Triage Cancer Estate Planning Toolkit: New Hampshire

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Generally, New Hampshire probate courts only accept written wills. To make a valid written will in New Hampshire:

1. You need to be in the right state of mind to create a will. This means you need to be:
   - At least 18 years old
   - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will, in front of two witnesses who are not included in your will.
3. Your will does not need to be notarized to be legal in New Hampshire. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign an affidavit affirming the will in front of a notary.

Due to the COVID-19 pandemic, New Hampshire now allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing). However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

Oral wills are only allowed in New Hampshire for soldiers or mariners in active military service.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

New Hampshire's statutory form for power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint a successor agent, and a second successor agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking.

You can also use this document to nominate a guardian in advance, in case a court decides one is necessary. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it, and will remain in effect if you become incapacitated. This document will remain in effect until you die, unless you revoke your power of attorney.

Part III of this toolkit includes a sample form.

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State Laws About Advance Health Care Directives

An advance health care directive is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In New Hampshire, this document includes three parts. You can complete part one and/or part two, but you must sign part three to make the document valid.

1. **New Hampshire Durable Power of Attorney for Health Care:** You can choose someone (your "agent") to make health care decisions for you, including decisions about life-sustaining care, any time your doctor determines that you cannot make them yourself. You can appoint an alternate person to make these decisions if the first person you chose isn't available. This section also allows you to express your preferences for advance planning decisions to help guide your agent. If there are additional directions you want your agent to honor, you can share those in the "other directions" section.
2. **New Hampshire Declaration:** Also known as a "living will," this document lets you express your preferences for life-sustaining procedures (including medically assisted nutrition and pain management) if you develop a terminal condition and can no longer make your own health care decisions. This document goes into effect if your doctor determines you have become terminally ill or entered a vegetative state. If you complete part one and record these advance planning preferences there, you may choose to leave your declaration blank.
3. **Signature and Witnessing Provisions:** You must sign your advance health care directive in front of a notary public or two witnesses. Only one witness can be an administrator or employee of your health care provider. Neither of your witnesses can be your spouse, your agent, a beneficiary in your will, or your physician.

At the end of your AHCD, you can indicate if you would like to make an organ donation upon death.

You can revoke your AHCD by:

- Creating a written statement and sending it to your agent or health care provider
- Orally revoke your advance health care directive in front of two witnesses, none of whom is your spouse or heir
- Destroying or tearing up the document
- Creating a new advance health care directive

If you appoint your spouse as your attorney-in-fact, this will be automatically revoked if your marriage dissolves.

Part III of this toolkit includes a sample advance health care directive.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance directive. You can complete a POLST form with your doctor. In New Hampshire, this form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Life-sustaining antibiotics
- Medically assisted nutrition, or food and hydration offered through surgically-placed tubes
- Other limitations (like dialysis or IVs) or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

New Hampshire has adopted the national POLST Form. You can find a sample form in Part III of this toolkit.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

New Hampshire does not have a dedicated funeral designation form, but you can include instructions for your remains in your advance health care directive.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

New Hampshire does not yet have an aid-in-dying law.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Cancer Estate Planning Toolkit: New Hampshire

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form

Triage Cancer Estate Planning Toolkit

Part III: Your State's Estate Planning Forms

Power of Attorney for Financial Affairs

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Section 564-E:301

564-E:301 Statutory Form Power of Attorney. –

A document substantially in the following form may be used to create a power of attorney that is in compliance with the provisions of this chapter:
NEW HAMPSHIRE
STATUTORY POWER OF ATTORNEY
INFORMATION CONCERNING THE POWER OF ATTORNEY
THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:
Notice to the Principal: As the "Principal," you are using this Power of Attorney to grant power to another person (called the "Agent") to make decisions, including, but not limited to, decisions concerning your money, property, or both, and to use your money, property, or both on your behalf. If this Power of Attorney does not limit the powers that you give to your Agent, your Agent will have broad and sweeping powers to sell or otherwise dispose of your property, and to spend your money without advance notice to you or approval by you. Unless you have expressly provided otherwise in this Power of Attorney, your Agent will have these powers before you become incapacitated, and unless you have expressly provided otherwise in this Power of Attorney, your Agent will continue to have these powers after you become incapacitated. You have the right to retain this Power of Attorney and to release it later or to request that another person retain this Power of Attorney on your behalf and release it only if one or more conditions specified in advance by you are satisfied. You have the right to revoke or take back this Power of Attorney at any time, so long as you are of sound mind. If there is anything about this Power of Attorney that you do not understand, you should seek professional advice.
Principal's Signature:
Date:
1. DESIGNATION OF AGENT
I, (Name of Principal), of (Address of Principal), name the following person as my agent:
Name of Agent:
Agent's Address:
2. DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)
If my agent is unable or unwilling to act for me, I name the following person as my successor agent:
Name of Successor Agent:
Successor Agent's Address:
If my successor agent is unable or unwilling to act for me, I name the following person as my second successor agent:
Name of Second Successor Agent:
Second Successor Agent's Address:
3. REVOCATION OF EXISTING POWERS OF ATTORNEY
(Initial the following statement if it is your choice.)
_____ This Power of Attorney revokes all existing powers of attorney previously executed by me.
4. GRANT OF GENERAL AUTHORITY
(Initial beside your choice of A or B, but not both.)
_____ A. I grant my agent general authority to act for me in all matters, including, without

limitation, all of the subjects enumerated in B below.
_____ B. I grant my agent general authority over the following subjects as defined in the following sections of the Uniform Power of Attorney Act:
(Initial each subject you want to include in the agent's general authority.)
_____ Real Property as defined in RSA 564-E:204
_____ Tangible Personal Property as defined in RSA 564-E:205
_____ Stocks and Bonds as defined in RSA 564-E:206
_____ Commodities and Options as defined in RSA 564-E:207
_____ Banks and Other Financial Institutions as defined in RSA 564-E:208
_____ Operation of Entity or Business as defined in RSA 564-E:209
_____ Insurance and Annuities as defined in RSA 564-E:210
_____ Estates, Trusts and Other Beneficial Interests as defined in RSA 564-E:211
_____ Claims and Litigation as defined in RSA 564-E:212
_____ Personal and Family Maintenance as defined in RSA 564-E:213
_____ Benefits from Governmental Programs or Civil or Military Service as defined in RSA 564-E:214
_____ Retirement Plans as defined in RSA 564-E:215
_____ Taxes as defined in RSA 564-E:216
_____ Digital Assets
5. GRANT OF SPECIFIC AUTHORITY (OPTIONAL)
(Initial each subject you want to include in the agent's authority. CAUTION: As to some of the following subjects, granting your agent authority will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death.)
My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:
_____ Create, amend, revoke, or terminate an inter vivos trust
_____ Make a gift, subject to the limitations of RSA 564-E:217 of the Uniform Power of Attorney Act
(If you have granted your agent the authority to make a gift, then as to each of the following statements, initial beside it if it is your choice.)
_____ My agent may make a gift, even if it will leave me without sufficient assets or income to provide for my care without relying on Medicaid, other public assistance or charity.
_____ My agent may make a gift to himself or herself and to any individual to whom my agent owes a legal obligation of support.

_____ Create or change rights of survivorship
_____ Create or change a beneficiary designation
_____ Delegate authority granted under this Power of Attorney to another person
_____ Waive my right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
_____ Exercise the fiduciary power(s) that I have the authority to delegate as specified in the "Special Instructions" in Paragraph 7 of this Power of Attorney
_____ Exercise authority over the content of electronic communication sent or received by me
_____ Exercise authority with respect to intellectual property, including, without limitation, copyrights, contracts for payment of royalties, and trademarks

6. LIMITATION ON AGENT'S AUTHORITY (OTHER THAN GIFTING)
(If an agent (including successor agent) named in this Power of Attorney is someone other than an ancestor of yours, your spouse, or a descendant of yours, you must initial the following statement if it is your choice that such agent have the following authority. An agent who is an ancestor of yours, your spouse, or a descendant of yours already has the following authority under New Hampshire law.)
_____ My agent may exercise authority under this Power of Attorney to create in my agent, or in an individual to whom my agent owes a legal obligation of support, an interest in my property by any manner (other than a gift), including, without limitation, by right of survivorship, beneficiary designation, or disclaimer.
7. SPECIAL INSTRUCTIONS (OPTIONAL)
(Here you may include special instructions. You may leave this Paragraph blank. You may attach additional pages as necessary.)
8. EFFECTIVE DATE AND AUTHORITY OF AGENT
This Power of Attorney is effective immediately unless I have stated otherwise in the Special Instructions in Paragraph 7 of this Power of Attorney. An agent (including successor agent) named in this Power of Attorney will have no authority to act as my agent until he or she has signed and affixed to this Power of Attorney an acknowledgment that is substantially the same as the Acknowledgment at the end of this Power of Attorney.
9. GOVERNING LAW
This Power of Attorney shall be governed by the laws of the State of New Hampshire.
10. RELIANCE ON THIS POWER OF ATTORNEY
Any person, including my agent, may rely upon this Power of Attorney if it is acknowledged before a notary public or other individual authorized to take acknowledgements (or a copy of the acknowledged Power of Attorney), unless that person knows it is void, invalid, or terminated.
SIGNATURE AND ACKNOWLEDGMENT
(You must date and sign this Power of Attorney. If you are physically unable to sign, it may be signed by someone else writing your name, in your presence and at your express direction. This Power of Attorney must be acknowledged before a notary public or other individual authorized by law to take acknowledgments.)
Principal's Signature:
Principal's Printed Name:
Principal's Address:
Date:

STATE OF NEW HAMPSHIRE
COUNTY OF _______________
The foregoing Power of Attorney was acknowledged before me on _______________, by _______________, known to me or satisfactorily proven to be the person named herein
Signature of Notarial Officer:
Title (and Rank):
My commission expires:

AGENT ACKNOWLEDGMENT
Notice to Agent: You will have no authority to act as agent under this Power of Attorney until you sign and affix this acknowledgment to the Power of Attorney.

I, _________________________, have read the attached power of attorney and am the person identified as the agent for the principal. I hereby acknowledge that when I act as agent I am given power under the power of attorney to make decisions about money, property, or both belonging to the principal, and to spend the principal's money, property, or both on the principal's behalf, in accordance with the terms of the power of attorney. When acting as agent, I have duties (called "fiduciary duties") to act in the principal's best interest, to act in good faith, and to act only within the scope of authority granted in the power of attorney, as well as other duties imposed by law to the extent not provided otherwise in the power of attorney. As an agent, I am not entitled to use the money or property for my own benefit or to make gifts to myself or others unless the power of attorney specifically gives me the authority to do so. As an agent, my authority under the power of attorney will end when the principal dies and I will not have authority to manage or dispose of any property or administer the estate of the principal. If I violate a fiduciary duty under the power of attorney, I may be liable for damages and may be subject to criminal prosecution. If there is anything about this power of attorney, or my duties under it, that I do not understand, I understand that I should seek professional advice.
Agent's Signature:
Date:

Source. 2017, 178:1, eff. Jan. 1, 2018.

Section 564-E:302

564-E:302 Agent's Certification. –

The following optional form may be used by an agent to certify facts concerning a power of attorney:

AGENT'S CERTIFICATION AS TO THE VALIDITY OF POWER OF ATTORNEY AND AGENT'S AUTHORITY
STATE OF NEW HAMPSHIRE
COUNTY OF _______________
I, _______________, certify under penalty of perjury that _______________ granted me authority as an agent in a power of attorney dated _______________.
I further certify that to my knowledge:
(1) the principal is alive and has not revoked the Power of Attorney or my authority to act under the Power of Attorney and the Power of Attorney and my authority to act under the Power of Attorney have not terminated;
(2) if the Power of Attorney was drafted to become effective upon the happening of an event or contingency, the event or contingency has occurred;
(3) if I was named as a successor agent, the prior agent is no longer able or willing to serve; and
(4) (Insert Other Relevant Statement(s)).

SIGNATURE AND ACKNOWLEDGMENT
Agent's Signature:____
Date:____
Agent's Name Printed _____________________________________
Agent's Address ____

Agent's Telephone Number ______________________________
Signed and sworn to (or affirmed) before me on _______________, by _______________,
known to me or satisfactorily proven to be the person named herein
Signature of Notarial Officer:
Title (and Rank):
My commission expires:

Source. 2017, 178:1, eff. Jan. 1, 2018.

Triage Cancer Estate Planning Toolkit

Part III: Your State's Estate Planning Forms

Advance Health Care Directive

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DISCLOSURE STATEMENT

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE (PART I)

AN ADVANCE DIRECTIVE IS A LEGAL DOCUMENT. YOU SHOULD KNOW THESE FACTS BEFORE SIGNING IT.

• This form allows you to choose who you want to make decisions about your health care when you cannot make decisions for yourself. This person is called your "agent". You should consider choosing an alternate in case your agent is unable to act.

• Agents must be 18 years old or older. They should be someone you know and trust. They cannot be anyone who is caring for you in a health care or residential care setting.

• This form is an "advance directive" that defines a way to make medical decisions in the future, when you are not able to make decisions for yourself. It is not a medical order (e.g., it is not in and of itself a DNR (do not resuscitate order or (POLST)).

• You will always make your own decisions until your medical practitioner examines you and certifies that you can no longer understand or make a decision for yourself. At that point, your "agent" becomes the person who can make decisions for you. If you get better, you will make your own healthcare decisions again.

• With few exceptions(*), when you are unable to make your own medical decisions, your agent will make them for you, unless you limit your agent's authority in Part I.B of the durable power of attorney form. Your agent can agree to start or stop medical treatment, including near the end of your life. Some people do not want to allow their agent to make some decisions. Examples of what you might write in include: "I do NOT want my agent ...
- to ask for or agree to stop life-sustaining treatment (such as breathing machines, medically-administered nutrition and/or hydration (tube feeding), kidney dialysis, other mechanical devices, blood transfusions, and certain drugs)."
- to ask for or to agree to a Do Not Resuscitate Order (DNR order)."
- to agree to treatment even if I object to it in the moment, after I have lost the ability to make health care decisions for myself."

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DISCLOSURE STATEMENT (CONTINUED)

• The law allows your agent to put you in a clinical trial (medical study) or to agree to new or experimental treatment that is meant to benefit you if you have a disease or condition that is immediately life-threatening or if untreated, may cause a serious disability or impairment (for example new treatment for a pandemic infection that is not yet proven). You may change this by writing in the durable power of attorney for health care form:
- "I want my agent to be able to agree to medical studies or experimental treatment in any situation." or
- "I don't want to participate in medical studies or experimental treatment even if the treatment may help me or I will likely die without it."

• Your agent must try to make the best decisions for you, based on what you have said or written in the past. Tell your agent that you have appointed them as your healthcare decision maker. Talk to your agent about your wishes.

• In the "living will" section of the form, you can write down wishes, values, or goals as guidance for your agent, surrogate, and/or medical practitioners in making decisions about your medical treatment.

• You do not need a lawyer to complete this form, but feel free to talk to a lawyer if you have questions about it.

• You must sign this form in the physical presence of 2 witnesses or a notary or justice of the peace for it to be valid. The witnesses cannot be your agent, spouse, heir, or anyone named in your will, trust or who may otherwise receive your property at your death, or your attending medical practitioner or anyone who works directly under them. Only one witness can be employed by your health or residential care provider.

• Give copies of the completed form to your agent, your medical providers, and your lawyer.

* Exceptions: Your agent may not stop you from eating or drinking as you want. They also cannot agree to voluntary admission to a state institution; voluntary sterilization; withholding life-sustaining treatment if you are pregnant, unless it will severely harm you; or psychosurgery.

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PART I: NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME, DATE OF BIRTH, AND ADDRESS

Name (Principal's Name): ______________________________________
DOB: ____
Address: ____

I choose the following person(s) as agent(s) if I have lost capacity to make health care decisions (cannot make health care decisions for myself).
(If you choose more than one person, they will become your agent in the order written, unless you indicate otherwise.)

A. Choosing Your Agent:

PRINT THE NAME ADDRESS, AND PHONE NUMBER OF YOUR AGENT

Agent: I appoint ______________, of ______________, and whose phone number is ______________ to be my agent to make health care decisions for me.

PRINT THE NAME AND ADDRESS OF YOUR ALTERNATE AGENT

Alternate Agent: If the person above is not able, willing, or available, I appoint ______________, of ______________, and whose phone number is ______________ to be my alternate agent.

If no one listed above can make decisions for you, a surrogate will be assigned in the order written in law (spouse, adult child, parent, sibling, etc.), and will have the same powers as an agent. If there is no surrogate, a court appointed guardian may be assigned.

B. Limiting Your Agent's Authority or Providing Additional Instructions

INSTRUCTION STATEMENTS

When you can no longer make your own health care decisions, your agent will be able to make decisions for you. Please review the Disclosure Statement that is attached to this advance directive for examples of how you may want to advise your agent. You may write in limits or additional instructions below or attach additional pages.

____
____
____
____
____
____
____

I have attached ______________ additional pages titled "Additional wishes for my Durable Power of Attorney for Health Care" to express my wishes.

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PART II. NEW HAMPSHIRE LIVING WILL

If you would like to provide written guidance to your agent, surrogate, and/or medical practitioners in making decisions about life sustaining medical treatment if you cannot make your own decisions, you may complete the options below.

CHOOSE ITEM A OR B. Initial your choice:

INITIAL ONLY ONE CHOICE

If I suffer from an advanced life-limiting, incurable and progressive condition:
_______________ A. I wish to have all attempts at life-sustaining treatment (within the limits of generally accepted health care standards) to try to extend my life as long as possible, no matter what burdens, costs or complications may occur.
OR
_______________ B. I do NOT wish to have any life-sustaining treatment attempted that I would consider to be excessively burdensome or that would not have a reasonable hope of benefit for me. I wish to receive only those forms of life-sustaining treatment that I would not consider to be excessively burdensome AND that have a reasonable hope of benefit for me. The following are situations that I would consider excessively burdensome: (Cross out and initial any of the below statements # 1-4 if you disagree.)

IF YOU DISAGREE WITH ANY OF STATEMENTS #1-4, CROSS OUT AND WRITE YOUR INITIALS BESIDE EVERY STATEMENT THAT IS NOT TRUE FOR YOU

__ 1. I do not wish to have life-sustaining treatment attempted if I am actively dying (medical treatment will only prolong my dying).

__ 2. I do not wish to have life-sustaining treatment attempted if I become permanently unconscious with no reasonable hope of recovery.

__ 3. I do not wish to have life-sustaining treatment attempted if I suffer from an advanced life-limiting, incurable and progressive condition and if the likely risks and burdens of treatment would outweigh the expected benefits.

__ 4. Other situations that I would consider excessively burdensome if I suffer from an advanced life-limiting, incurable and progressive condition: (I have attached __________ additional pages titled "Living Will Burdens"):

In these situations, I wish for comfort care only. I understand that stopping or starting treatments to achieve my comfort, including stopping medically-administered nutrition and hydration, may be a way to allow me to die when the treatments would be excessively burdensome for me.

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IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE WITNESSED, USE ALTERNATIVE NO. 1, BELOW (P. 6)

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE NOTARIZED, USE ALTERNATIVE NO. 2, BELOW (P. 7)

PART III: EXECUTION

This advance directive will not be valid unless it is EITHER:

Alternative No. 1: Signed by two (2) adult witnesses who are present when you sign or acknowledge your signature.

Neither of your witnesses **can be**:

- your agent,
- your spouse,
- your heir or any person entitled to any part of your estate either under your last will and testament or by operation of law,
- your attending physician or ARNP, or person acting under the direction and control of your attending physician or ARNP.

In addition, one of your witnesses **cannot** be:

- your health or residential care provider, or an employee of your health or residential care provider

OR

Alternative No. 2: Witnessed by a notary public or justice of the peace

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SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Alternative No. 1: Sign before witnesses.

I have received, reviewed, and understood the disclosure statement, and I have completed the durable power of attorney for health care and/or living will consistent with my wishes. I have attached __________ pages to better express my wishes.

Signed this _____ day of __________, 20_____

Principal's Signature: __________

(If you are physically unable to sign, this advance directive may be signed by someone else writing your name in your physical presence at your direction.)

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

WITNESS ATTESTATION

We declare that the principal appears to be of sound mind and free from duress at the time this advance directive 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:

Signature:____________________________________Date____________

Print Name: ____

Residence Address: ____

Witness 2:

Signature:____________________________________Date___________

Print Name: ____

Residence Address: ____

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SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Alternative No. 2: Sign before a notary public or justice of the peace.

I have received, reviewed, and understood the disclosure statement, and I have completed the durable power of attorney for health care and/or living will consistent with my wishes. I have attached __________ pages to better express my wishes.

Signed this _____ day of __________, 20_____

Principal's Signature: ___________________________

(If you are physically unable to sign, this advance directive may be signed by someone else writing your name in your physical presence at your direction.)

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

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC OR JUSTICE OF THE PEACE

STATE OF NEW HAMPSHIRE

COUNTY OF _____________________

The foregoing advance directive was acknowledged before me this ___ day of___________, 20___, by___________(the "Principal").

____

Notary Public/Justice of the Peace

My Commission Expires:______________

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ORGAN DONATION (OPTIONAL)

NEW HAMPSHIRE ORGAN DONATION FORM – PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under New Hampshire law.

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

_____I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

ADD NAME OR INSTITUTION (IF ANY)

Name of individual/institution:______________________

_____ Pursuant to New Hampshire law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

____

____

For (initial one):

_____ Any legally authorized purpose.
_____Transplant or therapeutic purposes only.

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

Declarant name: ____

Declarant signature:________________________, Date: ____________

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

The declarant voluntarily signed or directed another person to sign this writing in our presence. We signed this document as witnesses in the declarant's presence and in each other's presence.

Witness______________________________Date__________________

Address ____

____

Witness________________________________Date________________

Address ____

____

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Triage Cancer Estate Planning Toolkit

Part III: Your State’s Estate Planning Forms

Physician Orders for Life Sustaining Treatment (POLST)

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HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form	Patient First Name: ______ Middle Name/Initial: ______ Preferred name: ______ Last Name: ______ Suffix (Jr, Sr, etc): ______ DOB (mm/dd/yyyy): ___/___/_____ State where form was completed: ______ Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

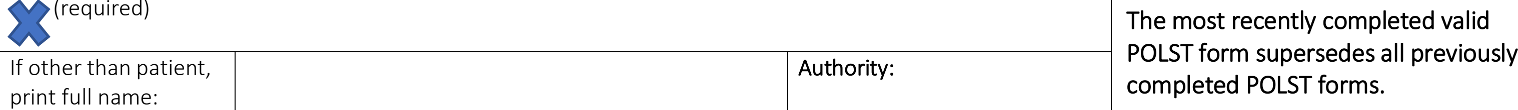
D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Trial period for artificial nutrition but no surgically-placed tubes
☐ Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

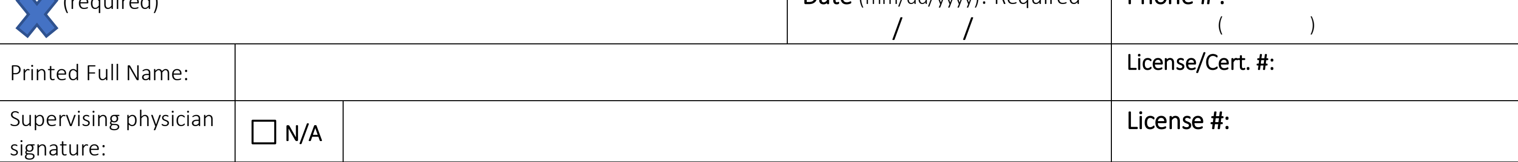
I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.



(required)		The most recently completed valid POLST form supersedes all previously completed POLST forms.
If other than patient, print full name:	Authority:	

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]



(required)		Date (mm/dd/yyyy): Required / /	Phone # : ( )
Printed Full Name:			License/Cert. #:
Supervising physician signature:	☐ N/A		License #:

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )
Primary Care Provider Name:		Phone: ( )
☐ Patient is enrolled in hospice	Name of Agency: Agency Phone: ( )	

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed:____________________ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists
Check everyone who participated in discussion:	☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: ______________________________________

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.polst.org/form
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info	For Barcodes / ID Sticker

Triage Cancer Estate Planning Toolkit

Part III: Your State's Estate Planning Forms

HIPAA Authorization Form

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Sample HIPAA Right of Access Form for Family Member/Friend

I, _________________________________, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____________________________ ____________________________________

Contact information: ____

____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):
    ____
    ____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

____ ____________________

Name of the Individual Giving this Authorization Date of birth

____ ____________________

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524