MONTANA
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

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, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or 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. The Montana End-of-Life Registry is your state's advance directive registry. By filing your advance directive with the registry, your healthcare 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.

INTRODUCTION TO YOUR MONTANA ADVANCE HEALTH CARE 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.

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.

You may complete any or all of the first four parts, depending on your advance planning needs. **You must complete Part 5**.

How do I make my Montana Advance Health Care Directive legal?

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

Whom should I appoint as my agent?

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

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Part I, **Terminal Conditions (Living Will),** goes into effect if both of the following two conditions exist:

- You have a terminal condition, and
- in the opinion of your attending physician, you will die in a relatively short time without life sustaining treatment that only prolongs the dying process.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

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 and your agent will be bound by the current laws of Montana as they regard pregnancy and termination of pregnancies.

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.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

PRINT YOUR FULL NAME HERE

Full Name: _____
Please print

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 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.

☐ 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.

CHECK ONLY ONE BOX

I have attached additional directives regarding medical treatment to this form:

☐ Yes ☐ No

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

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

Special directions (use additional pages if necessary) _____

CHECK ONLY ONE BOX

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

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

3. Health Care Representative (Power of Attorney for HealthCare) I wish to appoint a representative ☐ Yes ☐ No

A. Primary Representative

I appoint_____as my representative.

_____
Representative's Address

_____
City State Zip

_____
Home Phone Work Phone

My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

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.

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:

1._____
Print Alternate Representative's Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

2._____
Print Alternate Representative's Full Name

_____
Address

_____
City State Zip

_____
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

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)

_____

Signature _____ **Date** _____

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

A. 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

_____

City State Zip

_____

Home Phone Work Phone

Family Member: Relationship _____

_____

Name

_____

Address

_____

City State Zip

_____

Home Phone Work Phone

Hospital:

_____

Name

_____

Address

_____

City State Zip

_____

Home Phone Work Phone

Clergy:

_____

Name

_____

Address

_____

City State Zip

_____

Home Phone Work Phone