

DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, “the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a ‘scientific’ process.” Because of “political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective” (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that “The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow,” and suggesting that revised and enhanced documents “may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes” (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic professionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or “health care instruction” or “declaration”) and medical power of attorney (or “proxy”) forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, “*Should I Use a Shorter Standard Directive?*” available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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*Statutory
Advance Directive
For
Montana Residents*



*Statutory Compliant
Advance Directive for
Health Care Choices*

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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warranted to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Montana Residents

Print Full Name

Date of Birth

Your right (when age 18 or older): To Document Your Personal Wishes,
and to have these wishes followed ~~

The Montana legislature has provided statutes guiding the construction of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as “advance directives.” As the content of these documents was designed by your state government, each should be in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read both carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know your wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at any time by: **1)** writing “revoked” across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2)** by completing a Notice of Revocation; or **3)** by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4)** by *simply completing a new directive* in which you state that any prior directive is no longer valid.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only **Section I**, leaving just a statement of your values and wishes. Or you may complete only **Section II**, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should initial in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write “No,” “None,” or “Does Not Apply” in areas that would otherwise be left blank.

**SECTION I:
LIVING WILL DECLARATION
and Personal instructions**

(Pursuant to MCA Title 50: Chap.9: §50-9-101 to §50-9-206)

1. INTRODUCTION: *An individual of sound mind and 18 years of age or older may execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment. The declarant may designate another individual of sound mind and 18 years of age or older to make decisions governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the declarant, or another at the declarant's direction, and must be witnessed by two individuals. A declaration may, but need not, be in the following form:*

DECLARATION

2. If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or attending advanced practice registered nurse, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician or attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

3. Signed this _____ day of _____, 20_____.
(Do not sign until in the presence of two witnesses; see below)

4. Signed: _____

Date: _____

Address: _____

Statement and Signatures of Witnesses

5. The declarant voluntarily signed this document in my presence.

6. Witness: _____

Printed Name: _____

Address: _____

7. Witness: _____

Printed Name: _____

Address: _____

SECTION II:
PROXY APPOINTMENT DECLARATION

(Pursuant to MCA Title 50: Chap.9: §50-9-101 to §50-9-206)

8. INTRODUCTION: *A declaration that designates another individual to make decisions governing the withholding or withdrawal of life-sustaining treatment may, but need not, be in the following form:*

9. If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or attending advanced practice registered nurse, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I appoint:

10. **Name of Proxy:** _____
Address: _____
Telephone: Home: _____ Work: _____
Cell Phone or Pager: _____ E-mail: _____

~~ or, if he or she is not reasonably available or is unwilling to serve, I appoint:

11. **Name of Alternate:** _____
Address: _____
Telephone: Home: _____ Work: _____
Cell Phone or Pager: _____ E-mail: _____

~~ to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to the Montana Rights of the Terminally Ill Act.

10. If the individual I have appointed is not reasonably available or is unwilling to serve, I direct my attending physician or attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

12. Signed this _____ day of _____, 20_____.

(Do not sign until in the presence of two witnesses; see below)

13. Signed: _____
Date: _____
Address: _____

Statement and Signatures of Witnesses

14. The declarant voluntarily signed this document in my presence.

15. Witness: _____

Printed Name: _____

Address: _____

16. Witness: _____

Printed Name: _____

Address: _____