



# ADVANCE CARE PLANNING GUIDE



*A process to think about,  
talk about and plan for  
end-of-life care*



*New Hampshire Advance Directives:*  
Durable Power of Attorney for  
Health Care (DPOAH)  
Living Will



FOUNDATION FOR  
HEALTHY COMMUNITIES  
[www.healthynh.com](http://www.healthynh.com)

## Why Advance Care Planning?

**M**aking decisions about medical care is not always easy – especially now that machines can keep patients alive even when there is no hope for recovery. **It's your right to participate and plan for your care.** But at some point, you may become unable to make your own health care decisions. That's why it's important to think and talk about your feelings and beliefs with your loved ones – long before critical decisions must be made.

This guide provides you with information about creating two “*advance directives*” – legal documents that state your preferences about medical care. Please read it carefully and discuss it with your family, doctor, patient representative, chaplain or other caregiver.

You don't need to have an advance directive if you don't want one – no hospital, nursing home, doctor, nurse or insurance company can require you to have advance directives to provide you with services. However, it's a good idea to have advance directives in place if you want to make sure that your family and health care providers follow your wishes about your medical care. It will also make it much easier for your family should you become unable to participate in decisions about your care. They will not have to agonize over difficult decisions, uncertain of what you would want them to do. And, if family members or your health care providers disagree about what is right for you, advance directives will help you avoid having decisions made by the courts, which can be difficult, time consuming and costly.

**Health care provider** – A doctor, nurse practitioner or physician's assistant who provides clinical care.

NOTE: The first use of terms you may not understand have been indicated in *italics* and defined in the “Definitions” section at the end of this booklet.

Please note that these forms are not the same as NH statutes. You can get the statutory forms from NH Revised Statutes Annotated 137-J, 137-H. The enclosed forms are substantially similar to NH statutes but written in simpler language. This guide was prepared based on New Hampshire law as it existed in March 2001 and printed to inform, not to advise. This is not intended to be a substitute for legal, medical, or other professional advice. Consult a trained expert for interpretation and application of current New Hampshire law. You may republish or cite any portion of this work, with the following attribution: “Reprinted by permission from the Foundation for Healthy Communities copyright © 2001. All rights reserved.” These materials may not be reproduced for resale.

Your thoughts and answers to these questions can help provide you and your caregivers peace of mind.

### VALUES

- What gives your life its purpose and meaning?
- What do you value most about your physical or mental well being? For example, do you love the outdoors? To read or listen to music? To be aware of who is with you? Your ability to see, hear, taste or touch?

### FAMILY/FRIEND RELATIONSHIPS

- Who among your family and friends are important in your life?
- Have you talked about your choices with your loved ones and with those who will be around you when problems arise or death comes close?

### SPIRITUAL/RELIGIOUS BELIEFS

- How would you describe your spiritual or religious life?
- How does your faith community, church or synagogue support you?
- Do you have religious beliefs about medical treatment?

### MEDICAL

- What health problems do you fear in the future?
- Under what conditions would you want the goals of medical treatment to change from trying to continue your life to focusing on your comfort?
- Would you want a hospice team or other form of *palliative care* offered to you?
- How does cost influence your decisions about medical care?
- How do you feel about *life-sustaining treatment*, such as kidney dialysis? Do you want *CPR* used to revive you? Where do you prefer to receive medical treatment?

### MAKING PLANS

- If you could plan it today, what would the last day or week of your life be like? Where would you be? Who would be with you? What would you be doing?
- What general comments would you like to make about dying or death?
- What will be important to you when you are dying (comfort, no pain, family present, music, prayer, being touched or held, etc.)?
- Are you interested in *organ or tissue donation*?
- Are there people to whom you want to write a letter, or for whom you want to prepare a taped message, perhaps marked to be opened at a future time?
- What are your wishes for a memorial service: songs or readings you want, or people you hope will participate?
- Would you prefer to be buried or cremated, or do you have no preference? Have you contacted a funeral home?

## Questions about advance directives

### What is an advance directive?

An advance directive is a legal document, written **before** you have an *incapacitating* illness, that allows you to state your preferences about medical care. The State of New Hampshire recognizes two forms of advance directives: a Durable Power of Attorney for Health Care and a Living Will.

### What is a Durable Power of Attorney for Health Care (DPOAH)?

A Durable Power of Attorney for Health Care is a document in which you name another person to act as your *health care agent* to make medical decisions for you if you become incapacitated. You can include instructions about which treatments you do or do not want, or how long you want to try possible treatments. If you do not want *artificial feeding or hydration*, New Hampshire law requires that you say so in your document.

### What is a Living Will?

A Living Will instructs your doctor to give **no** life-sustaining treatment if you have a *terminal condition* or are *permanently unconscious*. If you do not want artificial feeding or hydration, New Hampshire law requires that you say so in your document.

### Do I need *both* a Durable Power of Attorney for Health Care and a Living Will?

It is a good idea to have both documents because they serve two different purposes. A Durable Power of Attorney for Health Care takes effect whenever you become unable to make decisions – for instance, during surgery, or even when you become temporarily unconscious. A Living Will takes effect only when there is **no hope** for recovery. Under New Hampshire law, if the terms of your advance directives conflict, the Durable Power of Attorney for Health Care will overrule the Living Will.

### What is artificial feeding?

Artificial feeding means intravenous feeding or feeding through a tube. It **does not** include the natural process of eating foods. There is little, if any, pain or discomfort in providing artificial feeding.

### What is artificial hydration?

Artificial hydration usually means intravenous fluids. It **does not** include the natural process of drinking fluids. There is little, if any, pain or discomfort in providing artificial hydration.

### How does the Durable Power of Attorney for Health Care relate to a “do not resuscitate” order?

Life-sustaining treatment includes cardiopulmonary resuscitation (CPR); however, you should talk with your doctor and health care providers about their practices with respect to issuing and implementing DNR orders.

### What don’t these advance directives accomplish?

These advance directive documents only cover certain important health care issues. They **do not** provide for many other important personal planning matters. For example, these advance directives do not allow your health care agent to handle your general, financial and decision-making matters if you become unable to legally handle your own affairs. A “General Durable Power of Attorney”



is recommended to handle this situation, and may avoid the expense and stress of getting a guardianship through the Probate Court. You should discuss this and other related important non-health care issues with your attorney.

### Do I need to renew my advance directives?

Advance directives do not need to be renewed. However, if you want to change something in either your Durable Power of Attorney for Health Care or your Living Will, you must complete a new document. You might want to re-examine your health care wishes before each annual physical exam, at the start of each decade of your life, after any major life or medical change and after losing your ability to live independently. New Hampshire's Living Will law was revised in 1991. If you have an advance directive that was executed before April 2001, your document is valid, but it will look different from the one in this guide.

### Can I revoke my advance directive?

You can revoke or cancel your advance directive orally or in writing **at any time**. A divorce action will automatically revoke your Durable Power of Attorney for Health Care if your spouse is your health care agent and you have not named an alternate in your document.

### What if my advance directive was executed in another state?

Your out-of-state advance directive is valid in New Hampshire as long as it was legally executed in the other state. However, it will be interpreted using New Hampshire law.

### Who should have copies of my advance directives?

Copies of your documents should be with your doctor, your hospital, family, and the person you select as your health care agent or long-term care facility. Ideally the **original** documents should be stored where you keep your other important legal papers such as wills, birth certificates and social security cards. This way you will always have quick access to these important directives.

### How will my health care providers know I have an advance directive?

You should tell your doctor, nurses or other health care providers that you have an advance directive and provide them with copies for your medical record. Any time you are admitted to a hospital, you will be asked if you have an advance directive. If you know that you will be admitted to a hospital, you should bring copies of your documents with you.

### Do I need an attorney?

You do not need an attorney to create an advance directive. You can simply use the forms in this brochure, which are printed substantially similar to New Hampshire laws. However, if you have questions, you can talk with an attorney or trained staff from your community hospital or hospice. You can get the statutory forms from NH Revised Annotated Statutes 137-J, 137-H.

### Who can witness the signing of my advance directive?

Your advance directive must be signed in the presence of two witnesses and a notary to be valid. Your health care agent named in your Durable Power of Attorney for Health Care, spouse, heir, attending doctor or person supervised by your doctor **may not** serve as a witness. Only one of the two witnesses may be your health or residential care provider or one of your provider's employees.

## Disclosure: Durable Power of Attorney for Health Care

**This is an important legal document. Before signing it, you should know these important facts:**

Except if you state otherwise, this document gives the person you name as your health care 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 health care agent, therefore, will have the power to make a broad range of health care decisions for you. Your health care agent may consent, 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
- 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 document any treatment you do not want, or treatment you want to be sure you receive. Your health care agent's authority will begin when your doctor *certifies* that you are no longer able to make health care decisions (*lack capacity*). If for moral or religious reasons you do not want to be examined by a doctor to certify that you lack capacity, you must say so in the document, and 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 ineligible to be your health care agent. You may attach additional pages if you need more space to complete your statement.

If you want to give your health care agent authority to withhold or withdraw artificial nutrition and fluids (artificial feeding and hydration), your document can say so. Otherwise, your health care agent **will not** be able to direct that. Under no condition will your health care agent be able to direct the withholding of food and drink for you to eat and drink normally.

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

It is important that you discuss this document with your doctor or other health care providers *before* you sign it, to make sure you understand the nature and range of decisions which could be made on your behalf. If you do not have a doctor, you should talk with someone 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 an attorney's assistance to complete this document, but if there is anything in this document you do not understand, you can ask an attorney to explain it to you.

The person you choose as a health care agent should be someone you know and trust, and must be at least 18 years old. If you choose your health or residential care provider (such as your doctor, 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; the law does not permit 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 ineligible to act as your health care agent. Any alternate health care agent you choose will 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 document with your health care agent and your doctor, and give each one a signed copy. You should write on the document 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 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 for you, over your objection. You have the right to revoke the authority granted to your health care agent by telling him or her, or your health care provider, orally or in writing.

This document cannot be changed or modified. If you want to make changes, you must make an entirely new document.

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 who will acknowledge your signature. The following persons may not act as witnesses:

- The person you have designated as your health care agent
- Your spouse
- Your lawful heirs, or beneficiaries named in your will or in a deed

Only one of the two witnesses may be your health or residential care provider or one of your provider's employees.



## Selecting Your Durable Power of Attorney for Health Care or Health Care Agent

When you decide to pick someone to speak for you in a medical crisis, in case you are not able to speak for yourself, there are several things to think about. This tool will help you decide who the best person is. Usually it is best to name **one person or agent to serve at a time**, with at least one alternate, or back-up person, in case the first person is not available when needed.

Compare up to 3 people with this tool. The person best suited to be your DPOAH or Health Care Agent rates well on these qualifications ...

Name #1:		
Name #2:		
Name #3:		
		1. Meets the legal criteria in your state for acting as agent or representative? (This is a must! See page 5 – Disclosure.)
		2. Would be willing to speak on your behalf.
		3. Would be able to act on your wishes and separate his/her own feelings from yours.
		4. Lives close by or could travel to be at your side if needed.
		5. Knows you well and understands what's important to you.
		6. Could handle the responsibility.
		7. Will talk with you now about sensitive issues and will listen to your wishes.
		8. Will likely be available long into the future.
		9. Would be able to handle conflicting opinions among family members, friends, and medical personnel.
		10. Can be a strong advocate in the face of an unresponsive doctor or institution.

### What to Do After you Pick a Health Care Agent

- Talk to your agent about the qualifications on this worksheet.
- Ask permission to name him or her as your agent.
- Discuss your health care wishes and values and fears.
- Make sure your agent gets a copy of your advance directive.
- Tell family members and close friends who you picked.

This worksheet adapted by the American Bar Association's Commission on Legal Problems of the Elderly from R. Pearlman, et. al., **Your Life Your Choices – Planning for Future Medical Decisions: How to Prepare a Personalized Living Will**, Veterans Administration Medical Center, Seattle, Washington. Reprinted by permission.

# DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(usually referred to as DPOAH)

I, \_\_\_\_\_, hereby appoint \_\_\_\_\_

(Name)

(Name of Health Care Agent)

of \_\_\_\_\_

(Health Care Agent's address and phone #)

as my health care agent to make any and all health care decisions for me, except if 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.

In the event the person I choose as health care agent is unable, unwilling, unavailable or ineligible to act as my health care agent, I choose \_\_\_\_\_

(Name of alternate health care agent)

of \_\_\_\_\_ as alternate health care agent.

(Address and phone # of alternate health care agent)

## Statement of Desires, Special Provisions, and Limitations about Health Care Decisions

Some general statements about the withholding or removal of **life-sustaining treatment** are used in this document. Life-sustaining treatment is defined as procedures without which a person would die. Some of these are: 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.

If I wish to indicate my agreement or disagreement with each of the following statements I will circle my choice and initial the line beside it, and give my health care agent power to act in these specific circumstances.

1. If I become permanently incompetent to make health care decisions, and if I am also suffering from a terminal illness, I authorize my health care agent to direct that life-sustaining treatment be discontinued. *(Circle your choice and initial beside it.)*

YES \_\_\_\_\_  
(Initials)

NO \_\_\_\_\_  
(Initials)

2. Whether terminally ill or not, if I become permanently unconscious, I authorize my health care agent to direct that life-sustaining treatment be discontinued. *(Circle your choice and initial beside it.)*

YES \_\_\_\_\_  
(Initials)

NO \_\_\_\_\_  
(Initials)

3. 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 instructions I have given in this document, I authorize my health care agent to direct that my choices indicated below be respected.

I wish to have my life continued with artificial feeding or artificial hydration.

YES \_\_\_\_\_  
(Initials)

NO \_\_\_\_\_  
(Initials)

If artificial feeding and hydration have been started, I want them:

STOPPED \_\_\_\_\_  
(Initials)

CONTINUED \_\_\_\_\_  
(Initials)

**I understand that if I do not complete item number 3, my health care agent will NOT have the power to stop artificial feeding and hydration.**

I wish to be given medication which is necessary to control my pain without regard to any of the above choices.

YES \_\_\_\_\_  
(Initials)

NO \_\_\_\_\_  
(Initials)

4. I understand that in this paragraph I may write specific desires I want or don't want, may attach extra pages or may leave this question blank.

*Under what conditions would you want the goals of medical treatment to switch from trying to continue your life to focusing on your comfort? What will be important to you when you are dying (comfort, no pain, family present, music, pray, be held etc.)? Do you want to indicate a timeframe for trying treatment options?*

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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 in the disclosure statement.

The original of this document will be kept at \_\_\_\_\_ and the following persons and institutions will have copies: \_\_\_\_\_  
(Address)

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In witness to this, I sign my name this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(Day) (Month) (Year)

Signed \_\_\_\_\_  
(Your Name)

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.

Witness \_\_\_\_\_ Address \_\_\_\_\_

Witness \_\_\_\_\_ Address \_\_\_\_\_

*To be completed by notary:*

State of \_\_\_\_\_ County of \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(Day) (Month) (Year)

Notary Public/Justice of the Peace \_\_\_\_\_ My commission expires: \_\_\_\_\_

*Make copies of these two pages for your doctor, hospital, health care agent and family*

# LIVING WILL

On this \_\_\_\_\_ day of \_\_\_\_\_ I, \_\_\_\_\_  
being of sound mind, willfully and voluntarily state that my dying should not be artificially  
prolonged because of medical care being given to me, if the following things happen:

- If I have a disease, injury, or illness that can't be cured, or
- If I am permanently unconscious,
- And if these conditions are stated by two doctors who have examined me themselves, one of whom is my attending doctor,
- And if the doctors have determined that I will die even if I am given life-sustaining treatment, or that I will remain permanently unconscious,
- And if this life-sustaining but artificial treatment will only make my dying take longer,

I direct that these life-sustaining treatments shall not be given, or be stopped, and that I die naturally, with only the medication, sustenance or medical procedures that are necessary to give me comfort care.

I know that situations could arise in which the only way to allow me to die would be to stop artificial feeding and hydration (fluids). I state that (*circle your choice and initial beside it*):

I wish to have my life continued with artificial feeding or artificial hydration.

YES \_\_\_\_\_  
(Initials)

NO \_\_\_\_\_  
(Initials)

If artificial feeding and hydration have been started, I want them:

STOPPED \_\_\_\_\_  
(Initials)

CONTINUED \_\_\_\_\_  
(Initials)

If I cannot give directions about using such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and doctors as the final expression of my right to refuse medical or surgical treatment and to accept the consequences of refusing it.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed \_\_\_\_\_  
(Your Name)

State of \_\_\_\_\_ County \_\_\_\_\_

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

1. The declarant signed this document 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 or her 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 old, and was of sane mind and under no constraint or undue influence.

Witness \_\_\_\_\_

Witness \_\_\_\_\_

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 a certificate in content and form substantially as follows:

*To be completed by notary.*

Sworn to and signed before me by \_\_\_\_\_, declarant

and \_\_\_\_\_, witnesses, on \_\_\_\_\_ (Date) .

Signature \_\_\_\_\_ Official Capacity \_\_\_\_\_

*Make copies of these two pages for your health care providers, hospital, health care agent and family*

## DEFINITIONS

**Artificial nutrition (feeding)** – Using IVs or tubes to supply food when you are unable to eat. A **feeding tube** is a medical tube through which food or water is put into your vein, stomach, nose, mouth or other body opening.

**Artificial hydration** – Using IVs or tubes to supply water when you are unable to drink.

**Attending doctor** – A doctor who has primary responsibility for your treatment and care.

**CPR or Cardiopulmonary resuscitation** – Emergency medical procedure used to try to restart heartbeat and breathing, which can involve blowing into the mouth, pushing on the chest and electrical shock.

**Certification of incapacity** – “Lack capacity,” “inca-pacitated.” If you cannot understand effectively or communicate your decisions, to the extent that you cannot manage your health care decisions. This is determined by a doctor.

**Comfort care** – Keeping you as comfortable and peaceful as possible, including pain medication, giving you ice chips and lip ointment, turning your body to prevent bed sores and bathing you.

**DNR or Do Not Resuscitate order** – A doctor’s order in your medical chart that says you do not want to be revived (CPR) if your heart or breathing stops.

**Execute** – A legal document is executed, or has the force of law, when it is signed, dated, witnessed and notarized as required.

**Health care agent** – Someone chosen as your Durable Power of Attorney for Health Care to make health care decisions when you are unable to express your own wishes for care or treatment.

**Hospice care** – A team approach to provide comprehensive medical, nursing and social services, spiritual care and bereavement support for you and your family. It is designed to give comfort and relief of symptoms near the end of life.

**Intravenous or IV line** – A tube placed in your vein that is used to give you fluids, blood or medication.

**Life-sustaining treatment** – Any medical procedure or intervention that, in the judgement of the doctor, would only prolong the dying

process but not avert death. This includes assistance to breathe (CPR, ventilator or mechanical respiration), artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis and other similar procedures, but does not include lessening pain through medication or with a medical procedure.

**Organ and tissue donation** – Giving your usable organs for transplantation into others, which will save or improve their lives. Organs you can donate: heart, kidneys, pancreas, lungs, liver, intestines. Tissue you can donate: cornea, skin, bone marrow, heart valves, connective tissue. To be transplanted, organs must receive blood until they are removed from your body. Therefore, it may be necessary to place you on a breathing machine temporarily or provide other organ-sustaining treatment. Doctors evaluate whether you have organs or tissue suitable for transplant at or near the time of death. Your body can still be shown and buried after your death.

**Palliative care** – Taking care of the whole person – body, mind and spirit. This approach views dying as natural and personal; its goal is to provide you with relief of symptoms (see Hospice care).

**Permanent medical record** – The place where a doctor will write a “Do Not Resuscitate” order. The place where a health facility will keep copies of your advance directives.

**Permanently unconscious** – If you are not aware of your environment and your own existence or thoughts and have no possibility of recovering your awareness.

**Persistent vegetative state** – An irreversible condition where reasonable medical judgement finds the complete loss of key brain functions. It results in the end of all thinking and consciousness, although heartbeat and breathing continue. Periods of sleep and wakefulness will still occur.

**Terminal condition, terminally ill** – An incurable condition caused by injury or illness that reasonable medical judgement finds will cause death at any time, so that life-sustaining treatment will only postpone death.

**Trial of treatment** – To try treatment(s) for a period of time (such as 1 or 2 weeks) until it is decided that the treatment will not succeed.



FOUNDATION FOR  
HEALTHY COMMUNITIES

*The information contained in this booklet was prepared by the*

### **New Hampshire Partnership for End-of-Life Care**

... a group of organizations that helps people to plan for their health care,  
talk about their choices and have them respected.

*It has been endorsed by the following organizations:*

New Hampshire Hospital Association  
New Hampshire Medical Society  
Home Care Association of New Hampshire  
New Hampshire Council of Churches  
New Hampshire Health Care Association  
New Hampshire Hospice Organization  
AARP New Hampshire

**Notice to  
Health Care Provider**

I have:

\_\_\_\_\_ a Durable Power of Attorney  
for Health Care

\_\_\_\_\_ a Living Will

The signed original document is  
located at:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In case of emergency, contact:

\_\_\_\_\_

Name

\_\_\_\_\_

Address

\_\_\_\_\_

City, State, Zip

\_\_\_\_\_

Phone

**Advance Directive Card**

\_\_\_\_\_

Name

\_\_\_\_\_

Address

\_\_\_\_\_

City, State, Zip

\_\_\_\_\_

Signature

**Please see reverse side  
for important information**

*Cut this Advance Directive card along the dotted line,  
fold it in half and keep it in your wallet.*

Foundation For Healthy Communities 125 Airport Road Concord, NH 03301  
phone (603) 225-0900 • fax (603) 225-4346 • web: [www.healthynh.com](http://www.healthynh.com)

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*Designed by Linden Jackett, Concord NH*