Estate Planning

OVERVIEW OF TERMS

TRANSFER ON DEATH Deed

- **Transfer on Death Deed:**
  - A legal instrument that will transfer ownership of property
  - Not effective until the death of the owner
  - Property can be transferred without going through the probate process
  - Must be signed by the grantor in the presence of a notary and be recorded in the County Clerk's office where the property is located

Transfer on death Deed

- Who can be a grantee beneficiary?
- Can there be more than one grantee beneficiary?
- Can it be revoked?

Declaration of Homestead

- **Declaration of homestead**:
  - Can protect up to $350,000 in value of a home against most claims of unsecured debt.
    - Example of "unsecured debt" is medical debt or credit card debt.

Return to:

Address

DECLARATION OF HOMESTEAD

KNOW ALL MEN BY THESE PRESENTS:

That Owner of Property, and Owner of Property of Street Address, City/Town, Montana ZIP Code, select, claim and declare a homestead on the dwelling house and all appurtenances which are situated and located in the County of County of Property, State of Montana:

Legal Description of Property

That the persons making this declaration are acting solely and makes this declaration for their own benefit and that of their family's; that the undersigned reside on the premises above described and claim the same as a homestead under the provisions of Sections 70-32-101 through 70-32-107, MCA.

This Declaration of Homestead amends and supercedes any Declaration of Homestead executed by prior to this.

IN WITNESS WHEREOF, the undersigned have hereunto set their hand and seal this Day day of Month, Year.

_____
Signature

_____
Signature

STATE OF MONTANA

County of County where document is being notarized

This instrument was acknowledged before me this Day day of Month, Year by Owner of Property (and) Owner of Property.

(Notarial Seal)

_____
Notary Signature

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Volunteer Documents Packet

Return to:

Address

Seniors will pay per-page when they file at the Clerk and Recorder's, so try to limit document length

DECLARATION OF HOMESTEAD

KNOW ALL MEN BY THESE PRESENTS:

That Owner of Property, and Owner of Property of Street Address, City/Town, Montana ZIP Code, select, claim and declare a homestead on the dwelling house and all appurtenances which are situated and located in the County of County of Property, State of Montana:

Legal Description of Property

Insert the legal description of the property, which can be found on the client's warranty deed.

That the persons making this declaration are acting solely and makes this declaration for their own benefit and that of their family's; that the undersigned reside on the premises above described and claim the same as a homestead under the provisions of Sections 70-32-101 through 70-32-107, MCA.

This Declaration of Homestead amends and supercedes any Declaration of Homestead executed by prior to this.

IN WITNESS WHEREOF, the undersigned have hereunto set their hand and seal this Day day of Month, Year.

Make sure the correct county is entered here!

_____
Signature

_____
Signature

You can delete the extra lines if there is only one owner.

STATE OF MONTANA

County of County where document is being notarized

This instrument was acknowledged before me this Day day of Month, Year by Owner of Property (and) Owner of Property.

(Notarial Seal)

_____
Notary Signature

Declaration of Homestead

- For which property can one prepare a Declaration of Homestead?
- What if the value of the property exceeds $350,000?

Declaration of Living Will

- **Declaration of living will:**
  - Purpose is to express to your medical providers and loved ones that you do not want them to apply life-support or life-sustaining treatment
  - Communicated formally and in writing
    - In case you can no longer survive without the medical assistance and the application of artificial means
    - Are no longer able to communicating your wishes regarding life-sustaining treatment.

DECLARATION OF LIVING WILL

If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or my 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 attending physician or my attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Signed this Date day of Month, Year.

_____
Signature

Address

Phone Number

The declarant voluntarily signed this document in my presence.

_____	_____
Witness Signature	Witness Signature
_____	_____
(Printed Name)	(Printed Name)
_____	_____
(Address)	(Address)
_____	_____

DECLARATION OF LIVING WILL

If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or my 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 attending physician or my attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Signed this Date day of Month, Year.

_____
Signature

This document does not get notarized, so there is no need for a notary block.

Address

Phone Number

The declarant voluntarily signed this document in my presence.

_____	_____
Witness Signature	Witness Signature
_____	_____
(Printed Name)	(Printed Name)
_____	_____
(Address)	(Address)
_____	_____

DECLARATION OF LIVING WILL APPOINTMENT

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 my 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 appoint Name of Appointee, or if he or she is not reasonably available or is unwilling to serve I appoint Name of Secondary Appointee in the alternative, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to the Montana Rights of the Terminally Ill Act.

If the individual(s) I have appointed are not reasonably available or are unwilling to serve, I direct my attending physician or my attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

Signed this Day day of Month, Year.

_____
Signature

The declarant voluntarily signed this document in my presence.

_____	_____
Witness Signature	Witness Signature
_____	_____
(Printed Name)	(Printed Name)
_____	_____
(Address)	(Address)
_____	_____

If a secondary appointee is not named, this line can be deleted.

DECLARATION OF LIVING WILL APPOINTMENT

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 my 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 appoint Name of Appointee, or if he or she is not reasonably available or is unwilling to serve I appoint Name of Secondary Appointee in the alternative, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to the Montana Rights of the Terminally Ill Act.

If the individual(s) I have appointed are not reasonably available or are unwilling to serve, I direct my attending physician or my attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

Signed this Day day of Month, Year.

This document does not get notarized, so there is no need for a notary block.

_____
Signature

The declarant voluntarily signed this document in my presence.

_____ Witness Signature	_____ Witness Signature
_____ (Printed Name)	_____ (Printed Name)
_____ (Address)	_____ (Address)
_____	_____

Declaration of Living Will

- When does it become effective?

Durable Power of Attorney (Health Care)

- **Durable power of attorney (health):**
  - Designates an agent to make health care decisions if the patient is no longer able to make them.
  - Directs the surrogate person to function as "attorney-in-fact" and make decisions regarding all treatment, including the final decision about end of treatment.

You can delete this section if it is not used.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, Name of Principal, the principal, of city, Montana, designate Name of Agent as my attorney-in-fact and agent to act in my name and for my benefit as set forth herein. I grant to my agent full power to do everything necessary in exercising any of the powers herein granted as fully as I could do if personally present and fully competent, hereby ratifying all that my agent shall lawfully do or cause to be done by virtue of this power of attorney.

Should Name of Primary Agent die, become disabled, resign or is determined by a court of competent jurisdiction to be incapacitated, I hereby appoint Name of Secondary Agent as my successor attorney-in-fact to act in accordance with this instrument.

For this Health Care Power of Attorney ("HCPOA"), my "Agent" means either the Primary Agent or Successor Agent, but not both at the same time.

1. **Powers of Health Care Over Principal**.

1.1 **General Grant of Power**. My agent shall have power to perform any act, power, duty, right or obligation whatsoever that I now have or may hereafter acquire relating to matters involving my health and medical care. In exercising such powers my agent should attempt to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner. My agent is further instructed that if I am unable to give an informed consent to any medical care or treatment, my agent shall give, withhold, withdraw or modify such consent for me based upon any treatment choices that I have expressed while competent regarding medical procedures or interventions to prolong the dying process, to nourish and hydrate me, to provide for my comfort or to alleviate pain. If my agent cannot determine the treatment choice I would want made under the circumstances, then my agent is authorized to make such choice for me based upon what my agent believes to be in my best interests.

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1.2 **Specific Powers**. Without in any way limiting the generality of the power conferred upon my agent under paragraph 1.1, my agent shall have the specific powers set forth in this paragraph 1.2.

(a) **Access to Medical Records**. To receive and review any information, verbal or written, regarding my physical or mental health, including medical and hospital records, to execute releases or other documents that may be required in order to obtain this information and to disclose this information to such persons or entities as my agent shall deem appropriate.

(b) **Employ and Discharge Health Care Personnel**. To employ medical personnel, to pay them reasonable compensation and to discharge any such providers, including, but not limited to, physicians, psychiatrists, dentists, nurses and therapists, as my agent shall deem appropriate for my physical, mental and emotional well-being.

(c) **Medical Care of Principal**. To give or withhold consent to any medical procedure, test or treatment, including surgery; to arrange for my hospitalization, convalescent care, nursing home, hospice or home care; to summon paramedics or other emergency medical personnel and seek emergency treatment for me, as my agent shall deem appropriate; and under circumstances in which my agent determines that certain medical procedures, tests or treatments are no longer of any benefit to me or, where the benefits are outweighed by the burdens imposed, to revoke, withdraw, modify or change consent to such procedures, tests or treatments, as well as hospitalization, convalescent care, nursing home, hospice or home care which I or my agent may have previously consented to or to which consent may have been implied due to emergency conditions. My agent's decision should be guided by taking into account (1) the provisions of this document, (2) any reliable evidence of preferences that I may have addressed on the subject, whether before or after the execution of this instrument, (3) what my agent believes I would want done in the circumstances if I

to express myself, and (4) any information given to my agent by my attending physician regarding my medical diagnosis and prognosis, and the intrusiveness, pain, risks and side effects associated with the procedure, test or treatment.

(d) **Refusal or Withdrawal of Life-Sustaining Procedures**. I wish to live and enjoy life as long as possible. However, I do not wish to receive medical treatment which will only postpone the moment of my death from a medical condition which is incurable, terminal or irreversible. Such medical condition may include, but is not limited to, an irreversible coma or persistent vegetative state, a coma with very slight and uncertain chance of recovery, irreversible brain damage or brain disease with or without a terminal illness or terminal illness in conjunction with my inability to give informed consent to medical treatment. Therefore, if two licensed physicians who are familiar with my medical condition have diagnosed and noted in my medical records that my condition is incurable, terminal or irreversible and that I am unable to give informed consent to medical treatment, then my agent is authorized:

(i) to sign on my behalf any documents necessary to exercise the powers conferred upon my agent by this instrument, including waivers or releases of liability required by any health care provider;

(ii) to grant releases to hospital staff, physicians, nurses, other medical and hospital administrative personnel and entities who act in reliance on the instructions of my agent, from all liability for damages suffered or to be suffered by me resulting from actions which are in accord with the instructions of my agent;

(iii) to give or withhold consent to any medical care or treatment, to revoke or change any previous consent given by me or my agent, or implied by law, for any medical care or treatment and to arrange for my placement in or removal from

any hospital, convalescent home, nursing home, hospice or other medical facility;

(iv) to require that any life-sustaining procedures or treatment which will only postpone the moment of my death or prolong an irreversible coma not be instituted or, if previously instituted, be discontinued;

(v) to require that procedures used to provide me with artificial nourishment and hydration not be instituted or, if previously instituted, be discontinued;

(vi) to require the administration of drugs, other medications and other treatments whose purposes are to keep me as comfortable and as free of pain as is reasonably possible, even though such drugs, medications or treatments may have adverse side effects, may cause addiction or may hasten the moment of, but not intentionally cause, my death.

1.3 **Incidental Powers**. My agent, without the authority or approval of any court, is fully authorized to perform any acts and to execute and deliver any documents, instruments and papers necessary, appropriate, incident or convenient to the exercise of the powers granted by this instrument, including, without limitation, the following:

(a) **Resort to Courts**. To seek on my behalf and at my expense, from any court of competent jurisdiction:

(i) a declaratory judgment interpreting this instrument and determining the validity of any act authorized by this instrument;

(ii) a mandatory injunction requiring compliance by any person, association or other legal entity with my agent's instructions; and

(iii) actual and punitive damages against any person, association or other legal entity who negligently or willfully fails or refuses to follow my agent's instructions.

(b) **Employ Other Personnel**. To employ, compensate and discharge such household workers, professional personnel, including lawyers, advisors, consultants, companions, servants and other employees, as my agent deems appropriate;

(c) **Execute Documents**. To execute and deliver agreements, receipts, releases, waivers, elections, vouchers, consents, and certificates related to the powers granted in this instrument;

Don't forget these selections!!!

(d) **Request Reimbursement**. My Agent Will Not be entitled to reasonable compensation AND will be entitled to reimbursement for all reasonable expenses incurred.

Reimbursement is to be paid by any agent who exercises power over my financial affairs under any power of attorney or from any fiduciary under any trust instrument for my benefit or from any court-appointed conservator.

2. **Interpretation**. This instrument is to be construed and interpreted as a durable power of attorney for health care. The enumeration of specific powers is not intended to, nor does it, limit or restrict the general powers granted to my agent.

3. **Revocability**. This instrument is revocable, provided I am competent to do so at the time. Insofar as any physician, hospital, hospital staff member, governmental agency, corporation or other legal entities or any other person is concerned, who shall rely upon this instrument, this instrument may be revoked only by a notice in writing executed by me or my agent and delivered to such third party.

4. **Prior Documents**. I revoke any previous power of attorney for health care that I may have signed. This HCPOA shall supersede a Physician Order for Life Sustaining Treatment (POLST), advance

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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 HCPOA or with my Agent's decisions on my behalf.

5. **Passage of Time**. This instrument shall not be revoked or otherwise become ineffective in any way by the mere passage of time, but rather shall remain in full force and effect until revoked by me or my agent in writing, as provided in paragraph 3.

6. **Third-Party Reliance**. Third parties may rely upon the representations of my agent as to all matters relating to any power granted to my agent, and no third party who may act in reliance upon the representations of my agent or the authority granted to my agent shall incur any liability to me or my estate as a result of permitting my agent to exercise any power. My agent is authorized to take legal action on behalf of me or my estate for any damages that may result from a third party's refusal to rely on the representations of my agent or to recognize the authority herein granted to my agent or failure to permit my agent to exercise any power granted by this instrument.

7. **Disability of Principal**. This Durable Power of Attorney for Health Care shall not be affected by my incapacity or disability.

8. **Inducement**. For the purpose of inducing all persons, organizations, corporations and entities, including but not limited to, any physician, hospital, nursing home, insurer or other party to act in accordance with the powers granted in this instrument, I hereby represent, warrant and agree, both for myself and on behalf of my heirs, distributees, legal representatives, successors and assigns, that if this power of attorney is terminated for any reason whatsoever, I and my heirs distributees, legal representatives, successors and assigns, will hold such party or parties harmless from any loss suffered or liability incurred by such party or parties in acting in accordance with this power of attorney prior to such third party's receipt of written notice of such termination.

9. **Exculpation**. Under no circumstances shall my agent incur any liability to me, or to my heirs, distributees, legal representatives, successors and assigns, for acting or refraining from acting hereunder, except for my agent's own willful misconduct or gross negligence.

10. **Nomination of Guardian.** If a petition is made on my behalf to a court requesting appointment of a guardian of my estate or of my person, I nominate my acting Agent.

The Agent is the default conservator. If someone else is selected, their information needs to be entered here.

11. **Fiduciary Powers**. Notwithstanding any other provision of this Durable Power of Attorney for Health Care, my agent shall have no rights or powers hereunder with respect to any act, power, duty, right or obligation relating to any person, matter, transaction or property owned by me or in my custody as a trustee, custodian, personal representative or other fiduciary capacity.

12. **HIPAA Release Authority**. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (a/k/a HIPAA), 42 USC §1320d and 45 CFR §§160-164. I authorize: any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc., or other health-care clearing house that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent,

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without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse. The authority given my agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider.

13. **Living Will**. If I have previously executed a so-called "living will", to the extent my living will is applicable to my circumstances, the terms of my living will shall govern the withholding of medical treatment as therein provided; otherwise, my "living will" shall in no way be deemed to limit the powers of my agent under this instrument.

14. **Governing Law**. This instrument is executed and delivered in the State of Montana, and the laws of the State of Montana shall govern all questions as to the validity and construction of this instrument.

15. **Counterparts and Photographic Copies**. This instrument may be executed in counterparts. Each executed counterpart is an original and any photographic copy of this instrument shall have the force and effect of an original.

16. **Special Instructions** Insert Special Instructions here

You can delete this section if it is not used.

17. **Effective Date**. This instrument is effective immediately unless I have stated otherwise in the Special Instructions.

SPRINGING LANGUAGE

A Power of Attorney drafted with springing language will go into effect when and only when the Principal is designated as incapacitated by a medical professional. This is meant to serve as a protection, ensuring

This section must be signed, whether or not springing language is used.

that the document is only used if it is needed. Sometimes, however, springing language can prevent a POA from being effective, should the medical community be hesitant to declare a senior as incapacitated. The potential complications of springing language need to be considered before employing it in your POA.

I, Name of Principal, hereby swear that springing language and complications associated with it have been explained to me and that I understand the implications of using springing language in my POA.

_____, _____, _____, _____
Signature day month year

IN WITNESS WHEREOF, I have executed this Durable Power of Attorney for Health Care this Day day of Month, Year.

_____
Name of Principal, **Principal**

STATE OF MONTANA

County of Name of County document is notarized in

This instrument was acknowledged before me this Day day of Month, Year, by Name of Principal.

(notarial seal)

_____
Notary's Signature

This project is funded in whole or in part under a contract with the Montana department of Public Health and Human services. The statements herein do not necessarily reflect the opinion of the department.

This project was supported by Grant No.V66-92155 awarded by the Montana Board of Crime Control (MBCC) through the Office of Justice Programs, US Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the US Department of Justice.

Durable Power of Attorney (Financial)

- **Durable power of attorney (financial):**
  - Allows someone else to manage your finances in the event that you become incapacitated and are unable to make those decisions yourself.
  - Grants someone you trust the legal authority to act on your behalf for financial issues.

POWER OF ATTORNEY FOR FINANCIAL

I. DESIGNATION OF AGENT

I, Principal's Name, name the following person as my agent:
Name of Agent
Agent's Address
Agent's Telephone Number

II. DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:
Name of Successor Agent
Successor Agent's Address
Successor Agent's Telephone Number

This section can be deleted if it is not used.

III. GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act, MCA Title 72, chapter 31, part 3: (INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

☐Real Property
☐Tangible Personal Property
☐Stocks and Bonds
☐Commodities and Options
☐Banks and Other Financial Institutions
☐Operation of Entity or Business
☐Insurance and Annuities
☐Estates, Trusts, and Other Beneficial Interests
☐Claims and Litigation
☐Personal and Family Maintenance
☐Benefits from Governmental Programs or Civil or Military Service
☐Retirement Plans

Make sure one of the options is marked. The notary will require the client to initial near the selection to confirm their choice.

☐Taxes
☐Individual Indian Money Account(s) (IIM)
☐Indian Trust Land
☐All Preceding Subjects

IV. REVOCATION OF PRIOR POWER OF ATTORNEY

This Power of Attorney revokes all previous Power of Attorney forms signed by me. This Power of Attorney may only be revoked in writing signed by me.

V. LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

VI. SPECIAL INSTRUCTIONS (OPTIONAL)

Any transaction or series of related transactions, totaling more than $Amount per month, made by my agent shall require two signatures, the signature of my agent named in this document and the signature of Name of second individual.

Any transaction or series of related transactions involving any of the following made by my agent shall require two signatures, the signature of my agent named in this document and the signature of Name of second individual

☐Sale, Purchase or Transfer of Real Property Including a Beneficiary Deed
☐Sale, Purchase or Transf
☐Sale, Purchase or Transf
☐Sale, Purchase or Transf
☐Sale, Purchase or Transf
☐Payment of Income/Prop
☐Withdrawals or Transfers
Accounts in Excess of Amo
☐Sale, Purchase or Transf

This is where protective measures can be added. Model language has been included, but part or all can be deleted if it isn't used. For more information, see the attached informational sheet, "Protective measures in POAs." If this entire section isn't used, it can be deleted.

☐All Preceding Subjects

My agent shall keep complete records of all transactions on my behalf and provide a quarterly accounting upon request by the principal or any beneficiaries under my Will. The quarterly accounting shall include copies of all financial statements, credit card or loan statements. Upon a request by Adult Protective Services, my agent must provide all financial information, including but not limited to, quarterly accounting reports, copies of all financial statements, credit card and/or loan statements.

Insert Special Instructions Here

VII. EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

VIII. SPRINGING LANGUAGE

Springing Language: A Power of Attorney drafted with springing language will go into effect when and only when the Principal is designated as incapacitated by a medical professional. This is meant to serve as a protection, ensuring that the document is only used if it is needed. Sometimes, however, springing language can prevent a POA from being effective, should the medical community be hesitant to declare a senior as incapacitated. The potential complications of springing language need to be considered before employing it in your POA.

I, Name of Principal, hereby swear that spr
complications associated with it have beer
understand the implications of using spring

The agent is the default conservator. If someone else is selected, their information needs to be entered here.

_____, _____, _____, _____
Signature day month year

IX. NOMINATION OF CONSERVATOR (OPTIONAL)

If a petition is made on my behalf to a court requesting appointment of a conservator of my estate, I nominate the following agents:

Name of Nominee for conservator of my estate
Nominee's Address
Nominee's Telephone Number

X. RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

_____, _____, _____, _____
Principal's Name, Day, Month, Year

Principal's Address

Principal's Phone Number

STATE OF MONTANA

County of County that document will be Notarized in

This document was acknowledged before me on this day day of Month, year, by Principal's Name.

(Notarial Seal)

_____
Notary Signature

If the client's agent is present, it is important to read through this section with them. If not, make sure the client knows that further action is required by the agent after the clinic. They will be reminded by the notary.

IMPORTANT INFORMATION FOR AGENT

I. AGENT'S DUTIES

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:

(1) do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;

(2) act in good faith;

(3) do nothing beyond the authority granted in this power of attorney; and

(4) disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner: (Principal's Name) by (Your Signature) as Agent.

Unless the Special Instructions in this power of attorney state otherwise, you must also:

(1) act loyally for the principal's benefit;

(2) avoid conflicts that would impair your ability to act in the principal's best interest;

(3) act with care, competence, and diligence;

(4) keep a record of all receipts, disbursements, and transactions made on behalf of the principal;

(5) cooperate with any person who has authority to make health care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's

expectations, to act in the principal's best interest; and

(6) attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

II. TERMINATION OF AGENT'S AUTHORITY

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

(1) death of the principal;

(2) the principal's revocation of the power of attorney or your authority;

(3) the occurrence of a termination event stated in the power of attorney;

(4) the purpose of the power of attorney is fully accomplished; or

(5) if you are married to the principal, a legal action is filed with a court to end or annul your marriage, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

III. LIABILITY OF AGENT

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act, Title 72, chapter 31, part 3. If you violate the Uniform Power of Attorney Act, Title 72, chapter 31, part 3, or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

IV. AGENT CERTIFICATION – OPTIONAL FORM

Agent's Certification is an optional form and may be used by an agent to certify facts concerning a power of attorney.

****Note: The Legal Service Developer Program recommends this form be signed by the agent.**

AGENT'S CERTIFICATION AS TO THE VALIDITY OF POWER OF ATTORNEY AND AGENT'S AUTHORITY

I, Name of Agent, Agent, certify under penalty of perjury that Name of Principal, Principal, granted me authority as agent or successor agent in a power of attorney dated Day, Month, and Year POA was executed.

I further certify that to my knowledge:

(1) the principal is alive and has not revoked the power of attorney or my authority to act under the power of attorney and the power of attorney and my authority to act under the power of attorney have not terminated;

(2) if the power of attorney was drafted to become effective upon the happening of an event or contingency, the event or contingency has occurred;

(3) if I was named as a successor agent, the prior agent is no longer able or willing to serve;

and

(4) Insert any other relevant statements

You can delete this section if it is not used.

SIGNATURE AND ACKNOWLEDGMENT

_____ _____, _____, _____

Agent's Name

Agent's Address

Agent's Telephone Number

County and State refers to the location where the agent's duties are notorized.

STATE OF _____

County of _____

This document was acknowledged before me on ___ day of _____, 201_ by _____, agent.

(Notarial Seal)

_____
Notary Signature

Durable Power of Attorney

- What is a principal?
- What is an agent?
- What is an alternate or successor agent?
- Why is it called a Durable Power of Attorney?
- Why do I need a DPOA for health care?
- Who should be named as an agent in a DPOA for health care?
- Can a DPOA be revoked?

Simple Will

- **Simple will/Statutory Will**
  - Common choice for those with a small, uncomplicated Estate and relatively straightforward wishes.
  - Generic "one size fits all" formulaic Wills, where one checks the appropriate boxes and fills in the blanks.
  - Does not include complex trusts or other provisions designed to minimize federal or state estate taxes that might be assessed against a large estate.

LAST WILL AND TESTAMENT
OF
Testator's Name

I. INTRODUCTION

I, Testator's Name, also known as Nickname, Alias, Maiden Name, etc., domiciled and residing in County of Residence County, Montana, declare this to be my Will, revoking all prior Wills and Codicils.

II. FAMILY INFORMATION

I am single, widowed, divorced. I have Number of Children children, namely, Names of Children. All references to "my children" refer to the Number of Children children named in this paragraph and any other children hereafter born to or adopted by me.

III. DEBT CLAUSE

I direct that all of my legally enforceable debts, funeral expenses and expenses in connection with the administration of my estate be paid as soon as practicable after my death.

IV. PRE-RESIDUARY GIFTS

A. Tangible Personal Property List

I might leave a written statement or list disposing of items of tangible personal property. If I do and if my written statement or list is found and identified by the personal representative no later than 30 days after my death, then the statement or list is to be given effect to the extent authorized by law. Any tangible personal property not effectively disposed of by such a statement or list shall be distributed to my surviving children (and not to their descendants) as they may agree. If my surviving children fail to reach agreement within 90 days after the probate of this Will, such tangible

_____ _____ _____

Testator Initials Witness Initials

personal property shall be divided among my surviving children as my personal representative determines appropriate, in shares of substantially equal value.

If any child of mine is a minor at the time of such division, my personal representative may distribute the child's share to the child or for the child's use to the child's guardian or to any person with whom the child is residing, without further responsibility, and the distributee's receipt shall be a sufficient discharge to my personal representative.

V. RESIDUARY CLAUSE

I give the residue of my estate to my descendants who survive me by representation.

VI. METHODS OF DISTRIBUTION TO CERTAIN BENEFICIARIES

If under this will any property is distributable to a minor or to a person under twenty-one (21) years of age, my personal representative, in my personal representative's absolute discretion, may distribute such property in any manner permitted by law and additionally in any one or more of the following ways:

(A) If the person is a minor, directly to the minor or on behalf of the minor for the minor's exclusive benefit;

(B) If the person is a minor, to a guardian or conservator for the minor; or

(C) If the person is under twenty-one (21) years of age, to any person (including my personal representative) selected as a custodian by my personal representative under the applicable Uniform Transfers to Minors Act of any State.

VII. APPOINTMENT OF PERSONAL REPRESENTATIVE

_____ _____ _____

Testator Initials Witness Initials

I appoint my son/daughter/sibling, as personal representative of my estate. In the event my son/daughter/sibling shall die, be adjudicated incompetent, or resign, I hereby name as successor personal representative to fill such vacancy or any vacancy that may thereafter occur, the first in the order named who is then willing and able to serve:

(A) Alternate Personal Representative

(B) Alternate Personal Representative

(C) Alternate Personal Representative

I. POWERS OF PERSONAL REPRESENTATIVE

In addition to the powers given to my personal representative by law effective at death, my personal representative shall have all powers authorized by the Montana Uniform Probate Code, as that Code exists on the date of this Will.

II. NOMINATION OF GUARDIAN

In the event of my death and any of my children are under age 18, then I nominate the following as Guardian(s) for such children:

Name of Nominee for Guardian
Nominee's Address
Nominee's Phone Number

Delete any unused lines for Guardian nomination

Name of Nominee for Guardian
Nominee's Address
Nominee's Phone Number

Montana Aging Services Bureau
Kelly Moorse Memorial Documents Clinics
Senior Financial Defense
Volunteer Documents Packet

I. MONTANA LAW

This instrument shall be construed under the laws of the State of Montana.

II. REPRESENTATION

The persons who take under this will as "descendants by right of representation" shall take in accordance with the rules of §72-2-116 MCA as that section exists on this date of this Will.

III. CAPTIONS

The captions set forth in this Will at the beginning of various provisions are for convenience of reference only, and shall not be deemed to define or limit the provisions of this Will, or to affect in any way its construction or application.

IV. CONCLUSION AND ATTESTATION

I, Testator's Name, the testator sign my name to this instrument this Day day of Month, Year and being first duly sworn, do hereby declare to the undersigned authority that I sign and execute this instrument as my Will and that I sign it willingly (or willingly direct another to sign for me), that I execute it as my free and voluntary act for the purposes therein expressed, that I am 18 years of age or older, of sound mind, and under no constraint or undue influence.

_____

Testator's Name

We, witnesses, sign our names to this instrument, consisting of Total Number of Pages pages, being first duly sworn, do hereby declare to the undersigned authority that the testator signs and executes this instrument as

the testator's Last Will and that the testator signs it willingly (or willingly directs another to sign for the testator), that each of us, in the presence and hearing of the testator, hereby signs the Will as a witness to the testator's signing, and that to the best of our knowledge the testator is 18 years of age or older, of sound mind, and under no constraint or undue influence.

_____	_____
Witness	Witness
Residing at:	Residing at:
_____	_____

STATE OF MONTANA

County of County where documents are being notarized

Signed and sworn to before me by Testator's Name, the testator, this Day day of Month, Year.

(Notarial Seal)

_____
Notary Signature

_____ Testator Initials

_____ _____ Witness Initials

Simple Will

- What is a codicil?
- What is a Tangible Personal Property List?