COMBINED MENTAL HEALTH CARE DECLARATION AND POWER OF ATTORNEY FORM

Part I. Introduction

I,_____, having capacity to make mental health decisions, willfully and voluntarily make this Declaration and Power of Attorney regarding my mental health care. I understand that mental health care includes any care, treatment, service or procedure to maintain, diagnose, treat or provide for mental health, including any medication program and therapeutic treatment. Electroconvulsive therapy may be administered only if I have specifically consented to it in this document. I will be the subject of laboratory trials or research only if specifically provided for in this document. Mental health care does not include psychosurgery or termination of parental rights. I understand that my incapacity will be determined by examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician or mental health treatment professional. Whenever possible, one of the decision makers will be one of my treating professionals.

A. When this Combined Mental Health Declaration and Power of Attorney becomes effective

This Combined Mental Health Declaration and Power of Attorney becomes effective at the following designated time:

☐ When I am deemed incapable of making mental health care decisions. I would prefer the following doctor(s) to evaluate me for my ability to make mental health decisions:

Name of Doctor: _____

Address/Phone Number: _____

☐ When the following condition is met: (List condition) _____

B. Revocation and Amendments

This Combined Mental Health Care Declaration and Power of Attorney may be revoked in whole or in part at any time, either orally or in writing, as long as I have not been found to be incapable of making mental health decisions. My revocation will be effective upon communication to my attending physician or other mental health care provider, either by me or a witness to my revocation, of the intent to revoke. If I choose to revoke a particular instruction contained in this Power of Attorney in the manner specified, I understand that the other instructions contained in this Power of Attorney will remain effective until:

(1) I revoke this Power of Attorney in its entirety;
(2) I make a new combined Mental Health Care Declaration and Power of Attorney; or
(3) Two years from the date this document was executed.

I may make changes to this Advance Directive at any time, as long as I have capacity to make mental health care decisions. Any changes will be made in writing and be signed and witnessed by two individuals in the same way as the original document. Any changes will be effective as soon the changes are communicated to my attending physician or other mental health care provider, either by me, my agent, or a witness to my amendments.

C. Termination

I understand that this Declaration will automatically terminate two years from the date of execution, unless I am deemed incapable of making mental health care decisions at the time that this Declaration would expire.

Part II. Mental Health Declaration

A. Treatment preferences

1. Choice of treatment facility

☐ In the event that I require commitment to a psychiatric treatment facility, I would prefer to be admitted to the following facility:

Name of facility: _____

Address: _____

City, State, Zip Code: _____

☐ In the event that I require commitment to a psychiatric treatment facility, I do not wish to be committed to the following facility:

Name of facility: _____

Address: _____

City, State, Zip Code: _____

I understand that my physician may have to place me in a facility that is not my preference.

2. Preferences regarding medications for psychiatric treatment

☐ I consent to the medications that my treating physician recommends.

☐ I consent to the medications that my treating physician recommends with the following exceptions, limitations, and/or preferences:

Medication	Reason for Exception

I consent to the following medications with these limitations:

Medication	Limitation	Reason for Limitation

I prefer the following medications:

Medication	Reason for Preference

The exception, limitation, or preference, applies to generic, brand name and trade name equivalents unless otherwise stated. I understand that dosage instructions are not binding on my physician.

☐ I have designated an agent under the Power of Attorney portion of this document to make decisions related to medication.

☐ I do not consent to the use of any medications.

3. Preferences for electroconvulsive therapy (ECT)

☐ I consent to the administration of electroconvulsive therapy.

☐ I have designated an agent under the Power of Attorney portion of this document to make decisions related to electroconvulsive therapy.

☐ I do not consent to the administration of electroconvulsive therapy.

4. Preferences for experimental studies

☐ I consent to participation in experimental studies if my treating physician believes that the potential benefits to me outweigh the possible risks to me.

☐ I have designated an agent under the Power of Attorney portion of this document to make decisions related to experimental studies.

☐ I do not consent to participation in experimental studies.

5. Preferences for drug trials.

☐ I consent to participation in drug trials if my treating physician believes that the potential benefits to me outweigh the possible risks to me.

☐ I have designated an agent under the Power of Attorney portion of this document to make decisions related to drug trials.

☐ I do not consent to participation in any drug trials.

6. Additional instructions or information.

Examples of other instructions or information that may be included:

Activities that help or worsen symptoms:

_____

_____

_____

_____

Type of intervention preferred in the event of a crisis:

_____

_____

_____

_____

Mental and physical health history:

Dietary requirements:

Religious preferences:

Temporary custody of children:

Family notification:

Limitations on the release or disclosure of mental health records:

Temporary care and custody of pets:

Other matters of importance:

Part III. Mental Health Care Power of Attorney

I,_____, having the capacity to make mental health decisions, authorize my designated health care agent to make certain decisions on my behalf regarding mymental health care. If I have not expressed a choice in this document or in the accompanying Declaration,I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

A. Designation of agent

I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document. This authorization applies only to mental health decisions that are not addressed in the accompanying signed Declaration.

Name of designated person: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____- _____

Agent's acceptance:

I hereby accept designation as mental health care agent for (insert name of declarant).

_____ .

Agent's signature:_____

Name of Agent:_____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____- _____

B. Designation of alternative agent

In the event that my first agent is unavailable or unable to serve as my mental health care agent, I hereby designate and appoint the following individual as my alternative mental health care agent to make mental health care decisions for me as authorized in this document:

Name of designated person: _____

Address: _____

City, State, Zip Code:_____

Phone Number: _____- _____-_____

Alternative Agent's acceptance:

I hereby accept designation as alternative mental health care agent for (insert name of declarant).

_____ .

Alternate Agent's signature: _____

Name of Alternate Agent: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

C. Authority granted to my mental health care agent

I hereby grant to my agent full power and authority to make mental health care decisions for me consistent with the instructions and limitations set forth in this document. If I have not expressed a choice in this Power of Attorney, or in the accompanying Declaration, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

1. Preferences regarding medications for psychiatric treatment.

☐ My agent is authorized to consent to the use of any medications after consultation with my treating psychiatrist and any other persons my agent considers appropriate.

☐ My agent is not authorized to consent to the use of any medications.

2. Preferences regarding electroconvulsive therapy (ECT).

☐ My agent is authorized to consent to the administration of electroconvulsive therapy.

☐ My agent is not authorized to consent to the administration of electroconvulsive therapy.

3. Preferences for experimental studies.

☐ My agent is authorized to consent to my participation in experimental studies if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.

☐ My agent is not authorized to consent to my participation in experimental studies.

4. Preferences regarding drug trials.

☐ My agent is authorized to consent to my participation in drug trials if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.

☐ My agent is not authorized to consent to my participation in drug trials.

PART IV. Nominating a Guardian

A. Preference as to a court-appointed guardian

I understand that I may nominate a guardian of my person for consideration by the court if incapacity proceedings are commenced under 20 Pa.C.S. § 5511. I understand that the court will appoint a guardian in accordance with my most recent nomination except for good cause or disqualification. In the event a court decides to appoint a guardian, I desire the following person to be appointed:

Name of Person: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

☐ The appointment of a guardian of my person will not give the guardian the power to revoke, suspend or terminate this Combined Mental Health Care Declaration and Power of Attorney.

☐ Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this Combined Mental Health Care Declaration and Power of Attorney.

PART V. Execution

I am making this Combined Mental Health Care Declaration and Power of Attorney on the

_____ day of (month)_____, (year)_____.

My Signature: _____

My Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

_____ _____

Witness Signature Witness Signature

Name of Witness: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

Name of Witness:_____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

If the principal making this Combined Mental Health Care Declaration and Power of Attorney is unable to sign this document, another individual may sign on behalf of and at the direction of the principal. An agent or a person signing on behalf of the principal may not also be a witness.

Signature of person signing on my behalf: _____

Name of Person:_____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

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MENTAL HEALTH CARE DECLARATION FORM

I,_____, having capacity to make mental health decisions, willfully and voluntarily make this Declaration regarding my mental health care. I understand that mental health care includes any care, treatment, service or procedure to maintain, diagnose, treat or provide for mental health, including any medication program and therapeutic treatment. Electroconvulsive therapy may be administered only if I have specifically consented to it in this document. I will be the subject of laboratory trials or research only if specifically provided for in this document. Mental health care does not include psychosurgery or termination of parental rights. I understand that my incapacity will be determined by examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician or mental health treatment professional. Whenever possible, one of the decision makers will be one of my treating professionals.

A. When this Declaration becomes effective

This Declaration becomes effective at the following designated time:

☐ When I am deemed incapable of making mental health care decisions. I would prefer the following doctor(s) to evaluate me for my ability to make mental health decisions:

Name of Doctor: _____

Address/Phone Number: _____

☐ When the following condition is met: (List condition)_____

B. Treatment preferences

1. Choice of treatment facility.

☐ In the event that I require commitment to a psychiatric treatment facility, I would prefer to be admitted to the following facility:

Name of facility: _____

Address: _____

City, State, Zip Code: _____

☐ In the event that I require commitment to a psychiatric treatment facility, I do not wish to be committed to the following facility:

Name of facility: _____

Address: _____

City, State, Zip Code: _____

I understand that my physician may have to place me in a facility that is not my preference.

2. Preferences regarding medications for psychiatric treatment.

☐ I consent to the medications that my treating physician recommends.

☐ I consent to the medications that my treating physician recommends with the following exceptions, limitations and/or preferences:

Medication	Reason for Exception

I consent to the following medications with these limitations:

Medication	Limitation	Reason for Limitation

I prefer the following medications:

Medication	Reason for Preference

The exception, limitation, or preference, applies to generic, brand name and trade name equivalents unless otherwise stated. I understand that dosage instructions are not binding on my physician.

☐ I do not consent to the use of any medications.

3. Preferences regarding electroconvulsive therapy (ECT).

☐ I consent to the administration of electroconvulsive therapy.

☐ I do not consent to the administration of electroconvulsive therapy.

4. Preferences for experimental studies.

☐ I consent to participation in experimental studies if my treating physician believes that the potential benefits to me outweigh the possible risks to me.

☐ I do not consent to participation in experimental studies.

5. Preferences for drug trials.

☐ I consent to participation in drug trials if my treating physician believes that the potential benefits to me outweigh the possible risks to me.

☐ I do not consent to participation in any drug trials.

6. Additional instructions or information.

Examples of other instructions or information that may be included:

Activities that help or worsen symptoms:

Type of intervention preferred in the event of a crisis:

Mental and physical health history:

Dietary requirements:

Religious preferences:

Temporary custody of children:

Family notification:

Limitations on the release or disclosure of mental health records:

Temporary care and custody of pets:

Other matters of importance:

C. Revocation and Amendments

This Declaration may be revoked in whole or in part at any time, either orally or in writing, as long as I have not been found to be incapable of making mental health decisions. My revocation will be effective upon communication to my attending physician or other mental health care provider, either by me or a witness to my revocation, of the intent to revoke. If I choose to revoke a particular instruction contained in this Declaration in the manner specified, I understand that the other instructions contained in this Declaration will remain effective until:

(1) I revoke this Declaration in its entirety;
(2) I make a new Mental Health Advance Directive; or
(3) Two years after the date this document was executed.

I may make changes to this Advance Directive at any time, as long as I have capacity to make mental health care decisions. Any changes will be made in writing and be signed and witnessed by two individuals in the same way the original document was executed. Any changes will be effective as soon the changes are communicated to my attending physician or other mental health care provider, either by me or a witness to my amendments.

D. Termination

I understand that this Declaration will automatically terminate two years from the date of execution, unless I am deemed incapable of making mental health care decisions at the time that this Declaration would expire.

E. Preference as to a court-appointed guardian

I understand that I may nominate a guardian of my person for consideration by the court if incapacity proceedings are commenced under 20 Pa.C.S. § 5511. I understand that the court will appoint a guardian

in accordance with my most recent nomination except for good cause or disqualification. In the event a court decides to appoint a guardian, I desire the following person to be appointed:

Name of Person: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

☐ The appointment of a guardian of my person will not give the guardian the power to revoke, suspend or terminate this Declaration.

☐ Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this Declaration.

F. Execution

I am making this Declaration on the _____ day of (month)_____, (year)_____.

My Signature: _____

My Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

_____ _____

Witness Signature Witness Signature

Name of Witness: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

Name of Witness: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

If the principal making this Declaration is unable to sign it, another individual may sign on behalf of and at the direction of the principal.

Signature of person signing on my behalf: _____

Name of Person:_____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

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MENTAL HEALTH POWER OF ATTORNEY

I,_____, having the capacity to make mental health decisions, authorize my designated health care agent to make certain decisions on my behalf regarding my mental health care. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

I understand that mental health care includes any care, treatment, service or procedure to maintain, diagnose, treat or provide for mental health, including any medication program and therapeutic treatment. Electroconvulsive therapy may be administered only if I have specifically consented to it in this document. I will be the subject of laboratory trials or research only if specifically provided for in this document. Mental health care does not include psychosurgery or termination of parental rights.

I understand that my incapacity will be determined by examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician or mental health treatment professional. Whenever possible, one of the decision makers shall be one of my treating professionals.

A. Designation of agent

I hereby designate and appoint the following person as my agent to make mental health care decisions for me as authorized in this document.

Name of designated person: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

Agent's acceptance:

I hereby accept designation as mental health care agent for (insert name of declarant).

_____

Agent's signature: _____

B. Designation of alternative agent

In the event that my first agent is unavailable or unable to serve as my mental health care agent, I hereby designate and appoint the following individual as my alternative mental health care agent to make mental health care decisions for me as authorized in this document:

Name of designated person: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

Alternative Agent's acceptance:

I hereby accept designation as alternative mental health care agent for (insert name of declarant).

_____

Alternate Agent's signature: _____

C. When this Power of Attorney becomes effective

This Power of Attorney will become effective at the following designated time:

☐ When I am deemed incapable of making mental health care decisions. I would prefer the following doctor(s) to evaluate me for my ability to make mental health decisions:

Name of Doctor: _____

Address/Phone Number: _____

☐ When the following condition is met: _____

D. Authority granted to my mental health care agent

I hereby grant to my agent full power and authority to make mental health care decisions for me consistent with the instructions and limitations set forth in this Power of Attorney. If I have not expressed a choice in this Power of Attorney, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

1. Treatment preferences.

(a). Choice of treatment facility.

☐ In the event that I require commitment to a psychiatric treatment facility, I would prefer to be admitted to the following facility:

Name of facility: _____

Address: _____

City, State, Zip Code: _____

☐ In the event that I require commitment to a psychiatric treatment facility, I do not wish to be committed to the following facility:

Name of facility: _____

Address: _____

City, State, Zip Code: _____

I understand that my physician may have to place me in a facility that is not my preference.

(b). Preferences regarding medications for psychiatric treatment.

☐ I consent to the medications that my agent agrees to after consultation with my treating physician and any other persons my agent considers appropriate.

☐ I consent to the medications that my agent agrees to, with the following exceptions or limitations:

Medication	Reason for Exception

I consent to the following medications with these limitations:

Medication	Limitation	Reason for Limitation

The exception or limitation applies to generic, brand name and trade name equivalents unless otherwise stated. I understand that dosage instructions are not binding on my physician.

☐ My agent is not authorized to consent to the use of any medications.

(c). Preferences regarding electroconvulsive therapy (ECT).

☐ My agent is authorized to consent to the administration of electroconvulsive therapy.
NOTE: Your agent MAY NOT consent to ECT unless you initial this authorization.

☐ My agent is not authorized to consent to the administration of electroconvulsive therapy.

(d). Preferences for experimental studies.

☐ My agent is authorized to consent to my participation in experimental studies if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.
NOTE: Your agent MAY NOT consent to experimental studies unless you initial this authorization.

☐ My agent is not authorized to consent to my participation in experimental studies.

(e). Preferences regarding drug trials.

☐ My agent is authorized to consent to my participation in drug trials if, after consultation with my treating physician and any other individuals my agent deems appropriate, my agent believes that the potential benefits to me outweigh the possible risks to me.
NOTE: Your agent MAY NOT consent to research including drug trials unless you initial this authorization.

☐ My agent is not authorized to consent to my participation in drug trials.

(f). Additional instructions or information.

Examples of other instructions or information that may be included:

Activities that help or worsen symptoms:

Type of intervention preferred in the event of a crisis:

Mental and physical health history:

Dietary requirements:

Religious preferences:

Temporary custody of children:

Family notification:

Limitations on the release or disclosure of mental health records:

_____

_____

_____

_____

Temporary care and custody of pets:

_____

_____

_____

_____

Other matters of importance:

_____

_____

_____

_____

E. Revocation and Amendments

This Power of Attorney may be revoked in whole or in part at any time, either orally or in writing, as long as I have not been found to be incapable of making mental health decisions. My revocation will be effective upon communication to my attending physician or other mental health care provider, either by me or a witness to my revocation, of the intent to revoke. If I choose to revoke a particular instruction contained in this Power of Attorney in the manner specified, I understand that the other instructions contained in this Power of Attorney will remain effective until:

(4) I revoke this Power of Attorney in its entirety;
(5) I make a new combined Mental Health Care Declaration and Power of Attorney; or
(6) Two years from the date this document was executed.

I may make changes to this Power of Attorney at any time, as long as I have capacity to make mental health care decisions. Any changes will be made in writing and be signed and witnessed by two individuals in the same way the original document was executed. Any changes will be effective as soon the changes are communicated to my attending physician or other mental health care provider, either by me, my agent, or a witness to my amendments.

F. Termination

I understand that this Power of Attorney will automatically terminate two years from the date of execution unless I am deemed incapable of making mental health care decisions at the time that the Power of Attorney would expire.

G. Preference as to a court-appointed guardian

I understand that I may nominate a guardian of my person for consideration by the court if incapacity proceedings are commenced under 20 Pa.C.S. § 5511. I understand that the court will appoint a guardian in accordance with my most recent nomination except for good cause or disqualification. In the event a court decides to appoint a guardian, I desire the following person to be appointed:

Name of Person: _____

Address: _____

City, State, Zip Code:_____

Phone Number: _____- _____-_____

☐ The appointment of a guardian of my person will not give the guardian the power to revoke, suspend or terminate this Power of Attorney.

☐ Upon appointment of a guardian, I authorize the guardian to revoke, suspend or terminate this Power of Attorney.

H. Execution

I am making this Mental Health Care Power of Attorney on the

_____ day of (month)_____, (year)_____.

Principle Signature:_____

Name of Principle: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

_____ _____

Witness Signature Witness Signature

Name of Witness: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

Name of Witness:_____

Address:_____

City, State, Zip Code:_____

Phone Number: _____- _____-_____

If the principal making this Mental Health Care Power of Attorney is unable to sign this document, another individual may sign on behalf of and at the direction of the principal.

Signature of person signing on my behalf: _____

Name of Person:_____

Address:_____

City, State, Zip Code: _____

Phone Number: _____- _____-_____

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