Durable Power of Attorney for Mental Health Care

INFORMATION NAMING MY ATTORNEY IN FACT FOR MENTAL HEALTH CARE

I, _____, appoint _____, whose address is _____, and whose telephone number(s) are: (home) _____ (cell) _____ as my surrogate decision-maker, known in this document as my "Attorney-in-Fact for Healthcare".

I appoint _____ whose address is _____ and whose telephone number(s) are: (home) _____ (cell) _____ as my successor Attorney-in-fact for Mental Health Care.

I authorize my Attorney-in-fact for Mental Health Care, appointed by this document, to receive information and make decisions on my behalf regarding my mental health care and treatment needs if and when I am determined to be unable to make my own mental health care and treatment decisions. My Attorney-in-fact for Mental Health Care will be responsible to advocate on my behalf for mental health care and treatment that ensures my physical, emotional, and spiritual well-being.

INFORMATION ABOUT MY GENERAL HEALTH CARE ADVANCE DIRECTIVES

I understand that this document refers specifically to my **mental health care and treatment needs.** Regarding my general health care and treatment needs (check one below):

☑ I have not completed separate Durable Power of Attorney for Health Care and/or Living Will documents at this time, and understand that my surrogate decision-maker for general health care and treatment needs will be identified from the following in this order: My spouse, adult children, parents, siblings, or closest next-of-kin.

☐ I have completed separate Durable Power of Attorney for Health Care and/or Living Will documents for my general health care and treatment needs. A copy is located: _____.

(Note: You may wish to ask your health care provider for additional information about completing general Durable Power of Attorney for Health Care and/or Living Will documents if you have not already done so).

SCOPE OF MY ATTORNEY-IN-FACT DECISION-MAKING AUTHORITY

I direct my Attorney-in-fact for Mental Health Care to comply with the following instructions regarding my mental health care and treatment needs *(check one of the following options):*

☐ 1. I have no specific instructions; my Attorney-in-fact for Mental Health Care may make decisions on my behalf that they believe are appropriate for my mental health care and treatment.

☐ 2. My Attorney-in-fact for Mental Health Care may make decisions on my behalf, based on my Wellness Recovery Action Plan (WRAP) or other similar type of document. A copy of this plan is located: _____

☐ 3. My Attorney-in-fact for Mental Health Care may make mental health care and treatment decisions on my behalf, based on the attached "Supplemental Information for Mental Health Care and Treatment" document.

INSTRUCTIONS TO MY ATTORNEY-IN-FACT FOR SHARING MY INFORMATION

In addition to the people listed above, I am instructing my Attorney-in-fact for Mental Health Care that the following individual(s) may be given information related to my mental health care and treatment:

(Note: You may wish to ask your health care provider for additional information about completing general Durable Power of Attorney for Health Care and/or Living Will documents if you have not already done so).

MY SIGNATURE, UNDERSTANDING AND AGREEMENT

TO BE SIGNED BY THE PERSON COMPLETING THIS DOCUMENT *(Required)*

I have read this Durable Power of Attorney for Mental Health Care document. I understand that it allows another person to make decisions on my behalf regarding my mental health care and treatment at times when I am incapable of making those decisions myself. I also understand that I can revoke this Durable Power of Attorney for Mental Health Care document under the following circumstances defined by state law:

» **For Nebraska Residents:** I can revoke this document when I have the capacity to make my own decisions by notifying my Attorney-in-fact for Mental Health Care named in this document and my mental health provider orally or in writing.

» **For Iowa Residents:** I can revoke this document at any time by notifying my Attorney in fact for Mental Health Care named in this document and my mental health care provider orally or in writing.

- Optional for Iowa Residents:
  ____ My initials here indicate that I want to be able to revoke this document only when I have the capacity to make my own mental health care and treatment decisions.

Printed Name: _____ Date: _____

Signature: _____

REVIEWING THIS INFORMATION WITH MY MENTAL HEALTH CARE PROVIDERS AND MY ATTORNEY-IN-FACT FOR MENTAL HEALTH CARE

FOR MY PHYSICIANS AND MENTAL HEALTH CARE PROVIDER(S) ***(Recommended)***

I have reviewed this information with the person who is completing this document.

Printed Name of Mental Health Care Provider(s) and other Physicians:

_____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

FOR MY ATTORNEY-IN-FACT FOR MENTAL HEALTH CARE ***(Recommended)***

I have reviewed this information with the person who has named me Attorney-in-fact for Mental Health Care.

Printed Name of Attorney-in-fact for Mental Health Care: _____

Signature: _____ Date: _____

Printed Name of Successor Attorney-in-fact for Mental Health Care: _____

Signature: _____ Date: _____

LEGAL SIGNATURES AND DECLARATIONS NEEDED TO COMPLETING MY ADVANCE DIRECTIVES DOCUMENT

NOTARY OR WITNESS OPTIONS

In order for this document to be legally valid, you must complete one of the two options below.

Option 1 – Notarization:

This option requires the person completing this document to have his/her signature notarized. In this case, no witnesses are necessary.

State of _____. County of _____.

On this____day of_____, 20____, before me personally came _____, personally to me known to be the identical person whose name is affixed to the above Durable Power of Attorney for Mental Health Care document as principle, and I declare that (he/she)_____ acknowledges the execution of the same to be (he/she) _____ voluntary act and deed, and that I am not the Attorney-in-fact for Mental Health Care or the successor Attorney-in-fact for Mental Health Care designated by this Durable Power of Attorney for Mental Health Care document.

Witness my hand and notarial seal at _____ (place notarized) in such county the day and year last above written.

_____

Signature of Notary Public

Option 2 – Declaration of Witnesses:

This option requires that the person completing this document have his/her signature witnessed by two adult witnesses. In this case, notarization is not necessary.

» For Iowa residents, each witness must be at least 18 years old, and cannot be the attending health care provider or an employee of the attending health care provider for the person completing this document. Only one witness can be related to the person completing this document.

» For Nebraska residents, each witness must be at least 19 years old, and cannot be the spouse, parent, child, grandchild, sibling, presumptive heir, or known devisees; or the attending physician of the person completing this document; the person named as your Attorney-in-fact for Mental Health Care within this document; or an employee of a life or health insurance provider. In addition, no more than one witness can be an administrator or employee of a health care provider who is treating the person completing this document.

We declare that the principal (person completing this document) is known to us, that the principal signed or acknowledged (his/her) _____ signature on this Durable Power of Attorney for Mental Health care document in our presence, and that neither of us, nor the principal's attending physician is the person appointed as the Attorney-in-fact for Mental Health Care within this document.

This section to be completed for Nebraska Residents only:

We also affirm that (he/she) _____ acknowledges the execution of this document to be (his/her) _____ voluntary act and deed.

This section to be completed by witnesses of both Nebraska and Iowa Residents:

Witness 1 Printed Name: _____

Signature: _____ Date: _____

Witness 2 Printed Name: _____

Signature: _____ Date: _____

This section to be competed for Iowa Residents only, by at least one of the two witnesses:

I further declare under penalty of perjury under the laws of the State of Iowa that I am not related to the person completing this document by blood, marriage, or adoption within the third degree of consanguinity.

Witness 1 and/or 2 Signature: _____ Date: _____