

NEW HAMPSHIRE Advance Directive Planning for Important Healthcare Decisions

Caring Connections

1731 King St., Suite 100, Alexandria, VA 22314

www.caringinfo.org

800/658-8898

Caring Connections, 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.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

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 healthcare providers

Engage in personal or community efforts to improve end-of-life care

Using these Materials

BEFORE YOU BEGIN

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

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. 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.
6. 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, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

INTRODUCTION TO YOUR NEW HAMPSHIRE ADVANCE DIRECTIVE

This packet contains two legal documents that protect 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:

1. The **New Hampshire Durable Power of Attorney for Healthcare** lets you name someone to make decisions about your healthcare – including decisions about life support – if you can no longer speak for yourself. The Durable Power of Attorney for Healthcare is especially useful because it appoints someone to speak for you any time you lack the capacity to make your own healthcare decisions, not only at the end of life. The phrase “capacity to make healthcare decisions” means the ability to understand and appreciate generally the nature and consequences of a healthcare decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care. Your Durable Power of Attorney for Healthcare becomes effective when your doctor or advanced registered nurse practitioner (ARNP) certifies in writing that you lack the capacity to make health care decisions and makes the certification part of your medical record.

2. The **New Hampshire Declaration** is your state’s living will. It lets you state your wishes about healthcare in the event that you become near death or permanently unconscious, without hope of recovery from such condition and can no longer actively participate in the decision-making process. The term “near death” means an incurable condition caused by injury, disease, or illness which is such that death is imminent and the application of life-sustaining measures would, to a reasonable degree of medical certainty, only postpone the moment of death. “Permanently unconscious” means a lasting condition, indefinitely without improvement, in which thought, awareness of self and environment, and other indicia of consciousness are absent as determined by an appropriate neurological assessment by a physician in consultation with the attending physician or ARNP. Your doctor or ARNP must diagnose and certify in writing that you are near death or permanently unconscious, without hope of recovery from such condition, and that you are unable to actively participate in the decision-making process.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Instructions for Completing Your New Hampshire Advance Directive

These instructions apply to both the New Hampshire Durable Power of Attorney for Health Care and the New Hampshire Declaration (or Living Will).

Who should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care and mental health treatment 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 must be an adult who is of sound mind and clearly understands your wishes and is willing to accept the responsibility of making medical decisions for you. (An agent may also be called an “attorney-in-fact” “proxy.”)

Your agent cannot be your health care provider or residential care provider. Your agent cannot be an employee of your health care provider or residential care provider unless that person is related to you.

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, who must also sign the document to show that they personally know you and believe you to be of sound mind and under no duress, fraud or undue influence. 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

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

Instructions for Completing Your New Hampshire Advance Directive (continued)

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 medical and/or mental health situation changes and deal with situations that you did not foresee. If you add limitations to this document, you might unintentionally restrict your agent's power to act in your best interest.

What if I change my mind?

You can revoke your 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 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 subsequent advance directive.

If you named your spouse as your agent, filing an action for divorce, legal separation, annulment, or legal separation will automatically revoke your advance directive, unless you provide otherwise or unless there is alternate agent named in your advance directive.

**NEW HAMPSHIRE STATUTORY FORM DURABLE POWER OF ATTORNEY FOR
HEALTH CARE – PAGE 1 OF 6**

**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 to the extent you state 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. "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, 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 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 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. If for moral or religious reasons you do not want to be treated by a doctor or 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.

If you want to give your health care agent power to withhold or withdraw medically administered nutrition and hydration, you must say so in your directive. Otherwise, your health care agent will not be able to direct that. Under no conditions will your 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 and 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 had, if those decisions by your health care agent are made consistent with state law.

NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR HEALTH CARE
– PAGE 2 OF 6

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 may 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 appoint 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 registered nurse practitioner, 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 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 registered nurse practitioner 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 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 ARNP'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.

**NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR HEALTH CARE
– PAGE 3 OF 6**

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 ARNP, or person acting under the direction or control of the attending physician or ARNP;

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

INSTRUCTIONS

**NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 4 OF 6**

NEW HAMPSHIRE DURABLE POWER
OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME

I, _____,
(name)

PRINT THE NAME
AND ADDRESS OF
YOUR AGENT

hereby appoint _____
(name of agent)

of _____
(address)

In the event the person I appoint above is unable, unwilling or unavailable,
or ineligible to act as my health care agent, I hereby appoint

PRINT THE NAME
AND ADDRESS OF
YOUR ALTERNATE
AGENT

(name of an alternate agent)

of _____
(address)

as alternate agent.

INSTRUCTION
STATEMENTS

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: 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.

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**NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 5 OF 6**

INITIAL THE
RESPONSE THAT
REFLECT YOUR
WISHES

TERMINAL ILLNESS

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. MEDICALLY ADMINISTERED NUTRITION AND HYDRATION.

1. I realize that situations could arise in which the only way to allow me to die would be to not start or to discontinue medically administered nutrition and hydration. In carrying out any instructions I have given in this document, I authorize my agent to direct that:

____(a) medically administered nutrition and hydration not be started or, if started, be discontinued.

or

____(b) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

C. ADDITIONAL INSTRUCTIONS.

Here you may include any specific desires or limitations you deem appropriate, such as 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 this question blank if you desire.

PERMANENTLY
UNCONSCIOUS

MEDICALLY
ADMINISTERED
NUTRITION AND
HYDRATION

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

**NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR
HEALTH CARE - PAGE 6 OF 6**

LOCATION OF THE ORIGINAL AND COPIES

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.

DATE AND SIGN THE DOCUMENT HERE

The original of this document 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)

[If you are unable to sign, this directive may be signed by someone else writing your name, in your presence and at your direction.]

WITNESSING PROCEDURE

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.

WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness: _____ Address: _____

AND

Witness: _____ Address: _____

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

**STATE OF NEW HAMPSHIRE
COUNTY OF _____**

The foregoing durable power of attorney for health care 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 Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898*

NEW HAMPSHIRE DECLARATION – PAGE 1 OF 4

INSTRUCTIONS

PRINT THE DATE

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

PRINT YOUR NAME

I, _____,
(name)

being of sound mind, willfully 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 2 physicians or a physician and an ARNP, and two physicians or a physician and an ARNP 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 or drinking, or the performance of any medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue medically administered nutrition and hydration.

In carrying out any instruction I have given under this section, I authorize that:

(Initial beside your choice of (a) or (b).)

____(a) medically administered nutrition and hydration not be started or, if started, be discontinued,

or

____(b) even if other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

INITIAL THE RESPONSE THAT REFLECTS YOUR WISHES ABOUT ARTIFICIAL FEEDING

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ADD PERSONAL INSTRUCTIONS (IF ANY)

Other directions:

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 meaning and significance 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)

[If you are unable to sign, this directive may be signed by someone else writing your name, in your presence and at your direction.]

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: _____

DATE AND SIGN THE DOCUMENT HERE

WITNESSING PROCEDURE

WITNESSES SIGN HERE

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A NOTARY PUBLIC,
JUSTICE OF THE
PEACE OR OTHER
OFFICIAL SHOULD
COMPLETE THIS
SECTION

STATE OF NEW HAMPSHIRE
COUNTY OF _____

The foregoing living will was acknowledged before me this _____
day of _____, 20_____,

by _____ ("the Principal").

Notary Public/Justice of the Peace

My commission expires: _____

ORGAN DONATION
(OPTIONAL)

ORGAN DONATION – DOCUMENT OF GIFT (OPTIONAL)

Under New Hampshire law, you may make a gift of all or part of your body. If any of the statements below reflects your desire, please check the option next to the option that reflects your wishes. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law unless you give them notice that you do not want a gift made. The donation elections you make below survive your death.

You must sign this Document of Gift for it to take effect. If you are unable to sign, the document of gift shall be signed by another individual, and by two witnesses, all of whom have signed at your direction and in the presence of you and of each other, and shall state that it has been so signed.

After signature, you may amend or revoke this Document of Gift by: a signed statement; any form of communication during a terminal illness or injury addressed to a physician or surgeon; or the delivery of a signed statement to a specified donee to whom the Document of Gift has been delivered.

I hereby make this organ and tissue gift, if medically acceptable, to take effect upon my death. The words and marks (or notations) below indicate my desires:

- (a) any needed organ or tissue
- (b) only the following organs or tissue for the purpose of transplantation, therapy, medical research or education:

- (c) my body for anatomical study if needed.

Limitations or special wishes, if any, list below:

INITIAL THE
RESPONSE THAT
REFLECTS YOUR
WISHES ABOUT
ORGAN DONATION

SIGN AND DATE

Donor Signature: _____ Date: _____

Courtesy of Caring Connections
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You Have Filled Out Your Advance Directive, Now What?

1. Your New Hampshire Durable Power of Attorney for Healthcare and New Hampshire Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your New Hampshire documents.
6. Be aware that your New Hampshire documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**