

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, JOHN DOE, of _____, New Hampshire, hereby appoint my spouse, JANE DOE, of _____, New Hampshire, as my agent to make any and all health care decisions 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 the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint _____, of _____, _____, as alternate agent.

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 and life-sustaining treatment has no reasonable hope of benefit, 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. TREATMENT AGAINST OBJECTION.

There may be situations, such as in advanced cases of dementia, in which you may want your agent's decisions to be honored, even if you vocalize an objection to those decisions. In this context, please consider the following statement: *Even if I am incapacitated and I object to treatment, treatment may be given to me against my objection. (Initial beside your choice of (a) or (b).)*

_____ (a) Yes, even if I am incapacitated and I object to treatment, treatment **may** be given to me against my objection.

-or-

_____ (b) No, even if I am incapacitated and I object to treatment, treatment **may not** be given to me against my objection.

C. DO NOT RESUSCITATE.

Pursuant to New Hampshire R.S.A. 137-J:26 (III), I may grant my health care agent the authority to consent to a Do Not Resuscitate ("DNR") Order. *(Initial beside your choice of (a) or (b).)*

_____ (a) **Yes**, I grant my health care agent the authority to consent to a Do Not Resuscitate ("DNR") Order.

-or-

_____ (b) **No**, I do not grant my health care agent the authority to consent to a Do Not Resuscitate ("DNR") Order.

D. ADDITIONAL INSTRUCTIONS.

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

(attach additional pages as necessary)

In accordance with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), 45 CFR Sections 160 and 164 ("HIPAA"), or any successors thereto, I authorize my health care agent to act as my Personal Representative solely for the purpose of obtaining and receiving any and all Protected Health Information related to my health care and related to payments in regard to such health care.

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 Robinson, Boesch, Sennott & Daly, Professional Association, 195 New Hampshire Avenue, Suite 255, Portsmouth, New Hampshire 03801, and the following persons and institutions will have signed copies:

Signed on _____, 2021.

 JOHN DOE

TWO WITNESSES OR A NOTARY PUBLIC ARE REQUIRED.

NEITHER WITNESS MAY BE THE PRINCIPAL'S NAMED HEALTH CARE AGENT, SPOUSE, HEIR-AT-LAW, ANY PERSON ENTITLED TO ANY PORTION OF THE ESTATE OF THE PRINCIPAL AT THE TIME OF THE PRINCIPAL'S DEATH, THE PRINCIPAL'S ATTENDING PHYSICIAN, APRN, OR PERSON ACTING UNDER THE DIRECTION OF THE PRINCIPAL'S ATTENDING PHYSICIAN. NO MORE THAN ONE WITNESS MAY BE THE PRINCIPAL'S HEALTH OR RESIDENTIAL CARE PROVIDER OR AN EMPLOYEE THEREOF.

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 ROCKINGHAM

The foregoing durable power of attorney for health care was acknowledged before me on _____, 2021, by JOHN DOE.

 Notary Public/Justice of the Peace/
 Commissioner of Deeds
 My commission expires:
 (Seal)

Principal's DOB _____

II. LIVING WILL

NOTE: I specifically intend for Part I, the Durable Power of Attorney for Health Care, to take precedence over this Living Will. It is my intention that my doctors, physicians, APRN and other health care providers recognize that my Health Care Agent's decisions with respect to my health care shall be controlling.

Declaration made on _____, 2021.

I, JOHN DOE, of _____, New Hampshire, 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 two (2) physicians or a physician and an advanced practice registered nurse (APRN), 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. 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.

(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 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 on _____, 2021.

JOHN DOE

TWO WITNESSES OR A NOTARY PUBLIC ARE REQUIRED.

NEITHER WITNESS MAY BE THE PRINCIPAL'S NAMED HEALTH CARE AGENT, SPOUSE, HEIR-AT-LAW, ANY PERSON ENTITLED TO ANY PORTION OF THE ESTATE OF THE PRINCIPAL AT THE TIME OF THE PRINCIPAL'S DEATH, THE PRINCIPAL'S ATTENDING PHYSICIAN, APRN, OR PERSON ACTING UNDER THE DIRECTION OF THE PRINCIPAL'S ATTENDING PHYSICIAN. NO MORE THAN ONE WITNESS MAY BE THE PRINCIPAL'S HEALTH OR RESIDENTIAL CARE PROVIDER OR AN EMPLOYEE THEREOF.

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 ROCKINGHAM

The foregoing living will was acknowledged before me on _____, 2021,
by JOHN DOE.

Notary Public/Justice of the Peace/
Commissioner of Deeds
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.

IF YOU WANT TO GIVE YOUR HEALTH CARE AGENT THE AUTHORITY TO DIRECT YOUR DOCTOR TO ISSUE A "DO NOT RESUSCITATE" ("DNR") ORDER, YOU MUST SAY SO IN YOUR DIRECTIVE. OTHERWISE, YOUR HEALTH CARE AGENT WILL NOT BE ABLE TO DIRECT THAT A DNR ORDER BE ISSUED.

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

Initial

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 (APRN), 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 (APRN) 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 APRNs 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.

Initial

NEW HAMPSHIRE ADVANCE DIRECTIVE DEFINITIONS

I. "Advance directive" means a directive allowing a person to give directions about future medical care or to designate another person to make medical decisions if he or she should lose the capacity to make health care decisions. The term "advance directives" shall include living wills and durable powers of attorney for health care.

II. "Advanced practice registered nurse" or "APRN" means a registered nurse who is licensed in good standing in the state of New Hampshire as having specialized clinical qualifications as provided in R.S.A. 326-B:11.

III. "Agent" means an adult to whom authority to make health care decisions is delegated under an advance directive.

IV. "Attending physician or APRN" means the physician or advanced practice registered nurse, selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient. If more than one physician or advanced practice registered nurse shares that responsibility, any one of those physicians or advanced practice registered nurses may act as the attending physician or APRN under the provisions of R.S.A. 137-J, as it may be amended from time to time, or any successor statute.

V. "Capacity to make health care decisions" means 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. The fact that a person has been diagnosed with mental illness, brain injury, or intellectual disability shall not mean that the person necessarily lacks the capacity to make health care decisions.

VI. "Cardiopulmonary resuscitation" means those measures used to restore or support cardiac or respiratory function in the event of a cardiac or respiratory arrest.

VI-a. "Close friend" means any person 21 years of age or older who presents an affidavit to the attending physician stating that he or she is a close friend of the patient, is willing and able to become involved in the patient's health care, and has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious and moral beliefs. The affidavit shall also state facts and circumstances that demonstrate such familiarity with the patient.

VII. "Do not resuscitate identification" means a standardized identification necklace, bracelet, card, or written medical order that signifies that a "Do Not Resuscitate Order" has been issued for the principal.

VIII. "Do not resuscitate order" or "DNR order" (also known as "Do not attempt resuscitation order" or "DNAR order") means an order that, in the event of an actual or imminent cardiac or respiratory arrest, chest compression and ventricular defibrillation will not be performed, the patient will not be intubated or manually ventilated, and there will be no administration of resuscitation drugs.

IX. "Durable power of attorney for health care" means a document delegating to an agent the authority to make health care decisions executed in accordance with the provisions of R.S.A. 137-J,

as it may be amended from time to time, or any successor statute. It shall not mean forms routinely required by health and residential care providers for admissions and consent to treatment.

X. "Emergency services personnel" means paid or volunteer firefighters, law-enforcement officers, emergency medical technicians, paramedics or other emergency services personnel, providers, or entities acting within the usual course of their professions.

XI. "Health care decision" means informed consent, refusal to give informed consent, or withdrawal of informed consent to any type of health care, treatment, admission to a health care facility, any service or procedure to maintain, diagnose, or treat an individual's physical or mental condition except as prohibited in this chapter or otherwise by law.

XII. "Health care provider" means an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care, for profit or otherwise, in the ordinary course of business or professional practice.

XIII. "Life-sustaining treatment" means any medical procedures or interventions which utilize mechanical or other medically administered means to sustain, restore, or supplant a vital function which, in the written judgment of the attending physician or APRN, would serve only to artificially postpone the moment of death, and where the person is near death or is permanently unconscious. "Life-sustaining treatment" includes, but is not limited to, the following: medically administered nutrition and hydration, mechanical respiration, kidney dialysis, or the use of other external mechanical or technological devices. Life sustaining treatment may include drugs to maintain blood pressure, blood transfusions, and antibiotics. "Life-sustaining treatment" shall not include the administration of medication, natural ingestion of food or fluids by eating and drinking, or the performance of any medical procedure deemed necessary to provide comfort or to alleviate pain.

XIV. "Living will" means a directive which, when duly executed, contains the express direction that no life-sustaining treatment be given when the person executing said directive has been diagnosed and certified in writing by the attending physician or APRN to be near death or permanently unconscious, without hope of recovery from such condition and is unable to actively participate in the decision-making process.

XV. "Medically administered nutrition and hydration" means invasive procedures such as, but not limited to the following: Nasogastric tubes; gastrostomy tubes; intravenous feeding or hydration; and hyperalimentation. It shall not include the natural ingestion of food or fluids by eating and drinking.

XVI. "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 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.

XVII. "Permanently unconscious" means 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.

XVIII. "Physician" means a medical doctor licensed in good standing to practice in the state of New Hampshire pursuant to R.S.A. 329.

XIX. "Principal" means a person 18 years of age or older who has executed an advance directive pursuant to the provisions of R.S.A. 137-J, as it may be amended from time to time, or any successor statute.

XX. "Qualified patient" means a patient who has executed an advance directive in accordance with this chapter and who has been certified in writing by the attending physician or APRN to lack the capacity to make health care decisions.

XXI. "Reasonable degree of medical certainty" means a medical judgment that is made by a physician or APRN who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

XXII. "Residential care provider" means a "facility" as defined in R.S.A. 161-F:11, IV, a "nursing home" as defined in R.S.A. 151-A:1, IV, or any individual or facility licensed, certified, or otherwise authorized or permitted by law to operate, for profit or otherwise, a residential care facility for adults, including but not limited to those operating pursuant to R.S.A. 420-D.

XXII-a. "Surrogate decision-maker" or "surrogate" means an adult individual who has health care decision-making capacity, is available upon reasonable inquiry, is willing to make health care decisions on behalf of a patient who lacks health care decision-making capacity, and is identified by the attending physician or APRN in accordance with the provisions of R.S.A. 137-J as the person who is to make those decisions in accordance with the provisions of R.S.A. 137-J.

XXIII. "Witness" means a competent person 18 years or older who is present when the principal signs an advance directive.