The Rest Of Your Life www.theroyl.com

Advance Directive and Durable Power of Attorney

My Choices Advance Directive

State of Montana

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

Advance Directives Electronic Forms

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

Why do an Advance Directive?

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

Description:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

Security:

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).

Montana Department of Justice
Office of Consumer Protection
MONTANA
END-OF-LIFE REGISTRY
www.doj.mt.gov/consumer/consumer

My Choices Advance Directive

For office use only

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

Full Name: EXAMPLE
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.

☐ 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 EXAMPLE 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_____

EXAMPLE

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

City | State | Zip

2. _____
Signature | Date

Printed Name

Address

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

Family Member: Relationship _____

_____
Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

Hospital:

_____
Name

_____
Address

_____
City State Zip

_____
Phone

Clergy:

_____
Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

Additional Pages: