Advance Directives
Planning for Important Healthcare Decisions

Caring Connections, 1700 Diagonal Road, Suite 625, 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, supported by a grant from The Robert Wood Johnson Foundation.

The goal of Caring Connections is for consumers to hear a unified message promoting awareness and action for improved end-of-life care. Through these efforts, NHPCO seeks to support those working across the country to improve end-of-life care and conditions for all Americans.

SERVICES FROM CARING CONNECTIONS

Information and Advice Services

You can call our toll-free helpline, 800-658-8898, if you need help completing your living will or health care power of attorney, if you wish to talk to someone about how to plan for decisions you might face near the end of your life, or if you are dealing with a difficult end-of-life situation and need immediate information and advice. Below is just a sampling of the kinds of questions that we respond to:

- How do I complete my advance directives?
- What questions should I ask my mother's doctors about her care?
- My father's health care providers will not honor his wishes. What shall I do?
- Do I have to be in pain?

Education Services

For the Public: We can provide publications and videos that offer practical information to educate consumers about how to get the best possible care near the end-of-life. We are building grassroots activities to help the public be involved in improving care for dying people. We also give consumers the opportunity to add their voices to the call for good end-of-life care.

For the Professionals: We can provide education and consultation to doctors, nurses, social workers, attorneys, clergy, and others. By becoming Partners, professional organizations gain access to a wide variety of materials and services that can help them improve end-of-life care in their institution or community.

Legal Services:
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 always up to date, and to ensure that we are the source for the most up-to-date information about legislation and case law affecting end-of-life decision making and care.

HOW TO USE THESE MATERIALS

1. Check to be sure that you have the materials for your state. You should complete a form for the state in which you expect to receive health care.

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

3. Read the instructions in their entirety. They give you specific information about the requirements in your state.

4. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

5. When you begin to complete the form, refer to the gray instruction bars - they indicate where you need to mark, insert your personal instructions, or sign the form.

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

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, you may call our toll free number (800) 658-8898 and a staff member will be glad to assist you.

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Alexandria, VA 22314
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For more information contact:

The National Hospice and Palliative Care Organization
1700 Diagonal Road, Suite 625
Alexandria, VA 22314

Call our HelpLine: 800/658-898
Visit our Web site: www.caringinfo.org

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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 Health Care** lets you name someone to make decisions about your medical care – including decisions about life support – if you can no longer speak for yourself. The Durable 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 medical decisions, not only at the end of life. It becomes effective when your doctor certifies in writing that you are unable to make health care decisions.

2. The **New Hampshire Declaration** is your state's living will. It lets you state your wishes about medical care in the event that you become terminally ill or enter a permanently unconscious state and can no longer make your own medical decisions. Your doctor and one other physician must personally examine you and certify in writing that you are permanently unconscious or in a terminal condition.

Caring Connections recommends that you complete both of these documents to best ensure that you receive the medical care you want when you can no longer speak for yourself.

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

COMPLETING YOUR NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical 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 medical decisions for you. (An agent may also be called an "attorney-in-fact" or "proxy.") The person you appoint as your agent **cannot** be:

- your doctor,
- an employee of your doctor, unless he or she is related to you,
- your residential care provider, or
- an employee of your residential care provider, unless he or she is related to you.

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

How do I make my New Hampshire Durable Power of Attorney for Health Care legal?

In order to make your Durable Power of Attorney legally binding, you must:

1. Have your signature witnessed by a notary public or justice of the peace, and
2. sign your document, or direct another to sign it, in the presence of two witnesses, who must also sign the document to show that they believe you to be of sound mind and free from duress and that you have said that you understand the document and signed or acknowledged it freely and voluntarily. These witnesses **cannot** be:
   - the person you name as your agent,
   - your spouse or heir, or
   - a person entitled to any part of your estate.

Note: At least one witness must be a person who is not your health or residential care provider or an employee of your health or residential care provider.

Should I add personal instructions to my Durable Power of Attorney for Health Care?

Caring Connections advises you not to add any further instructions to this document. One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your agent's power to act in your best interest.

Instead, we urge you to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use your New Hampshire Declaration (the living will).

COMPLETING YOUR NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR HEALTH CARE (CONTINUED)

What if I change my mind?

You may revoke your New Hampshire Durable Power of Attorney for Health Care by notifying your agent, doctor, or residential care provider orally, in writing or by any other act which shows your intent to revoke your document. Your Durable Power of Attorney for Health Care is automatically revoked if:

- you execute a new Durable Power of Attorney, or
- you appointed your spouse as your agent and your marriage ends (unless you also appointed an alternate).

What other important facts should I know?

- If you do not want to receive artificial nutrition and hydration, you must indicate your wish under item 3 on page 4. You must circle and initial option "(a)" under item 3 in order for your agent to have the power to refuse artificial nutrition and hydration on your behalf.
- Due to restrictions in the state law, your agent does not have the power to consent to the withholding of life-sustaining treatment if you are pregnant, unless the continued application of life-sustaining treatment will not permit the live birth of the unborn child, or will be physically harmful to you or prolong severe pain. If this issue concerns you, contact Caring Connections for more information.
- If you do not rely on a physician for your medical care due to moral or religious beliefs, you have the right to designate someone under item 4 on page 4 to determine when you can no longer make decisions for yourself. The determination must be certified in writing and acknowledged before a notary or justice of the peace. The person you designate to make the determination cannot be your agent or fall into any of the categories of people who cannot serve as your agent. Contact Caring Connections for more information.

COMPLETING YOUR NEW HAMPSHIRE DECLARATION

How do I make my New Hampshire Declaration legal?
In order to make your Declaration legally binding, you must do two things:

1. Have your signature witnessed by a notary public, justice of the peace, or other official authorized to administer oaths, and
2. sign your Declaration, or direct another to sign it, in the presence of two witnesses, who must also sign the document to show that you are at least 18 years of age, of sound mind and under no constraint or undue influence, that you voluntarily signed or acknowledged the Declaration, and that they signed at your request, in your presence and in the presence of each other.

These witnesses **cannot** be:

- your spouse,
- your heir at law,
- your doctor or a person acting under the direction or control of your doctor, or
- anyone who has a claim against your estate.

If you are a resident of a health care facility or a patient in a hospital, one of your witnesses may be your doctor or an employee of your doctor.

Can I add personal instructions to my Declaration?
Yes. You can add personal instructions in the part of the document called "Other directions." For example, you may want to refuse specific treatments by a statement such as, "I especially do not want cardiopulmonary resuscitation, a respirator, or antibiotics." You may also want to emphasize pain control by adding instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death." If you do not want to receive artificial nutrition and hydration, you must indicate your wish on page 1 of your Declaration by circling "YES." If you fail to complete this section, or if you circle "NO," artificial nutrition and hydration will be provided and will not be removed.

If you have appointed an agent and you want to add personal instructions to your Declaration, it is a good idea to write a statement such as "Any questions about how to interpret or when to apply my Declaration are to be decided by my agent."

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Caring Connections booklet, "Advance Directives and End-of-Life Decisions."

What if I change my mind?
You may revoke your New Hampshire Declaration by:

- burning, tearing or obliterating the document or directing another to do so in your presence,
- orally revoking the document in the presence of 2 or more witnesses, neither of whom can be your spouse or heir at law, or
- signing and dating a written revocation in the presence of 2 or more witnesses, neither of whom can be your spouse or heir at law.

Your revocation becomes effective once you notify your doctor, who must then make your revocation part of your medical record.

What other important facts should I know?
A pregnant patient's New Hampshire Declaration will not be honored due to restrictions in the state law. If this issue concerns you, contact Caring Connections for more information.

AFTER YOU HAVE COMPLETED YOUR DOCUMENTS

1. Your New Hampshire Durable Power of Attorney for Health Care 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 health care. 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. Caring Connections does not distribute these forms. We suggest you speak to your physician.

If you would like more information about this topic contact Caring Connections or consult the Caring Connections booklet "Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions."

NEW HAMPSHIRE STATUTORY FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

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

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. “Health care ” means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent, therefore, can have the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment.

Your agent cannot consent or direct any of the 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 failure to withhold the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this document any treatment you do not desire, except as stated above, or treatment you want to be sure you receive. Your agent’s authority 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 wish to be treated by a doctor or examined by a doctor for the certification that you lack capacity, you must say so in the document and name a person to be able to certify your lack of capacity. That person may not be your agent or alternate agent or any person ineligible to be your agent. You may attach additional pages if you need more space to complete your statement.

If you want to give your agent authority to withhold or withdraw the artificial providing of nutrition and fluids, your document must say so. Otherwise, your agent will not be able to direct that. Under no conditions will your agent be able to direct the withholding of food and drink for you to eat and drink normally.

Your agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have had, if made consistent with state law.

It is important that you discuss this document with your physician 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 on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer’s assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust and must be at least 18 years old. If you appoint your health or residential care provider (e.g., your physician, or an employee of a home health agency, hospital, nursing home, 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; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who will have signed copies. Your agent will not be liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, 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 objection. You have the right to revoke the authority granted to your agent by informing him or her or your health care provider orally or in writing.

This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one.

You should consider designating an alternate agent in the event that your agent is unwilling, unable, unavailable, or ineligible to act as your agent. Any alternate agent you designate will have the same authority to make health care decisions for you.

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

— the person you have designated as your agent;
— your spouse;
— your lawful heirs or beneficiaries named in your will or a deed;

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

INSTRUCTIONS

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)

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document or as prohibited by law. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

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

INSTRUCTION STATEMENTS

CIRCLE AND INITIAL THE RESPONSE THAT REFLECT YOUR WISHES

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: cardiopulmonary resuscitation, 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.

TERMINAL ILLNESS

1. If I become permanently incompetent to make health care decisions, and if I am also suffering from a terminal illness, I authorize my agent to direct that life-sustaining treatment be discontinued.

   YES   NO (Circle your choice and initial beneath it.)

PERMANENTLY UNCONSCIOUS

2. Whether terminally ill or not, if I become permanently unconscious I authorize my agent to direct that life-sustaining treatment be discontinued.

   YES   NO (Circle your choice and initial beneath it.)

ARTIFICIAL NUTRITION AND HYDRATION

3. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial feeding (artificial nutrition and hydration). In carrying out any instructions I have given above in #1 or #2 or any instructions I may write in #4 below, I authorize my agent to direct that (circle your choice of (a) or (b) and initial beside it):

   (a) artificial nutrition and hydration not be started or, if started, be discontinued,

   —OR—

   (b) although all other forms of life-sustaining treatment be withdrawn, artificial nutrition and hydration continue to be given to me.

ADD PERSONAL INSTRUCTIONS (IF ANY)

4. 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 unacceptable to you for any other reason. You may leave this question blank if you desire.

(attach additional pages as necessary)

ALTERNATE AGENT

PRINT THE NAME AND ADDRESS OF YOUR ALTERNATE AGENT

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

_ _

(name of alternate agent)

of _

(address of alternate agent)

as alternate agent.

LOCATION OF THE ORIGINAL AND COPIES

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

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

DATE AND SIGN THE DOCUMENT HERE

In witness whereof, I have hereunto signed my name this _____ (day)

day of _____ (month), 20 _____ (year).

_____
(signature)

WITNESSING PROCEDURE

I 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 has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES AND A NOTARY PUBLIC OR JUSTICE OF THE PEACE MUST COMPLETE THIS SECTION

Witness: _____

Address: _____

Witness: _____

Address: _____

STATE OF NEW HAMPSHIRE
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____

day of _____, 20_____,

by_____.

_____
Notary Public/Justice of the Peace
My commission expires:

Courtesy of Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

CIRCLE AND INITIAL THE RESPONSE THAT REFLECTS YOUR WISHES ABOUT ARTIFICIAL FEEDING

NEW HAMPSHIRE DECLARATION

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

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 certified to be a terminal condition or a permanently unconscious condition by 2 physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized or that I will remain in a permanently unconscious condition and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, 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 artificial nutrition and hydration. In carrying out any instruction I have given under this section, I authorize that artificial nutrition and hydration not be started or, if started, be discontinued.

YES NO

(Circle your choice and initial beneath it. If you want to refuse artificial nutrition and hydration, you must choose “yes.”)

ADD PERSONAL INSTRUCTIONS (IF ANY)

Other directions:

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physicians 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.

SIGN AND PRINT YOUR COUNTY AND STATE OF RESIDENCE

Signed _

_____ County State of _____

WITNESSING PROCEDURE

We, the following witnesses, being duly sworn, each declare to the notary public or justice of the peace or other official signing below as follows:

1. The declarant signed the instrument as a free and voluntary act for the purposes expressed, or expressly directed another to sign for him.

2. Each witness signed at the request of the declarant, in his presence, and in the presence of the other witness.

3. To the best of my knowledge, at the time of the signing the declarant was at least 18 years of age, and was of sane mind and under no constraint or undue influence.

WITNESSES SIGN HERE

Witness _

Witness _

NEW HAMPSHIRE DECLARATION 3OF 3

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

The affidavit shall be made before a notary public or justice of the peace or other official authorized to administer oaths in the place of execution, who shall not also serve as a witness, and who shall complete and sign this certificate:

Sworn to and signed before me by _____,

declarant, _____

and _____, witnesses

on _____.

Signature _____

Official Capacity _____

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