains the signature and witnessing provisions so that your document will be effective.

Following the advance directive is an **Organ Donation Form**.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult who is at least 18 years of age.

Instructions for Completing Your New Hampshire Advance Directive

How do I make my Advance Directive legal?

In order to make your Advance Directive legally binding you have two options:

1. Sign your document in the presence of two witnesses. Neither of your witnesses can be:
    - your agent,
    - your spouse,
    - your heir or any person entitled to any part of your estate, or
    - your attending physician or Advanced Registered Nurse Practitioner (ARNP), or any person acting under the direction and control of your attending physician or ARNP.

    In addition, one of your witnesses **cannot** be:
    - your health or residential care provider, or
    - an employee of your health or residential care provider

OR

2. Sign your document in the presence of a notary public or justice of the peace.

Who should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Your agent and alternate agent **cannot** be:

- your health care or residential care provider,
- an employee of your health care or residential care provider, unless such person is related to you

Should I add personal instructions to my Advance Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act

in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You can revoke you advance directive by:

1. A written revocation delivered to your agent or to your health care provider or residential care provider that expresses your intent to revoke your advance directive and that is signed and dated by you.
2. Orally revoking your advance directive in the presence of two or more witnesses, none of whom is your spouse or heir.
3. Any other act evidencing your intent to revoke the advance directive, such as burning, tearing, or obliterating the advance directive, or directing somebody else to destroy the document in your presence.
4. Executing a new advance directive.

If you named your spouse as your agent, filing an action for divorce, legal separation, annulment, or a protective order against your spouse will automatically revoke your spouse's authority as agent, unless you specify otherwise in the "instruction statements" section on page 3 of your form.

What other important facts should I know?

Your agent does not have the power to authorize any of the following:

- Voluntary admission to any state institution;
- Voluntary sterilization;
- Withholding life-sustaining treatment if you are pregnant, unless, to a reasonable degree of medical certainty, as certified by your doctor and an obstetrician who has examined you, such treatment will not aid in the continuing development and live birth of your fetus or it will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

DISCLOSURE STATEMENT

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE (PART I)

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."

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DISCLOSURE STATEMENT (CONTINUED)

• 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.

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PART I: NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME, DATE OF BIRTH, AND ADDRESS

Name (Principal's Name): _____
DOB: _____
Address: _____

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:

PRINT THE NAME ADDRESS, AND PHONE NUMBER OF YOUR AGENT

Agent: I appoint _____, of _____, and whose phone number is _____ to be my agent to make health care decisions for me.

PRINT THE NAME AND ADDRESS OF YOUR ALTERNATE AGENT

Alternate Agent: If the person above is not able, willing, or available, I appoint _____, of _____, and whose phone 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

INSTRUCTION STATEMENTS

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

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PART II. NEW HAMPSHIRE 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:

INITIAL ONLY ONE 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: (Cross out and initial any of the below statements # 1-4 if you disagree.)

IF YOU DISAGREE WITH ANY OF STATEMENTS #1-4, CROSS OUT AND WRITE YOUR INITIALS BESIDE EVERY STATEMENT THAT IS NOT TRUE FOR YOU

__ 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.

__ 4. Other situations that I would consider excessively burdensome if I suffer from an advanced life-limiting, incurable and progressive condition: (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.

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PART III: EXECUTION

This advance directive will not be valid unless it is EITHER:

Alternative No. 1: Signed by two (2) adult witnesses who are present when you sign or acknowledge your signature.

Neither of your witnesses **can be**:

- your agent,
- your spouse,
- your heir or any person entitled to any part of your estate either under your last will and testament or by operation of law,
- your attending physician or ARNP, or person acting under the direction and control of your attending physician or ARNP.

In addition, one of your witnesses **cannot** be:

- your health or residential care provider, or an employee of your health or residential care provider

OR

Alternative No. 2: Witnessed by a notary public or justice of the peace

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE WITNESSED, USE ALTERNATIVE NO. 1, BELOW (P. 6)

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE NOTARIZED, USE ALTERNATIVE NO. 2, BELOW (P. 7)

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Alternative No. 1: Sign before witnesses.

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.

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Signed this _____ day of _____, 20_____

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.)

WITNESS ATTESTATION

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 he or she is aware of the nature of the advance directive and is signing it freely and voluntarily.

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness 1:

Signature:_____Date_____

Print Name: _____

Residence Address: _____

Witness 2:

Signature:_____Date_____

Print Name: _____

Residence Address: _____

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Alternative No. 2: Sign before a notary public or justice of the peace.

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

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 _____, 20_____

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.)

A NOTARY PUBLIC OR JUSTICE OF THE PEACE MUST COMPLETE THIS SECTION

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC OR JUSTICE OF THE PEACE

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing advance directive was acknowledged before me this ___ day of_____, 20___, by_____(the "Principal").

_____

Notary Public/Justice of the Peace

My Commission Expires:_____

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Courtesy of CaringInfo

1731 King St., Suite 100, Alexandria, VA 22314 www.caringinfo.org, 800-658-8898

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

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NEW HAMPSHIRE ORGAN DONATION FORM – PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under New Hampshire law.

_____I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.
_____I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to New Hampshire law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

_____
_____

For (initial one):

_____ Any legally authorized purpose.
_____Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature:_____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in our presence. We signed this document as witnesses in the declarant's presence and in each other's presence.

Witness_____Date_____

Address _____

_____

Witness_____Date_____

Address _____

_____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA
22314 www.caringinfo.org, 800-658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your New Hampshire Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your New Hampshire document.

7. Be aware that your New Hampshire document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous <u>tax-deductible donation</u>**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

— —

YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_________	to support the mission of the National Hospice Foundation.

<u>Return to:</u>
National Hospice Foundation
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Philadelphia, PA 19182-4401

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OR donate online today: www.NationalHospiceFoundation.org/donate