MONTANA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
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CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

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

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

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

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. The Montana End-of-Life Registry is your state's advance directive registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://www.endoflife.mt.gov.

6. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Montana Advance Directive

This packet contains a legal document—the **Montana Advance Directive**, which is based on the form developed by the Montana Department of Justice, Office of Consumer Protection—that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete any or all of the first four parts, depending on your advance planning needs. You must complete Part 5 in order to make your advance directive valid.

Part 1, the **Terminal Conditions Declaration**, is your state's living will. Part 1 allows you to make decisions regarding your health care in the event you can no longer make decisions yourself and you have developed a terminal condition.

Part 2 is an optional description of **Chronic Illness or Serious Disability**. This part allows you to describe any chronic illness or serious disability that you have that should not be misinterpreted as a terminal condition. This part also allows you to give special directions regarding your condition as well as the contact information for your treating physician.

Part 3 is a **Power of Attorney for Health Care** that allows you to choose an adult representative to make health care decisions for you. Part 3 is especially useful, because it allows your representative to make decisions for you at any time you are unable to make or communicate your health care decisions, not just when you are in a terminal condition.

Part 4 is a section that allows you to state **Special Directions** with regard to your advance planning, such as your spiritual preferences, organ donation, and the final disposition of your remains. Part 4 also allows you to state whether you plan to register your advance directive with the Montana End-of-Life Registry and to whom you plan to give copies of your document.

Part 5 contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs

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

Instructions for Completing Your Montana Advance Directive

Whom should I appoint as my representative?

Your representative is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your representative may be a family member or a close friend whom you trust to make serious decisions. The person you name as your representative should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

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

How do I make my Montana Advance Directive legal?

The law requires that you sign your advance directive, or direct another to sign it, in the presence of two witnesses.

Should I add personal instructions to my Montana Advance Directive?

One of the strongest reasons for naming a representative is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your representative carry out your wishes, but be careful that you do not unintentionally restrict your representative's power to act in your best interest. In any event, be sure to talk with your representative about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your *Montana Advance Directive* at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective once you, or a witness to your revocation, notify your doctor, advanced practice registered nurse, or other health care provider.

Your representative's powers under a Power of Attorney for Health Care are automatically revoked if your spouse is your representative and you are legally separated or divorced.

What other important facts should I know?

Instructions to withhold or withdraw life-sustaining treatment from a pregnant patient will not be honored if it is probable that the fetus will survive to live birth with continuing life-sustaining treatment.

PRINT YOUR FULL NAME HERE

Full Name: _____
Please print

Part 1. Terminal Conditions (Living Will)

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want if I cannot communicate or make my own decisions. These directions are only valid if both of the following two conditions exist:

1. **I have a terminal condition, and**
2. **in the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment that only prolongs the dying process.**

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

General Treatment Directions

Check the boxes that express your wishes: (Check only one)

CHECK ONLY ONE BOX

☐ I provide no directions at this time.

☐ I direct my attending physician to withdraw or withhold treatment that merely prolongs the dying process.

☐ I direct my attending physician to provide life-sustaining treatment if I have a terminal condition, even though it may only serve to prolong the dying process.

I further direct that (check all boxes that apply):

CHECK ALL BOXES THAT APPLY

☐ Treatment be given to maintain my dignity, keep me comfortable and relieve pain even if it shortens my life.

☐ If I cannot drink, I do not want to receive fluids through a needle or catheter placed in my body unless for comfort.

☐ If I cannot eat, I do not want a tube inserted in my nose or mouth, or surgically placed in my stomach to give me food.

☐ If I have a serious infection, I do not want antibiotics to prolong my life. Antibiotics may be used to treat a painful infection.

PRINT THE DIAGNOSIS OF YOUR CHRONIC ILLNESS OR SERIOUS DISABILITY, IF ANY

PRINT THE NAME OF THE PHYSICIAN WHO TREATS YOUR CONDITION

ADD ADDITIONAL DIRECTIONS, IF ANY, REGARDING YOUR CHRONIC ILLNESS OR SERIOUS DISABILITY

Part 2. Chronic Illness or Serious Disability (Optional)

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

Diagnosis _____

Consult my physician _____
Name Phone

Additional directions (use additional pages if necessary) _____

CHECK ONLY ONE BOX

PRINT THE NAME, ADDRESS, AND PHONE NUMBERS OF YOUR PRIMARY REPRESENTATIVE

Part 3. Health Care Representative (Power of Attorney for Health Care)

I wish to appoint a representative ☐ Yes ☐ No

A. Primary Representative

I appoint _____ as my representative.

_____

Representative's Address

_____

Home Phone Work Phone

This health care power of attorney becomes effective upon my disability or incapacity. My representative has authority to make any health care decision that I could make, including decisions regarding the withholding or withdrawing of life-sustaining treatment and artificial administration of nutrition or hydration. My representative's authority to make these decisions is operative at any time I am unable to make or communicate my health care decisions, regardless of whether I am expected to recover or not.

When making health care decisions for me, my representative should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my representative should make decisions for me that my representative believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

If, for any reason, I should need a guardian of my person designated by a court, I nominate my representative, or alternate representative(s), named below.

Part 3. Health Care Representative (Power of Attorney for Health Care)

B. Alternate Representative(s)

If: 1. I revoke my representative's authority; or
2. My representative becomes unwilling or unable to act for me; or
3. My representative is my spouse and I become legally separated or divorced,

I name the following person(s) as alternates to my representative in the order listed:

PRINT THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR ALTERNATE REPRESENTATIVES

1. _____
Print Alternate Representative's Full Name

_____
Address

_____
Home Phone Work Phone

2. _____
Print Alternate Representative's Full Name

_____
Address

_____
Home Phone Work Phone

ALL OF THE FOLLOWING IN PART 4 ARE OPTIONAL

INDICATE YOUR RELIGIOUS OR SPIRITUAL PREFERENCE

CHECK THE BOX TO INDICATE WHERE YOU WOULD PREFER TO DIE

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Part 4. Special Directions (Optional)

A. _____ Spiritual Preferences

My religion _____

My faith community _____

Contact person _____

I would like spiritual support ☐ Yes ☐ No

B. Where I Would Like to be When I Die

☐ My home ☐ Hospital ☐ Nursing home ☐ Hospice

☐ Other _____

C. Donation of Organs at My Death (check one of the following):

☐ I do not wish to donate any of my body, organs, or tissue.

☐ I wish to donate my entire body.

☐ I wish to donate **only** the following (check all that apply):

☐ Any organs, tissues, or body parts ☐ Heart ☐ Kidneys

☐ Lungs ☐ Bone Marrow ☐ Eyes ☐ Skin ☐ Liver

☐ Other(s) _____

D. After-Death Care (care of my body, burial, cremation, funeral home preference)

_____

_____

_____

_____

E. Additional Directions (use additional pages if necessary) _____

_____

_____

_____

_____

_____

_____

_____

_____

CHECK THE BOX INDICATING WHETHER YOU PLAN TO REGISTER YOUR ADVANCE DIRECTIVE

PRINT THE NAME(S), ADDRESS(ES), AND PHONE NUMBER(S) OF THE PERSON(S) YOU PLAN TO SEND COPIES OF YOUR ADVANCE DIRECTIVE

F. Distributing this Advance Directive

I plan to deposit this Advance Directive in the Montana End-of-Life Registry: ☐Yes ☐No

I plan to send copies of this document to the following people or locations:

Physician:

Name

Address

Home Phone Work Phone

Family Member: Relationship _____

Name

Address

Home Phone Work Phone

Other:

Name

Address

Home Phone Work Phone

Clergy:

Name

Address

Home Phone Work Phone

PRINT THE DATE HERE

SIGN AND PRINT YOUR NAME, ADDRESS AND TELEPHONE NUMBERS HERE

YOUR WITNESSES MUST SIGN AND PRINT THE DATE AND THEIR NAMES AND ADDRESSES HERE

Part 5. Signing and Witnessing this Advance Directive

A. Your Signature

Ask two people to watch you sign and have them sign below.

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

I sign this document on the _____ day of _____, 20_____

_____ _____
Signature Print Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

B. Ask Your Witnesses to Read and Sign

I declare that I am over the age of 18 and the person who signed this document is personally known to me, and has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud or undue influence.

1. _____
Signature Date

_____
Printed Name

_____
Address

2. _____
Signature Date

_____
Printed Name

_____
Address

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your *Montana Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your representative and alternate representative, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your representative(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. The Montana End-of-Life Registry is your state's advance directive registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://www.endoflife.mt.gov.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your Montana document.

8. Be aware that your Montana document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advance directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

- -

YES! I want to support the important work of the National Hospice Foundation.

$23	helps us provide free advance directives
$47	helps us maintain our free InfoLine
$64	helps us provide webinars to hospice

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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OR donate online today: www.caringinfo.org/donate