~ New Hampshire ~
Durable Power of Attorney For Health Care Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make health care decisions for you. It revokes any prior power of attorney for health care that you may have made. If you wish to change your power of attorney for health care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, your health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior document of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care agent, close family, or friends, if needed.

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 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 practice registered nurse, 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 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 APRN'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:

- _____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.

STATE OF NEW HAMPSHIRE
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

Written in accordance with New Hampshire Revised Statutes §§ 137-J:14 to 137-J:19

DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint _____ of
Name of principal Name of health care agent

_____
Address of health care agent

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 – Christian Version shall take effect in the event I become unable to make my own health care decisions.

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

I hereby appoint _____ of _____
Name of alternate health care agent Address

_____ 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

1. I realize that situations could arise in which the only way to allow me to die would be to not start or 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 administer nutrition and hydration not to be started or, if started, be discontinued,

OR

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

2. I request that the attached Addendum (pages 8-14) be included as a valid part of this Durable Power of Attorney for Health Care document.

C. ADDITIONAL INSTRUCTIONS

Here you may include any specific desires or limitation 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 section blank if you desire.

_____

_____

_____

_____

_____

_____

[Attach additional pages as needed]

HIPAA RELEASE STATEMENT

I intend for my health care agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The principal and witnesses (or notary public or justice of the peace) must sign the document at the same time.

STATEMENT OF PRINCIPAL

(Person creating this Durable Power of Attorney for 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 document will be kept at _____ and the following persons and institutions will have signed copies:

1) Name: _____

   Address: _____

2) Name: _____

   Address: _____

3) Name: _____

   Address: _____

4) Name: _____

   Address: _____

I sign my name to this Advance Directive on

_____ at _____, _____
Date City State

Signature: _____

Print name: _____

STATEMENT OF WITNESSES

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 – Christian Version 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.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

OR

(ALTERNATIVE: Sign before a notary public or justice of the peace.)

I sign my name to this Advance Directive on

_____ at _____, _____
Date City State

Signature: _____

Print name: _____

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing advance directive was acknowledged before me this _____ day of _____, _____,
Month Year

by _____ (the "Principal").

Signature: _____
Notary Public/Justice of the Peace

My Commission Expires: _____/_____/_____

ADDENDUM TO THE STATE OF NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR HEALTH

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my health care agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration,

even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Power of Attorney for Health Care Document, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withheld or withdrawn from me.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my health care agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

ADMISSION TO NURSING HOMES

My health care agent may admit me to a nursing home or community–based residential facility for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

A nursing home **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care agent may only admit me for short–term stays for recuperative care or respite care.

ANATOMICAL GIFTS

Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____

_____

[Attach additional pages as needed]

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

The principal and witnesses (or notary or justice of the peace) must sign the document at the same time.

STATEMENT OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

I hereby acknowledge the information included in this Addendum to my New Hampshire Durable Power of Attorney for Health Care – Christian Version, and my intent is to include this Addendum as a further explanation of my beliefs and desires. I have read and understand the information contained in this Addendum.

Signature: _____ Date: _____

STATEMENT OF WITNESSES

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 – Christian Version and Addendum are signed and that the principal affirms that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

OR

(ALTERNATIVE: Sign before a notary public or justice of the peace.)

I sign my name to this Advance Directive on

_____ at _____, _____
Date City State

Signature: _____

Print name: _____

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing advance directive was acknowledged before me this _____ day of _____, _____,
Month Year

by _____ (the "Principal").

Signature: _____
Notary Public/Justice of the Peace

My Commission Expires: _____/_____/_____

STATEMENT OF HEALTH CARE AGENT

I understand that _____ has designated me to be his or her health care agent
Name of principal
if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Agent's signature: _____

Address: _____

STATEMENT OF ALTERNATE HEALTH CARE AGENT

I understand that _____ has designated me to be his or her alternate
Name of principal
health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Alternate agent's signature: _____

Address: _____

CLERGY
Optional

The principal has requested that the agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the agent to help meet the directives as described in this Durable Power of Attorney for Health Care document and attached Addendum.

Clergy's signature: _____ Phone: (____) _____

Church address: _____

I have given copies of this Durable Power of Attorney for Health Care – Christian Version to:

_____

_____

_____

_____

_____

_____