

INSTRUCTIONS

Montana Health Care Power of Attorney (With Two Optional Attachments on Life-Sustaining Treatment and Special Directions)

Appointing an Agent to act as your health care power of attorney is an important decision. **Once properly filled out and signed, the Health Care Power of Attorney is a legal document.**

This model form for a Health Care Power of Attorney is designed to provide you with meaningful choices as you appoint someone you trust to act as your Agent to help you with health care matters. *Optional Attachment A* allows you to exercise your rights under the Montana Rights of the Terminally Ill Act. *Optional Attachment B* allows you to exercise your rights under the Montana Right of Disposition Act and to give other special directions. Take time to understand each document before you sign it. The Health Care Power of Attorney sections are briefly described below.

- **Section 1 – Appointment of Agent:** Identifies yourself and your Agent. This section must be filled-in. For instance, if you want your spouse to be your Agent, identify him or her in Section 1.
- **Section 2 – Appointment of Back-up Agents:** Identifies up to two Back-up Agents. This section is optional. For instance, if you want an adult child or a close friend to be a Back-up Agent, list each one of them in order of priority. You may revoke the authority of your Agent or Back-up Agent at any time either in writing or by a clear verbal statement. The revocation will be effective after it is conveyed to people who rely on your Health Care Power of Attorney.
- **Section 3 – Agent's Authority and Obligations:** Describes your Agent's authority. Your Agent must always act for you based on your wishes and your best interests. Once your Agent's authority is effective, your Agent will be able to act for you on health matters and to receive and disclose information about you on those matters. Your Agent will be able to work with your physicians and other health care providers as well as with people in insurance, billing, and medical records to the same extent as you. The Health Care Power of Attorney gives your Agent the ability to act for you under the federal privacy law known as the Health Insurance Portability and Accountability Act (HIPAA).
- **Section 4 – When My Agent's Authority Becomes Effective:** Determines when your Agent's authority to act for you becomes effective. There are two options. Choose only one.
 - Option A makes your Agent's authority effective immediately. If you choose Option A, your Agent will 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 decisions, for as long as you want to and are able to. Choosing Option A allows your Agent to act for you immediately, without having to prove you cannot make your own decisions. For example, if you choose your spouse or a close friend as your Agent, he or she will never have to ask a physician to declare you are not capable of making health care decisions so he or she could act as your Agent. Choosing Option A will make it clear to health care providers and insurance companies your Agent has authority to act for you, even if the health care provider or insurance company does not know whether or not you are able to make your own health decisions. For example, choosing Option A would allow an insurance company or the billing or medical records office at your health care

provider to deal with your Agent (including over the telephone), without knowing if you are able to make your own health care decisions. Option A allows your Agent to receive information about your health care when you want help scheduling appointments, getting medications, doing what the physician asks you to do, moving between physicians, understanding and paying medical bills, and other similar matters.

- Option B makes your Agent's authority effective only when you are not able to make health care decisions for yourself as determined by your attending physician or advanced practice registered nurse. Until such a determination is made, health care providers and health plans will be prohibited by the federal privacy law (HIPAA) from disclosing health care information about you to your designated Agent (except in limited circumstances), unless you execute a separate written authorization for the Agent. Do not choose Option B if you want your Agent to be able to help you by receiving health information about you from physicians or on billing, medical records, or insurance matters while you are still capable of making health care decisions. Also, consider sometimes it may not be clear whether you are capable of making your own health care decisions, such as when you are under the influence of strong medications, when you are experiencing pain or stress, or when your dementia or mental illness worsen. Do not choose Option B if you want your Agent's authority to be effective during periods when it is unclear whether or not you are capable of making your own health care decisions.
- Section 5 – **Other Instructions on Attachments A and B:** Addresses two optional Attachments to the Health Care Power of Attorney: *Attachment A* relates to use of life-sustaining treatment. *Attachment B* allows you to give special directions related to religious preference, preferred place of death, and disposition of your body after death. Checking the appropriate boxes in Section 5 will guide anyone relying on this Health Care Power of Attorney to the information you have included in those optional attachments.
- Section 6 – **Other Guidance and Preferences:** Allows you to provide guidance to your Agent about specific matters of health care treatment of concern to you, which are not otherwise addressed in the Health Care Power of Attorney or the two Attachments.
- Section 7 – **Nomination of Guardian:** Allows you to nominate the Agent or a Back-up Agent as your legal guardian if it becomes necessary for a court to appoint a legal guardian to make decisions for you in specific areas.
- Section 8 – **Administrative Provisions:** Addresses issues that help with enforcement of your Health Care Power of Attorney.
- **Signature and Notary.** In Montana, a Health Care Power of Attorney is effective upon your signature, without having your signature notarized or witnessed. A notary block is included on the form because notarization makes it easier to prove your signature is genuine if any questions should arise.

INSTRUCTIONS for Attachments A and B are included in those Attachments. *Attachment A*, Relating to the Use of Life-Sustaining Treatment, requires two witnesses. *Attachment B*, Special Directions, may require either notarization or witnesses, depending on your choices.

These documents are designed to apply to any Montanan. Yet, everyone's situation is unique. You may want to ask a lawyer to help you understand this form or to tailor a Health Care Power of Attorney for your specific situation.

Health Care Power of Attorney

1. Appointment of Agent

I, _____ [*insert your full legal name*], hereby appoint as my Agent and health care power of attorney the person named below to act for me in matters related to health care as authorized in this document.

Agent's Name: _____

Agent's Address: _____

Telephone or cell number: _____

2. Appointment of Back-up Agents [Optional.]

If I revoke my Agent's authority, 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 or cell number: _____

2nd Back-up Agent: _____

Agent's Address: _____

Telephone or cell number: _____

If a lower priority agent becomes authorized because of the temporary unavailability of a higher priority agent, then authority reverts to an agent of higher priority when such an agent again becomes available to act.

I may revoke an Agent's authority at any time in writing or by a verbal statement while I am competent, and the Agent with the next highest priority who is available shall become my Agent.

3. 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 that 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.

Your Initials: _____

My Agent knows my goals and wishes based on our conversations and on any other guidance I may have provided, including in this Health Care Power of Attorney and the Attachments. My Agent has full authority to make decisions for me about my health care according to my goals and wishes. If the choice I would make is unclear, then 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 that affect any bodily function, such as artificial respiration, artificially supplied nutrition and hydration (that is, tube feeding), cardiopulmonary resuscitation, or other forms of medical support, even if deciding to stop or withhold treatment could result in my death;
- b. To have access to medical records and information to the same extent that I am entitled to, 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 refuse using any medication or procedure intended to relieve pain or discomfort;
- h. To decide about body, organ and tissue donations and autopsy;
- i. To take any other action necessary to do what I authorize here, including signing waivers or other documents, pursuing any dispute resolution process, or filing claims or taking legal action in my name.

4. When My Agent's Authority Becomes Effective

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

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

Option A: Effective Immediately

My Agent's authority becomes effective immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to do so.

Option B: When I Can NOT Make My Own Health Care Decisions

[Do not check Option B on the next page if you chose Option A above.]

Your Initials: _____

- My Agent's authority becomes effective only when my attending physician or attending advanced practice registered nurse determines that I lack the capacity to make my own health care decisions.

5. Other Instructions on Attachments A and B. [Optional. You may provide additional instructions on the two Attachments at the end of this Health Care Power of Attorney. Attachment A relates to use of life-sustaining treatment. Attachment B concerns religious preferences, preferred location of death, and the disposition of your remains.]

- I have provided additional instructions on Use of Life-Sustaining Treatment in Attachment A.
 I have provided additional Special Directions in Attachment B.
 I choose to not attach any additional information.

6. Other Guidance and Preferences. [Optional. Below you may provide additional guidance to your Agent about your preferences on specific health matters. Examples include guidance related to blood or blood products; chemotherapy; diagnostic tests; surgery; etc.]

My Agent should make decisions for me consistent with the guidance below:

[You may add pages.]

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

7. Nomination of Guardian. [Optional.]

- I nominate my Agent (and, if my Agent is not able or willing, my Back-up Agent) as my legal guardian if it becomes necessary for a court to appoint a guardian with the legal authority to make decisions for me in areas in which I lack capacity to make my own decisions.

8. 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 Back-up Agent) will be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.
- b. I revoke any previous power of attorney for health care that I may have signed. This Health Care Power of Attorney and Attachments (if any) shall supersede a Physician Order for Life Sustaining Treatment (POLST), advance directive, or similar document, whether created in the past or created in the future by someone other than my Agent, to the extent that document is inconsistent with my wishes expressed in this Health Care Power of Attorney or Attachments or with my Agent's decisions on my behalf.
- c. I intend this power of attorney to be universal; it is valid in any jurisdiction of the United States in which it is presented.
- d. I intend that copies of this document are as effective as the original.

Your Initials: _____

- e. My Agent will not be entitled to compensation for services performed under this Health Care Power of Attorney. However, he or she will be entitled to reimbursement for all reasonable expenses that result from acting under this Health Care Power of Attorney.
- f. If a court finds any provision of this Health Care Power of Attorney to be invalid or unenforceable, I intend that this document be interpreted as if that provision was not part of this document.

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

Signed on this _____ day of _____, 20_____.

My Signature: _____

My Legal Printed Name: _____

Current home address: _____

Notary: Montana law does not require this 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)
 : ss
COUNTY OF _____)

This instrument was acknowledged before me this _____ day of _____, 20_____,
by [print your name] _____.

NOTARY PUBLIC FOR THE STATE OF MONTANA

Printed Name: _____

Address: _____

My Commission Expires: _____

Notarial Seal >>>

ATTACHMENT A: DECLARATION RELATING TO USE OF LIFE-SUSTAINING TREATMENT
(Based on the Montana Rights of the Terminally Ill Act, MCA § 50-9-103)

[Instructions: *This Attachment is optional. If you do not fill it in, your Agent has authority to make treatment decisions based on your Health Care Power of Attorney. This Declaration Relating to Use of Life-Sustaining Treatment is based on the Montana Rights of the Terminally Ill Act. It will be effective to guide your Agent and your health care provider for decisions relating to use of life-sustaining treatments at the end of life.*]

Declaration Relating to Use of Life-Sustaining Treatment

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 direct my Agent and any health care providers involved in my care to:

[Instructions: *Mark only one box.*]

- Withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.
- Provide life-sustaining treatment, within the limits of accepted medical practice, even if it only serves to prolong the dying process.

[Additional Instructions: *The Specific Treatment Decisions below allow you to be more specific about life-sustaining treatments at the end of life.*]

Additional Specific Treatment Decisions Relating to Use of Life-Sustaining Treatment:

[Instructions: *Mark all boxes that apply.*]

- Administer treatments 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, including pneumonia or other infections, I do not want antibiotics used solely to prolong my life. Antibiotics may be used if needed to treat a painful infection, to make nursing care easier, or to prevent the spread of contagious infection.

Your Initials: _____

I sign my name to this Declaration Relating to the Use of Life-Sustaining Treatment on this
____ day of _____, 20____.

My Signature: _____

My Legal Printed Name: _____

Current home address: _____

Witnesses: [Instructions: *For this Declaration Relating to Use of Life-Sustaining Treatment to be valid under Montana law, two individuals 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 Name: _____

Current Home Address: _____

2nd Witness Signature: _____

Printed Name: _____

Current Home Address: _____

ATTACHMENT B: SPECIAL DIRECTIONS

[Instructions: *Mark the appropriate boxes below to indicate your preferences.*]

1. Spiritual or Religious Preferences

- I do not want formal spiritual or religious support.
- I would like spiritual or religious support.

My religion or faith community: _____

Contact person: _____

2. Preference of Where I Would Like to be When I Die

I would prefer, if it is in my best interest at the time, to die in the following place:

- My home Hospital Nursing Home
- Assisted Living / Memory Care / Hospice Facility _____
- Other _____

3. Decisions About Disposition of My Body After My Death

The following selections indicate my preference for the control of the disposition of my remains after my death, based on the Montana Right of Disposition Act, MCA Sec. 37-19-903-904.

[Instructions: *Mark only one of Options A – D, and mark E if applicable.*]

- A. **No Preference:** I do **not** wish to make any disposition directions or to authorize another to control the disposition of my remains.
- B. **Funeral Contract:** I have already executed / will execute [*circle one*] a prepaid funeral contract with a licensed mortuary.
- C. **Video:** I have already made / will make [*circle one*] a video describing my wishes for disposition that is witnessed and attested by two individuals at least 18 years of age.
- D. **Disposition Directions:** I specifically direct that my remains be disposed according to the following preferences:

[Instructions: *You may include preferences for burial, cremation, funeral home, or any additional direction relating to the location, manner, and conditions of disposition of your remains, as well as the arrangements for funeral goods and services to be provided upon your death.*]

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

[Additional Instructions: *If you direct your remains to be disposed of according to specific preferences in this section, you must sign on the following page in front of two witnesses who are at least 18 years of age, and they must also sign.*]

Your Initials: _____

- E. **Authorize Another to Control Disposition:** I am at least 18 years of age and of sound mind, and designate the following individual as the person with the right to control the disposition of my remains upon my death: [Instructions: mark only one box.]
- the Agent (and Back-up Agents) named in my Health Care Power of Attorney; or
 Another person: _____ [print name].

This right to control shall be: [Instructions: mark only one box.]

- Absolute according to the above person's discretion; or
 Limited by directions I provided in Options B, C and D.

[Additional Instructions: If you authorize another to control the disposition of your remains in this section, you must sign below in front of a notary public.]

I sign my name to this instrument on this _____ day of _____, 20 _____.

My Signature: _____

Printed Name: _____

[Witness Instructions: To be completed if you selected Option 3D.]

I state that I am at least 18 years of age, and the declarant voluntarily signed this instrument in my presence.

1st Witness: _____ 2nd Witness: _____

Printed Name: _____ Printed Name: _____

[Notarization Instructions: To be completed if you selected Option 3E.]

STATE OF MONTANA)
 : ss
COUNTY OF _____)

Subscribed and sworn before me this _____ day of _____, 20_____,
by [print your name] _____.

NOTARY PUBLIC FOR THE STATE OF MONTANA

Printed Name: _____

Address: _____

My Commission Expires: _____

Notarial Seal >>>