Please note: Cake is providing this form to help you plan. In supplying this form, Cake is not providing legal advice. For legal advice, please consult with an attorney or estate planner. Cake did not author this form, nor does it lay ownership claim to the contents therein.
Full Name: __________________________________________

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 __________________________________________ 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______________

__________________________
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. __________________________  2. __________________________
Signature   Date   Signature   Date

__________________________
Printed Name

__________________________
Printed Name

__________________________
Address

__________________________
Address

__________________________
City    State    Zip  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: ____________________________ Family Member: Relationship ______________
   Name
   Address
   City   State   Zip
   Home Phone   Work Phone

   Hospital: ____________________________
   Name
   Address
   City   State   Zip
   Phone

   Hospital: ____________________________
   Name
   Address
   City   State   Zip
   Phone

Revised 03/14
CRITICAL STEP:
SHARE YOUR COMPLETED DOCUMENT!

Your document is only helpful if people know where to find it when it is needed. It's important to discuss the decisions outlined in your document with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your document once it has been completed and satisfies the legal requirements for your state (if applicable).

WHO NEEDS A COPY OF YOUR DOCUMENT?

- Anyone assigned a decision-making role in the document
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

HOW TO SHARE YOUR DOCUMENT

1) **Use Cake!** Upload your document to a free Cake account for safekeeping. Share 24/7 secure document access with anyone that has an email address*

   Create your free Cake account: [www.joincake.com/share-free](http://www.joincake.com/share-free)

2) **Or, print** and provide copies to everyone who needs one

WHY PLAN & SHARE WITH CAKE?

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print all your end-of-life documents
- Share 24/7 document access with anyone that has an email address*

Create your free Cake account: [www.joincake.com/share-free](http://www.joincake.com/share-free)

*Some healthcare providers may require a paper copy of your document to be able to enter it into their records.*