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?
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)."

- ☐ Yes
- ☐ No

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_____.

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: _____ / _____ / **20**_____.

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: _____ / _____ / **20**_____.

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: _____ / _____ / **20**_____.

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.

c. 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.

f. 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: _____ / _____ / **20**_____.

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

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: _____ / _____ / **20**_____.

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.

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: _____ / _____ / **20**_____.

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: _____ / _____ / **20**_____.

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