

# Health Care Power of Attorney and Related Documents for Montanans



## Authors

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## Disclaimer

This publication is not a substitute for legal or medical advice. Rather, it is to help families become aware of Health Care Powers of Attorney for Montanans and related health care decisions. Future changes in laws are not predictable. Statements in this document reflect laws in force on the date of publication.



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# Health Care Power of Attorney

**END-OF-LIFE AND HEALTH CARE DECISIONS ARE PERSONAL.** They are based upon our family and life experiences, spiritual and religious beliefs, and knowledge gained throughout life. You may have shared feelings about medical and end-of-life issues with your health care providers, family and friends. However, when it comes to the legalities surrounding formal decision-making, talking simply isn't enough. If you should become incapacitated or have difficulty communicating when a decision needs to be made, your health care wishes need to be in writing. Written legal documents will ensure your wishes are followed by those making decisions with and for you.

One challenge often encountered is the difference in terminology used by the legal profession and health care providers. Many of us have heard about or seen different forms on the Web, in hospitals or physicians' offices. Some documents are the latest versions, while others may not be recognized by health care providers. The documents may also not adequately communicate your wishes.

To address these concerns, several organizations have collaborated to develop a model Health Care Power of Attorney (Form A) for Montanans. They have also created two optional forms (Form B and Form C) along with a worksheet. These forms should be used to appoint health care agent(s) and assist others in understanding your health care preferences.

This publication specifically explains a Health Care Power of Attorney for Montanans. For information about a financial power of attorney, see the MSU Extension MontGuide [“Power of Attorney \(Financial\)”](#) (MT199001HR) available from your local MSU Extension office.

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## Forms

**Worksheet.** The purpose of the worksheet is to provide questions that, when answered, help you, your agent, family, health care providers, and others who are involved, to make decisions about your health care. You may want to complete the worksheet before designating a health care agent or before making end of life decisions.

**Form A.** This form is a model Health Care Power of Attorney. The form provides a formal, legal way to appoint your health care agent(s) to assist you and make health care decisions for you. The form also provides information to your agent(s) about your health care and end-of-life wishes.

**Forms B and C.** Montanans who want to provide additional directions to their families about specific health care treatments and related decisions will want to complete these forms.

Forms B and C are optional. If you do not fill them out, your agent still has authority to make treatment decisions based on your Health Care Power of Attorney.

## Instructions for Form A

The following pages describe sections of the model Health Care Power of Attorney (**Form A**). After you have filled out and signed Form A, your Health Care Power of Attorney becomes a legal document.

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## Instructions for Form A

The following pages describe sections of the model Health Care Power of Attorney (**Form A**). After you have filled out and signed Form A, your Health Care Power of Attorney becomes a legal document.

## 1 Appointment of an Agent

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**Identify yourself and your agent.** Appointing an agent to act as your health care power of attorney is an important decision. If you want your spouse to be your agent, identify him/her in this section. Write your spouse's full legal name, not a nickname. Do not use social titles, for example, my wife, my husband, or my spouse.

## 2 Appointment of Back-up Agent(s)

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**Identify your back-up agents.** In case your agent is unable to perform his/her duties, naming a back-up agent is a good idea. As an example, your agent could become ill or be traveling outside the United States when you need him/her to make a health-related decision. If you want an adult child or a close friend to be a back-up agent, list the name of each person in order of priority.

You may cancel (revoke) the authority of your agent or back-up agent at any time. You may revoke your health care power of attorney either in writing, signed by you or by a verbal statement in the presence of a person relying on the revocation, such as telling your physician or nurse, ***"I revoke my health care power of attorney."***

Your revocation is effective after individuals who rely on your Health Care Power of Attorney see your revocation in writing or hear you revoke your power of attorney. After you revoke your Health Care Power of Attorney, your agent will no longer have authority to make health care decisions for you.

## 3 Agent's Authority and Obligations

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**Describe your agent's authority.** Your agent should make decisions about your health care based on your wishes and best interests. Once your agent's authority is effective, he/she can act on your behalf about any health matters you have listed. Your agent can receive

and disclose information about your health condition to others. Your agent can talk with your physician and other health care providers, as well as staff in insurance, billing, and medical records on your behalf.

A Health Care Power of Attorney gives your agent authorization to act for you under the state and federal law, including the Health Insurance Portability and Accountability Act, commonly called HIPAA.

## 4 When An Agent's Authority Becomes Effective

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**Decide when your agent's authority to take actions for you becomes effective. You have two options. On Form A choose ONLY Option A or Option B.**

### CHOOSING OPTION A

**Option A makes your agent's authority effective as soon as you sign the document.**

- 1.** Allows your agent to take actions for you immediately, without having to prove you are incapable of making your own health care decisions.
- 2.** Allows your agent to have the authority to help you, even while you are able to make your own health care decisions. You always keep the ability to make your own health care decisions, for as long as you want and are able.
- 3.** Means your agent will not have to ask a physician, other health care provider, or person designated by you whether you are incapable of making health care decisions before the appointment becomes effective.
- 4.** Makes it clear to health care providers and insurance company personnel your agent has authority to take actions, even if the health care provider or insurance company does not know whether you are able to make your own health decisions.
- 5.** Allows personnel from an insurance company or a billing or medical records office or your health care provider to speak with your agent (including over the telephone), without knowing if you are able to make your own health care decisions.

6. Allows your agent to receive information about your health care when you want help scheduling appointments, doing what the physician asks you to do, moving between physicians, understanding and paying medical bills, getting medications, and other similar matters.

#### CHOOSING OPTION B

**Option B makes your agent's authority effective only when you are not able to make health care decisions for yourself.**

Your primary care or attending physician, advanced practice registered nurse or other person designated by you is the one to determine whether you are capable of making health care decisions for yourself.

Until such a determination is made, health care providers and health plans will be prohibited by state and federal laws, including HIPAA, from disclosing health care information about you to your designated agent (except in limited circumstances), unless you sign a separate written authorization for the agent.

Do not choose Option B if you want your agent's authority to be effective during periods when it is **unclear** whether you are capable of making your own health care decisions. Such situations may include being under the influence of strong medications, when you are experiencing pain or stress, or when dementia or a mental illness worsens.

## 5 Guidance and Preferences

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*Provide additional directions to your agent.* Express guidance and your preferences about specific matters of health care treatments and other decisions not covered on Forms A, B, or C.

## 6 Nomination of Legal Guardian

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*Nominate your chosen agent or a back-up agent as your legal guardian.* Nominating a guardian is important if it becomes necessary for the district court to appoint a legal guardian for you. Your guardian makes additional decisions for you such as living arrangements. Your

nominated guardian has priority over other persons for appointment by the district court as your guardian.

## 7 Determination of My Capacity to Make Decisions

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*Indicate who has authority to determine your ability to make your own decisions.* This section allows you to designate one or more persons to determine whether you are capable of making your own health care decisions. You may grant such authority to your primary care physician, attending physician or advanced practice registered nurse. If you prefer to grant "capability" authority to your spouse, adult, child, or other trusted person, ask an attorney to explain the pros and cons of allowing a person without medical training to make the determination.

## 8 Administrative Provisions

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*Enforcement of your Health Care Power of Attorney.* This section covers miscellaneous issues such as the validity of the form in other states, compensation for services for your agent(s), and how to revoke a Health Care Power of Attorney you signed previously.

## 9 Instructions for Forms B and C.

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*Optional Forms B and C provide additional information that could be relevant to you and your family members.*

On **Form B**, you indicate the termination or continuation of life-sustaining treatment which is your right under the Montana Rights of the Terminally Ill Act. For additional information about this Act, see MSU Extension MontGuide "[Montana Rights of the Terminally Ill Act](#)" (MT199202HR).

**Form C** allows you to provide additional instructions about religious preference and preferred place of death. You may provide how you want your body disposed of (e.g. burial, cremation) under the Montana Rights of Disposition Act. For information about this Act, see MSU Extension MontGuide "[What Are Your Rights Over Your Remains?](#)" (MT200918HR).

# 10 Signature and Notary

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**Sign your Health Care Power of Attorney.** In Montana, a Health Care Power of Attorney is effective upon your signature, without having your signature notarized or witnessed. However, notarization provides proof your signature is genuine should any questions arise from family members and/or health care professionals. For this reason, a notary section is included on Form A.

## Unique Situations

Although the worksheet and Forms A, B, and C are designed to apply to all Montanans, everyone's health situation is different. Ask an attorney to provide further clarification about information in the worksheet and forms. An attorney could customize a Health Care Power of Attorney and related documents for your specific situation. You, your health care providers and your attorney should review these documents when there is a change in your health condition or life circumstance such as a divorce.

## Who Should Have a Copy of Your Health Care Documents

You should give copies of your health care documents to the following:

- Appropriate family members;
- Your health care agent;
- Your physician and other health care providers;
- Your local hospital; and
- Your attorney

You may also want to store your health care documents with the [Montana End-of-life Registry](#). The registry is a place where advance directives are

electronically stored. Registered health care providers can access them 24 hours a day. You and your family members can also access your documents with a code you provide. The Montana Attorney General's Office oversees registry filings, security and operations.

Because of the difficulty of accessing documents when needed, a safe deposit box is NOT a wise place to store Health Care Power of Attorney and related documents.

For additional information, see the MSU Extension MontGuide "[Montana's End-of-life Registry](#)," (MT200602HR); and the "[Montana Rights of Terminally Ill Act](#)," (MT199202HR).

## Acknowledgement

Members of the following Montana organizations have reviewed the worksheet and Forms A, B, and C:

- Health Care Law Section, State Bar of Montana;
- Business, Estates, Trusts, Tax, and Real Property Section, State Bar of Montana;
- Montana Alzheimer's Workgroup, Legal and Financial Committee; and
- Montana Generational Justice.

Appreciation is also expressed to Montana citizens who piloted the forms and provided helpful suggestions.

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## End of Life Worksheet

You may want to complete this form before designating a health care agent or before making end of life decisions. The form may assist your agent(s), family members and health care providers to gain a better understanding of your health care decisions.

**Instructions:** This worksheet is optional, to encourage you to think about what you value most for end-of-life health care.

**1. Rate your current health on a scale of 1–10, with 1 as terminally ill and 10 as healthy.**

Terminally Ill

Healthy

1    2    3    4    5    6    7    8    9    10

**2. If you were so sick that you would die soon, rate the priority of your end-of-life goals on a scale of 1–10, with 1 being living as long as possible and 10 being quality of life.**

Living as Long as Possible

Quality of Life

1    2    3    4    5    6    7    8    9    10

**3. Of the following experiences, which ones would make you want to focus on comfort rather than trying to live as long as possible?**

[mark as many boxes as apply]

Being in a coma and not able to wake up or talk to loved ones.

Not being able to live without being hooked up to machines.

Not being able to recognize loved ones, as in the case of dementia.

Not being able to feed, bathe, or take care of myself.

Not being able to live on my own.

Having constant, severe pain or discomfort.

Other. Describe: \_\_\_\_\_

\_\_\_\_\_

I am attaching additional directions on separate page(s).

Are you willing to live through all these for a chance of living longer?    **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**4. What do you believe will be important to you at end-of-life?**

[mark as many boxes as apply]

Being with loved ones. Explain: \_\_\_\_\_

A certain setting (e.g. home). Explain: \_\_\_\_\_

An experience (e.g. a ceremony). Explain: \_\_\_\_\_

Other. Describe: \_\_\_\_\_

\_\_\_\_\_

I am attaching additional directions on separate page(s).

**5. What would be most unacceptable to you in your health care treatment?**

[e.g. what experiences do you want to avoid in your healthcare treatment?]

Describe: \_\_\_\_\_

\_\_\_\_\_

I am attaching additional directions on separate page(s).

**6. What is your preference about the use of life support treatments (such as CPR, tube feeding or use of a ventilator)?**

[mark only one box]

Try life support treatments that my doctors think could help, and stay on life support treatments even if there is little hope of getting better.

Try life support treatments that my doctors think could help. But, not stay on life support treatments if the treatments do not work and there is little hope of getting better.

Avoid all life support treatments and focus on being comfortable.

Prefer to have a natural death.

Other. Describe: \_\_\_\_\_

\_\_\_\_\_

**7. Have you documented your wishes about organ or tissue donation? Yes \_\_\_\_\_ No \_\_\_\_\_**

Your wishes can be included in your Health Care Power of Attorney. More information is in the MSU Extension MontGuide, "[Montana Body Donation Program \(MT201804\)](#)."

**8. How do you prefer to make medical decisions with your doctors?**

[mark only one box]

Make all decisions on my own, with all information available.

Make decisions equally with my doctor.

Follow my doctors' recommendations.

Other. Describe: \_\_\_\_\_

\_\_\_\_\_

I am attaching additional directions on separate page(s).

**9. Is there anyone you do NOT want involved in your medical care and decision-making, and you do NOT want to have access to your medical information?**

List their name(s) here: \_\_\_\_\_

I am attaching additional directions on separate page(s).

**10. Do you have any specific priorities that you have not included above?**

Describe: \_\_\_\_\_

\_\_\_\_\_

I am attaching additional directions on separate page(s).

**11. Have you informed your family members or other loved ones about your personal health care priorities and wishes?**

Yes

No

**My Signature:** \_\_\_\_\_

**Date I completed this worksheet:** \_\_\_\_\_ / \_\_\_\_\_ / 20\_\_\_\_\_.

CUT ALONG DASHED LINE

# Health Care Power of Attorney Form A

## Appointment of Agent.

I, \_\_\_\_\_

[Insert your full legal name], hereby appoint the person named below as my Agent to act for me in matters about health care as authorized in this document.

Agent's Name: \_\_\_\_\_

Agent's Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
Home Work Cell

## Appointment of Back-up Agents.

If I revoke my Agent's authority or if my Agent becomes unwilling or unavailable to act or if my Agent is my spouse and I become legally separated or divorced, I name the following (each to act independently and successively, in the order named) as alternates to my Agent:

1st Back-up Agent: \_\_\_\_\_

Agent's Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
Home Work Cell

2nd Back-up Agent: \_\_\_\_\_

Agent's Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
Home Work Cell

If a lower priority Agent becomes authorized because of the temporary unavailability of a higher priority Agent, then my authority reverts to the Agent of higher priority when he or she becomes once again available to act for me.

While I am competent, I may revoke my Agent's authority at any time in writing signed by me or by a verbal statement made by me in the presence of the person relying upon such revocation. If I do so, the Agent with the next highest priority who is available shall become my Agent.

Your Initials: \_\_\_\_\_

Date: \_\_\_\_\_

**Agent's Authority and Obligations.**

My Agent has the authority to make health care decisions for me and to act as my personal representative, as the term is used in the Health Insurance Portability and Accountability Act (HIPAA). This Health Care Power of Attorney is durable and will continue to be effective if I become disabled, incapacitated or incompetent.

My Agent knows my goals and wishes based on our conversations and on any other guidance I have provided, including this Health Care Power of Attorney, and any other documents I have signed relating to my health care or end-of-life decisions. My guidance also includes any declarations about life-sustaining treatment (see Form B or similar document), directions about disposition of my remains, religious preferences, or where I prefer to die (see Form C or similar document). My Agent has full authority to make decisions for me about my health care according to my goals and wishes. If the choice is unclear, my Agent should decide based on what he or she believes to be in my best interests. My Agent's authority to interpret my goals and wishes and to act for me is intended to be broad and includes, but is not limited to, the following authorities:

- a. To agree to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedures, tests, or medications. This includes decisions about using mechanical or other procedures affecting any bodily function, such as artificial respiration, artificially supplied nutrition and hydration (for example, tube feeding), cardiopulmonary resuscitation, or other forms of medical support, even if the decision is to stop or withhold treatment that could result in my death.
- b. To have access to medical records and information to the same extent I am entitled, including the right to disclose health information to others.
- c. To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted-living or similar facility or service.
- d. To contract for any health care-related service or facility for me or apply for public or private health care benefits, with the understanding my Agent is not personally financially responsible for those contracts.
- e. To hire and fire medical, social service, and other support personnel who are responsible for my care.
- f. To authorize my participation in medical research related to my medical condition.
- g. To agree to or to refuse the use of any medication or procedure intended to relieve pain or discomfort.
- h. To decide about body, organ and tissue donations.
- i. To execute Provider Orders for Life-Sustaining Treatment (POLST) on my behalf, provided that such POLST must be consistent with any advance directive I have previously signed and have not revoked.
- j. To take any other action necessary to accomplish what I authorize here, including the signing of waivers or other documents, pursuing any dispute resolution process, or filing claims or taking legal action in my name.

**Your Initials:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**When My Agent’s Authority Becomes Effective.**

My Agent’s authority to make health care decisions for me takes effect at the following time

**[Choose either Option A or B, but not both, by marking the box in front of the option you choose]:**

**Option A: Authority is effective immediately:** My Agent’s authority becomes effective immediately after I sign this document. However, I still have the right to make any decisions about my health care if I want to and have the capacity to do so.

**Option B: Authority is effective ONLY when I can NOT make my own health care decisions:** My Agent’s authority becomes effective only when my attending or primary care physician, advanced practice registered nurse or other person I designate determines I lack the capacity to make my own health care decisions.

**Guidance and Preferences (Optional).**

*[Below you may provide additional directions to your Agent to express your preferences about specific health matters. Examples include directions about blood or blood products; chemotherapy; diagnostic tests; surgery; and so on]:*

My Agent should make decisions for me consistent with my directions below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*[You may attach additional pages.]*

I am attaching additional directions and preferences on separate page(s).

**Nomination of Legal Guardian.**

I nominate my Agent (or my Back-up Agent if my Agent is unavailable or unwilling to serve) as my legal guardian if it becomes necessary for a district court to appoint a guardian, with the legal authority to make decisions as determined by the court.

**Your Initials:** \_\_\_\_\_

**Date:** \_\_\_\_\_

CUT ALONG DASHED LINE

CUT ALONG DASHED LINE

**Determination Regarding My Capacity to Make Decisions.**

If it is necessary to determine whether I lack the capacity to make my own health care decisions, I appoint the following persons to make such determination **[You may choose one or more of the following persons to make a determination regarding your capacity by marking the box in front of the person(s) you choose. If you choose more than one, any of those chosen may make the determination without consulting the others you have chosen. If you do not choose any of these persons, a district court will make the determination]:**

My attending or primary care physician or advanced practice registered nurse.

The person named as Agent in this Health Care Power of Attorney (or Back-up Agent if my Agent is unavailable or unwilling to make such determination).

Other: *[insert name]* \_\_\_\_\_

**Administrative Provisions.**

- a.** Health care providers can rely on my Agent. No one who relies in good faith on any representations by my Agent (including my Back-up Agent) is liable to me, my estate, or my heirs for recognizing the Agent's authority.
- b.** I revoke any previous Health Care Power of Attorney I have signed.
- m.** To the extent this Health Care Power of Attorney and any attachments are inconsistent with a prior advance directive or other document previously executed by me, this document shall have precedence.
- d.** I direct my Agent and health care providers who are provided with this document to ensure any future Providers Orders for Life Sustaining Treatment (POLST) or similar document are consistent with my wishes expressed in this Health Care Power of Attorney, my most current Declaration for Use of Life-Sustaining Treatment (Living Will), such as that in Form B, and additional written directions related to my religious preference, preferred location of death, disposition of remains and other related matters, such as those preferences detailed in Form C or a similar document.
- e.** I intend this Health Care Power of Attorney to be universal and valid in any jurisdiction in which it is presented.
- p.** I intend for copies of this document to be effective as the original.
- g.** My Agent **[mark one]: is** OR **is not** entitled to reasonable compensation for services performed under this Health Care Power of Attorney. Regardless, my Agent is entitled to reimbursement for all reasonable expenses resulting from acting under this Health Care Power of Attorney.
- h.** If a court finds any provision of this Health Care Power of Attorney to be invalid or unenforceable, I intend this document to be interpreted as if that provision was not part of this document.

**Your Initials:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Instructions for Optional Forms B and C.**

[You may provide additional instructions on the two forms following this Health Care Power of Attorney.

**Form B** allows you to express your preferences about the use of life-sustaining treatment under the Montana Rights of the Terminally Ill Act. **Form C** provides an opportunity to indicate religious preferences, preferred location of death, and the disposition of your remains under the Montana Right of Disposition Act.]

I have provided additional instructions about the Use of Life-Sustaining Treatment on Form B or a similar document.

I have provided additional directions about my religious preferences, my preferred location of death, and disposition of my remains on Form C or a similar document.

I choose **NOT** to attach Form B or C.

**Signature and Notary.**

**SIGNING BELOW, I INDICATE I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THE GRANTING OF A HEALTH CARE POWER OF ATTORNEY TO MY AGENT.**

I sign my name to this instrument on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
Month Year

My Signature: \_\_\_\_\_

My Printed Legal Name: \_\_\_\_\_

Current Home Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
Home Work Cell

**Witnesses are not a requirement of a Montana Health Care Power of Attorney.**

**Notary:** Montana law does not require a Health Care Power of Attorney to be notarized to be valid. Having the form notarized is recommended as evidence your signature is genuine.

STATE OF MONTANA

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

This instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by  
Month Year

\_\_\_\_\_  
Print name of signer

\_\_\_\_\_  
Notary Signature

CUT ALONG DASHED LINE

# USE OF LIFE-SUSTAINING TREATMENT (DECLARATION) FORM B

**Instructions: Form B is optional.** If you do not fill out Form B, your Agent still has authority to make treatment decisions based on your Health Care Power of Attorney.

The purpose of this form is to express your preference about the withholding or withdrawal of life-sustaining treatment. Form B follows the **Montana Rights of the Terminally Ill Act (MCA §§ 50-9-101 et seq.)**. Form B guides your Agent and your health care providers about life-sustaining treatment decisions at the end of life. Do not fill out this form if you want your attending physician, attending physician’s assistants, or attending advanced practice registered nurse to provide life-sustaining treatment within the limits of accepted medical practice, even if it only serves to prolong dying. (Additional information is in the MSU Extension MontGuide “Montana Rights of Terminally Ill Act,” MT199202HR).

## My Declaration on Use of Life-Sustaining Treatment.

I, \_\_\_\_\_ [*print your legal name*], aged 18 years or older and of sound mind, state that if:

- 1. I have an incurable and irreversible condition; and
- 2. In the opinion of my attending physician, attending physician’s assistants, or attending advanced practice registered nurse,
  - a. This condition will cause my death within a relatively short time if life-sustaining treatment is not administered, and
  - b. I am no longer able to make decisions regarding my medical treatment, whether from incapacity, disability, or any other reason, then:

**[Instructions: Mark only one of the next two boxes. See witness requirements on page 2.]**

I direct my attending physician, attending physician’s assistants, or attending advanced practice registered nurse to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

I appoint \_\_\_\_\_ [*print designee’s legal name*], or, if that person is not reasonably available or is unwilling to serve as my designee, \_\_\_\_\_ [*print alternate designee’s legal name*], to make decisions on my behalf to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

**Your Initials:** \_\_\_\_\_

**Date:** \_\_\_\_\_

I sign my name to this instrument on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
Month Year

My Signature: \_\_\_\_\_

My Printed Legal Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_  
Address Phone

**Witnesses:** For this Declaration about the use of Life-Sustaining Treatment to be valid under Montana law, two individuals of sound mind and age 18 and older must witness your signature and sign below.

The declarant voluntarily signed this Declaration Relating to Use of Life-Sustaining Treatment in my presence.

**1st Witness Signature:** \_\_\_\_\_

Printed Legal Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_  
Address Phone

**2nd Witness Signature:** \_\_\_\_\_

Printed Legal Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_  
Address Phone

The signature of a Notary Public is not required on a Montana Declaration.

CUT ALONG DASHED LINE 

# Additional Directions Religious Preferences, Preferred Location of Death, and Disposition of Remains FORM C

**Instructions: Form C is optional.** If you do not fill out Form C, your agent still has authority to make treatment decisions based on your Health Care Power of Attorney.

The purpose of Form C is to provide additional information to your agent and family members about your spiritual or religious preferences. You may also express where you would like to be when you die, if possible. Form C can also guide your agent and family members to decisions you have made about the disposition of your body under the **Montana Right of Disposition Act (MCA §§ 37-19-901 et seq.)**. (Additional details are provided in the MSU Extension MontGuide: “What Are Your Rights Over Your Remains?” MT200918HR.)

### Spiritual or religious preferences.

[mark only one box]

I do not want any formal spiritual or religious support.

I want spiritual or religious support.

My spiritual or religious community: \_\_\_\_\_

Contact person: \_\_\_\_\_  
Name Mailing Address

Telephone: \_\_\_\_\_  
Home Work Cell

### Preference for where I would like to be when I die.

[mark only one box]

I want to die in the following place, preferably with palliative care provided for my comfort and for relief from any last serious illness or condition.

My home

Hospital

Nursing Home

Assisted Living / Memory Care

Other location (please describe): \_\_\_\_\_

### Decisions about the disposition of my body after my death.

After my death, I want my remains disposed of according to the choices I mark on the next page, based on the **Montana Right of Disposition Act**. (Additional details about each alternative are provided in the MSU Extension MontGuide “What Are Your Rights Over Your Remains?” MT200918HR).

Your Initials: \_\_\_\_\_

Date: \_\_\_\_\_

CUT ALONG DASHED LINE

**Instructions.** Mark the following boxes, A – E, as applicable to your wishes.

[you may mark more than one box, as applicable]

**a. No disposition direction.** I do not wish to make any disposition directions or to authorize another person to control the disposition of my remains. I realize if I do not make any disposition preference, Montana law provides a priority list of individuals who can make the decision.

**b. Prepaid funeral contract.** I have a prepaid funeral contract with the following licensed mortuary [which may or may not be in Montana]:

\_\_\_\_\_ [Name of mortuary]

\_\_\_\_\_ [Name of state, town]

**c. Video.** I have made a video describing my wishes for my disposition. My signature on page 3 serves as my written confirmation of the video’s existence.

**[Additional Instructions: Two witnesses who are at least 18 years of age must sign on page 3 to indicate they can attest to the video’s accuracy either by having witnessed its creation or by having later reviewed it with you.]**

**d. Written disposition directions.** I specifically direct my remains be disposed of according to the following preferences [You may include preferences for burial, cremation, funeral home, or any additional directions about the location, manner, and conditions of disposition of your remains, as well as arrangements for funeral goods and services.]:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am attaching additional directions on separate page(s).

**[Additional Instructions: Two witnesses who are at least 18 years of age and of sound mind must witness your signature on page 3 and sign on the appropriate line.]**

**e. Instrument to authorize another person to control the disposition of my body.**

I am at least 18 years of age and of sound mind. I designate the following individual as the person with the right to control the disposition of my remains:

[mark only one box]

The Agent (or Back-up Agents) named in my Health Care Power of Attorney, or

Another person: \_\_\_\_\_ [Print name].

This right to the control of the disposition of my body by another person shall be:

[mark only one box]

Absolute according to the above person’s discretion; or

Limited by other directions I have provided in Form C.

**[Additional Instructions: You must sign page 3 in front of a Notary Public.]**

**Your Initials:** \_\_\_\_\_

**Date:** \_\_\_\_\_

I sign my name to this instrument on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
Month Year

My Signature: \_\_\_\_\_

My Printed Legal Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_  
Address Phone

**Witness Instructions:** *Witnesses are required if you checked box c or d on this form (Form C).*

I state that I am at least 18 years of age and of sound mind. The above-named person voluntarily signed this form in my presence. For box c only, I attest to the video's accuracy.

**1st Witness Signature:** \_\_\_\_\_

Printed Legal Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_  
Address Phone

**2nd Witness Signature:** \_\_\_\_\_

Printed Legal Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_  
Address Phone

**Notary Instructions:** *A Notary Public is required if you checked box e on this form (Form C).*

STATE OF MONTANA

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

This instrument was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by  
Month Year

\_\_\_\_\_  
Print name of signer

\_\_\_\_\_  
Notary Signature

CUT ALONG DASHED LINE

