

# How to Create an Advance Directive

**Note:** Use these instructions and forms to create an Advance Directive.

These instructions and form letter may not be right for your case. They cannot take the place of advice from a lawyer. Talk to a lawyer if you have any questions.

Do not change these forms. If you change the forms, you might lose language you need.



## What is the “My Choices” Advance Directive?

It can be difficult to talk about what might happen if you become ill and cannot make health care decisions. It helps to have your choices written down. Your My Choices Advance Directive can tell your family and health care providers your decisions.

## Who Can Use These Forms?

You can use these forms if you want to say what you think should happen if you become seriously ill and cannot speak for yourself. You can use these forms to say what you want health care providers to do or not do. You can also use these forms to name a Health Care Representative, who is someone you trust to make decisions for you. You must be 18 or older to have an advance directive.

## What Forms Will I Need?

You may decide to use all of the forms in this packet, or only some of them. Read these instructions to help you decide which forms you want to use. This packet contains the following forms, which appear after these instructions:

- The My Choices Advance Directive, including:
  - a Living Will, which tells your wishes about your care if you have a serious illness, and

- a Health Care Power of Attorney, which gives someone else the power to make health care decisions for you if you cannot make those decisions yourself. That person is called the Health Care Representative.
- A Consumer Registration Agreement. If you fill out this agreement, you can store your Advance Directive with the Montana Attorney General's End-of-Life Registry. The Montana End-of-Life Registry makes your Advance Directive available to health care providers and other people you have authorized to look at it. The Montana End-of-Life Registry provides this service free of charge.

## **What is the difference between a Living Will and a Health Care Power of Attorney?**



### **Living Will**

A Living Will is written direction that says what kind of treatment you want if you ever have a serious illness and cannot express what you want. This direction will go to your health care provider. If you name a Health Care Representative, your Living Will should also go to him or her. With a Living Will, your health care provider will know what kind of treatment you want even if you cannot say anything when the time comes.

For example, you may not want a machine to feed you or breathe for you, but you may want medical treatment to keep you comfortable. You can fill out a Living Will saying that you do not want feeding or breathing tubes, but you do want medical treatment to keep you comfortable. Then, if you ever become

unable to say what treatment you want, your health care providers and Health Care Representative can read your Living Will.



### **Health Care Power of Attorney (to name a Health Care Representative)**

If you fill out a Health Care Power of Attorney, you give someone else permission to make health care decisions for you. The person you name is called your Health Care Representative. Your Health Care Representative can only make decisions for you if:

- (1) you cannot express your wishes to your health care provider; and
- (2) you are faced with a terminal condition.

A Health Care Power of Attorney gives the person you name a lot of power to make decisions for you. That person would **not** have to ask your permission first. It is very important that you talk with the person you want to name as your Health Care Representative before you sign anything. It is also important that the person knows about your health care choices. If you think the person will not follow your wishes, you should not name that person as your Health Care Representative.

For example, you may decide to name your daughter as your Health Care Representative. You could tell your daughter that you do not want a machine to feed you or breathe for you. If you have a Living Will, you could also give that to your daughter. Then, if you become terminally ill and unable to say what you want, your daughter can tell your doctor not to use the machine.



## How do I fill out the My Choices Advance Directive?

### 1 Section 1: Living Will

- Decide if you want to complete the Living Will, which is Section 1 of the Advance Directive. This section allows you to tell your health care provider what kind of medical care you want if you have a serious illness.
- If you decide to complete the Living Will, check the boxes in front of the options that you want. For example, you can choose not to be hooked up to tubes and machines that help you eat and drink. You can also choose to get medicine only to help with pain. You can choose more than one option.
- You may also want to write out your own directions. If you have additional directions, make sure to check “Yes” where the form says “I have attached additional directions regarding medical treatment to this form.” Then, write out your directions and keep them with the Advance Directive.
- If you do not want to complete the Living Will section of the My Choices Advance Directive, check the box that says “I provide no directions at this time.”

### 2 Section 2: Identify any Chronic Illness or Serious Disability

In Section 2 of the My Choices Advance Directive, you can explain if you have any chronic illness or serious disability. You can let health care

providers know that this illness or disability should not be mistaken for a terminal condition. If you do not want to tell health care providers about a chronic illness or serious disability, you can leave this section blank.

### 3 Section 3: Health Care Power of Attorney

- Decide if you want to name a Health Care Representative. If you want to name a Health Care Representative, check “Yes” where the advance directive states “I wish to appoint a Representative.” If you do not want to name anyone, check “No.”
  
- If you choose to name a Health Care Representative, decide who is your first choice to make health care decisions for you when you are unable to do so. Make sure you trust this person. This person will be your Primary Representative. Write down this person’s name, address, and phone number in the section marked **A**.
  
- Name alternative representatives. Whenever you name someone to make major decisions for you, it is a good idea to name other people who can take over the decision-making role if your first choice cannot or will not serve. It is important that you trust all the people you name.

Write the name and contact information for two Alternate Representatives in the section marked **B**. The people you choose would serve in the order listed. If your first choice cannot serve, the second person you list will make the decisions. If the second choice could not serve, the third person you list will make the decisions.

- If you cannot think of anyone you trust to make medical decisions for you, it is better that you do not name anyone as your Health Care Representative. You should not name someone who will not

follow your written health care instructions. If you do not name a Health Care Representative, you can still fill out a Living Will. Your health care provider must follow your written health care instructions in the Living Will.

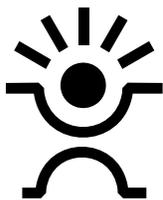
#### **4 Sign your Advance Directive in front of two witnesses**

You must have two witnesses watch you sign the form. They must also sign the form in the spaces provided. Your two witnesses can be family members, friends, co-workers, or acquaintances. If you are worried that a person will not agree with your health care decisions, you may want to choose someone else to be your witness.

In addition, it is a good idea to get the form notarized, if possible. There is a space for the notary public to fill out.

#### **5 Include any special instructions you would like your health care provider and family members to know**

Section 5 of the My Choices Advance Directive is a space for you to list special instructions for your health care provider or family. You can list a spiritual preference, decisions regarding organ donation, and where you would like to be when you die. You can say if you will store your Advance Directive with Montana's End-of-Life Registry. You can also say if any other individuals will get a copy of your Advance Directive.



### **Can I make health care decisions for myself after I sign the Advance Directive?**

Yes. You can make decisions about life-sustaining treatment and other health care as long as you are able to do so. Your Advance Directive will only be used

when you are unable to make your health care decisions or communicate them to your health care provider. You can make health care decisions for yourself and express them to your health care provider as long as you are able.



## **What if I have signed my Advance Directive, but no longer want it?**

You may cancel your Advance Directive at any time. You can cancel it either in writing or orally (by speaking). Either you or someone who witnessed you cancel your Advance Directive must tell the health care provider that you cancelled your Advance Directive. It is important that you let your health care provider know you have cancelled your Advance Directive before you need life-sustaining treatment.



## **How do I make sure that my health care provider has a copy of my Advance Directive?**

The My Choices Advance Directive also includes a Consumer Registration Agreement. If you fill out this agreement, you can store your Advance Directive with the Montana End-of-Life Registry. The Montana End-of-Life Registry makes this document available to health care providers and other people you have authorized to look at it. The Montana End-of-Life Registry provides this service free of charge.

If you want to store your Advance Directive with Montana's End-of-Life Registry, you must fill out the Consumer Registration Agreement. Follow these steps:

### **1 Fill out information that will identify you**

The first section asks for your name, birth date, mailing address, social security number, and mother's maiden name. It is important that you fill out this section completely.

## **2 Choose who you would like to have access to your Advance Directive**

The second section asks who you would like to have access to your Advance Directive. If you choose “Standard Privacy,” your health care provider and anyone who has your social security number, birth date, and mother’s maiden name can view your information. If you choose “Higher Privacy,” only your health care provider and individuals who have information on a wallet card provided to you by the End-of-Life Registry can view your information. This section also asks if you want to store an advanced directive with the End-of-Life Registry, replace an advanced directive with a new one, remove your advanced directive from the End-of-Life Registry, or request a replacement wallet card.

## **3 Sign and Date the Registration Agreement**

The third section explains the agreement between you and the End-of-Life Registry. Sign and date the agreement here.

## **4 Mail the Advance Directive and Registration Agreement**

If you wish to store your Advance Directive with the End-of-Life Registry, mail your completed Advance Directive and Consumer Registration Agreement to the address listed on the Consumer Registration Agreement. The address is also listed below:

Office of Consumer Protection  
2225 11th Avenue  
P.O. Box 201410  
Helena, MT 59620-1410

If your Advance Directive or Registration Agreement is missing information, the End-of-Life Registry will return the forms to you with a letter explaining what information you need to provide.

## Where can I get more information?

The laws of Montana are called the Montana Code Annotated or “MCA.” The laws about advance directives begin in the MCA at Title 50, Chapter 9, Section 101. An easier way to write that is § 50-9-101, MCA. The symbol § means section. The MCA can be found at your local library or on the Montana State Law Library website at [www.lawlibrary.mt.gov](http://www.lawlibrary.mt.gov). Click on the “MCA” option near the top of the page.



## Where Can I Get Legal Help?

These organizations may be able to help you:

- **Montana Legal Services Association (MLSA)** gives free legal help to low-income people. To find out if you qualify for MLSA, call the MLSA HelpLine at 1-800-666-6899.
- **The State Bar Lawyer Referral and Information Service (LRIS)** refers people to Montana lawyers who might be able to help. Call LRIS at 1-406-449-6577.
- **The State Law Library** can help you find and use legal resources such as books, forms, and websites. You can visit the Law Library website at [www.lawlibrary.mt.gov](http://www.lawlibrary.mt.gov). Or you can contact a Reference Librarian at 1-800-710-9827 or by email at [mtlawlibrary@mt.gov](mailto:mtlawlibrary@mt.gov).

## Please take a short survey about these forms.

When you are done with the forms, please take our online survey at this address:

[http://www.surveymonkey.com/s.aspx?sm=fCBbhbbJj4MdOWw\\_2fjsCjlg\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=fCBbhbbJj4MdOWw_2fjsCjlg_3d_3d)



Or you can access the survey on the “Forms” page of the State Law Library website, at [www.lawlibrary.mt.gov](http://www.lawlibrary.mt.gov). Your answers will help make the forms better. Thank you!

# My Choices Advance Directive

For office use  
only

**Full Name:** \_\_\_\_\_  
Please print

These directions apply only in situations when I am not able to make or communicate my health care choices directly. Put an X through any sections you are not completing at this time.

## 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:

- **I have a terminal condition, and**
- **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:

- 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):

- 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.

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

- Yes
- No

## 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) \_\_\_\_\_

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

My Representative may make all health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

I wish to appoint a Representative  Yes  No

### A. Primary Representative

I appoint \_\_\_\_\_ as my Representative.  
Print Representative's Full Name

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

## 4. Signing and Witnessing this Advance Directive

### A. Your Signature

Ask two people to watch you sign and have them sign below. If you can, it's best to sign this document in front of a Notary Public.

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. \_\_\_\_\_ 2. \_\_\_\_\_  
Signature Date Signature Date

\_\_\_\_\_  
Printed Name Printed Name

\_\_\_\_\_  
Address Address

\_\_\_\_\_  
City State Zip City State Zip

### C. Notarizing This Document

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, the said known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

\_\_\_\_\_  
Notary Public for the State of \_\_\_\_\_

Residing at \_\_\_\_\_

My commission expires \_\_\_\_\_

## 5. Special Directions

### 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  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 \_\_\_\_\_

### 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

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Home Phone Work Phone

#### Hospital:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone

#### Family Member: Relationship \_\_\_\_\_

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Home Phone Work Phone

#### Clergy:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Home Phone Work Phone

# Consumer Registration Agreement

For office use only

2225 11<sup>th</sup> Avenue, PO Box 201410, Helena, MT 59620-1410 • Phone (406) 444-0660 or (866) 675-3314 • E-mail: [endofliferegistry@mt.gov](mailto:endofliferegistry@mt.gov)

This form indicates your desire to store an advance directive in the Montana End-of-Life Registry, to replace or remove an Advance Directive already in the Registry, or to request a replacement wallet card.

- Read this Agreement carefully and fill in Sections A through C completely.
- Attach your witnessed Advance Directive.
- Return this Agreement with your Advance Directive to the Office of Consumer Protection at the address above.
- Your Consumer Registration Agreement will be processed within three weeks. You will receive further information in the mail.

## Section A

Prefix	First Name	Middle Name or Initial	Last Name	Suffix
Gender	Date of Birth (Month/Day/Year)	Mother's Maiden Name	Social Security Number	Phone Number
Mailing Address				
City	State	Zip	County	Country

## Section B

Pick a level of privacy:

- Standard Privacy:** If the information on my wallet card is unavailable, in addition to health care providers, people who enter my Social Security Number, date of birth and mother's maiden name can view my advance directive.
- Higher Privacy:** Only people who have the information from my wallet card and health care providers can view my advance directive.

I want to:

- Store an advance directive in the Registry.**
- Replace an advance directive in the Registry with a new one.**
- Remove my advance directive from the Registry.**
- Request a replacement wallet card.**

## Section C Revised 7/07

I am providing this personal information along with my advance directive, with the understanding that my personal information will be stored in a secure Department of Justice database and will not be available to the public. I certify that the advance directive that accompanies this Agreement is my current effective advance directive and was duly executed, witnessed and acknowledged in accordance with [Section 50-9-103](#) of the Montana Code Annotated.

I understand that:

- my advance directive will be entered in the Montana End-of-Life Registry free of charge;
- this authorization is voluntary;
- this authorization to store my advance directive in the Montana End-of-Life Registry will remain in force until I revoke it;
- I may revoke this authorization at any time by giving written notice of my revocation to the address listed above; and
- no agency, provider or individual may be held liable for any action based on this authorization before a written notice of revocation has been entered into the Registry.

\_\_\_\_\_  
Signature of Person Signing This Agreement

\_\_\_\_\_  
Date

If the person named in the advance directive is unable to sign this form, and you have legal authority to sign for that person, please check the source of your authority and provide proof thereof.  Durable Power of Attorney  Court Appointed Guardian