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:

<u>Important Disclaimer:</u> Please note that this document is being provided online at this time without the usual guidance of one of our attorneys because of the pandemic the nation is presently facing. The document in and of itself should not be construed as legal advice. It is simply a form that our lawyers usually tool to fit the instructions of our clients. Should you have any questions we stand ready to answer them. Please call 603-623-7222

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 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 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 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 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 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 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 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.

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 <u>NOT</u> ACT AS WITNESSES:

Ø The person you have designated as your health care agent;

Ø Your spouse or heir at law;

Ø 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.

NEW HAMPSHIRE
ADVANCE DIRECTIVE

NOTE: This form has two sections

You may complete both sections, or only one section

1. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint _____ 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.

If _____ is unable, unwilling or unavailable I hereby appoint

_____ 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: 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 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.

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:

(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.

(If you fail to complete item B, your agent will not have the power to direct the withholding or withdrawal of medically administered nutrition and hydration.)

INITIAL HERE:_____

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.

_____

_____

_____

_____

(Add additional pages as necessary.)

ADDITIONAL AUTHORITY OF MY AGENT:

To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all of my individually identifiable health information and health care facility records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160-164. I hereby authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose, and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition. This authority given my agent shall supersede any other agreement which I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. This authority given my agent shall be effective immediately, has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

(a) To execute on my behalf any releases or other documents that may be required in order to obtain this information;

(b) To consent to the further disclosure of this information if necessary;

INITIAL HERE:_____

(c) To select, employ, and discharge health care personnel, such as physicians, nurses, therapists and other medical professionals , including individuals and services providing home health care, as my agent shall determine to be appropriate;

(d) To select and contract with any medical or health care facility on my behalf, including, but not limited to, hospitals, nursing homes, assisted residence facilities, and the like; and,

(e) To execute on my behalf any or all of the following:

(1) Documents that are written consents to medical treatment or written requests that I be transferred to another facility;

(2) Documents that are Do Not Resuscitate Orders, Discharge Orders or other similar orders; and

(3) Any other document necessary or desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

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

INITIAL HERE:_____

The original of this document will be kept at _____

and the following persons and institutions will have signed copies:

_____

_____

_____

_____

Signed this _____ day of _____, 2020.

_____

Signature

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 is aware of the nature of the directive and is signing it freely and voluntarily.

_____ _____

[signature – please print name under this line] Address

_____ _____

[signature – please print name under this line] Address

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing durable power of attorney for health care was acknowledged before me this _____ day of _____, 2020, by _____ ("the Principal").

_____

Notary Public / Justice of the Peace

My commission expires: _____

INITIAL HERE:_____