CHI Health

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Psychiatric Advance Directives

Durable Power of Attorney for Mental Health Care

Revised August 2014

Mission

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the church, supported by education and research. Fidelity to the gospel urges us to emphasize human dignity and social justice as we create healthier communities.

At CHI Health, we are committed to hearing the voice of our patients and clients throughout their care. We know there are times when our patients and clients cannot make their own decisions known because of their illness or situation. At these times, Advance Directives documents, such as a Durable Power of Attorney for Mental Health Care can be helpful in making health care and treatment decisions on your behalf.

This booklet contains information and forms you will need to complete your own Advance Directives related to your mental health care and treatment needs. Should you wish to complete general Advance Directives documents, information and forms can be found on the CHI Health website (www.CHIhealth.com) or can be requested from a member of your CHI Health Care team for assistance.

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Frequently Asked Questions About Advance Directives and Durable Power of Attorney for Mental Health Care Documents

What are "Advance Directives"?

"Advance Directives" are legal documents you can complete to make your wishes about your health care and treatment needs known to others in the event that you cannot make decisions on your own. They are called "Advance Directives," because they are completed in advance of a time when you could not make your own decisions, and because they allow you to give directions about your future health care and treatment. Two types of Advance Directives documents are:

» Durable Power of Attorney for Health Care: In this document, you can name someone to be your representative when you are unable to make health care decisions for yourself. This representative is known as your "Attorney-in-fact."

» Living Will Declaration: In this document, you can give directions about your preferences for life-sustaining treatments if you become terminally ill or are in a state of permanent unconsciousness from which you will not likely recover (sometimes known as a persistent vegetative state or "PVS").

What is a "Durable Power of Attorney for Mental Health Care" document?

A "Durable Power of Attorney for Mental Health Care" document is a type of Advance Directives document in which you can name another person to be your representative for decisions related specifically to your mental health care and treatment needs. This person is known as your "Attorney-in-fact for Mental Health Care." You can also include information and directions about your mental health care and treatment preferences in this document, or as a supplemental part of this document, if you wish.

Is the "Durable Power of Attorney for Mental Health Care" document the same thing as a general "Durable Power of Attorney for Health Care" document?

Not always. Sometimes people have Durable Power of Attorney for Health Care documents written in a way that applies to both general health care and mental health care decisions. Other times these documents are separate. The documents in this packet allow you to complete separate Durable Power of Attorney for Mental Health Care documents.

Do these Durable Power of Attorney for Mental Health Care documents apply to decisions about my general health care and treatment needs?

No. In the documents in this packet, the person assigned as your Attorney-in-fact for Mental Health Care will only be responsible for making decisions regarding your mental health care and treatment needs. You may wish to fill out separate general Durable Power of Attorney for Health Care documents for decisions about your general health care.

Do these "Durable Power of Attorney for Mental Health Care" documents address decisions about medical treatment needs related to alcohol or substance use or addictions?

No. Decisions related to medical conditions that result from alcohol or substance use or addictions would be made on your behalf by the Attorney-in-fact named in your general Durable Power of Attorney for Health Care document, or by your guardian or your closest relative.

Who can fill out Advance Directives documents, such as the Durable Power of Attorney for Mental Health Care?

Any adult with decision-making capacity can fill out Advance Directives documents, including a Durable Power of Attorney for Mental Health Care form. If you live in Iowa, "adult" means you are at least 18 years old. If you live in Nebraska, "adult" means you are at least 19 years old.

Do I need to complete Durable Power of Attorney for Mental Health Care documents to receive treatment for my mental health care needs?

No. You will receive treatment for your mental health care needs whether or not you have completed Durable Power of Attorney for Mental Health Care documents. Completing Durable Power of Attorney for Mental Health Care documents, however, gives you an opportunity to provide information and directions ahead of time to the person making decisions on your behalf.

Who can I name to be my Attorney-in-fact for Mental Health Care?

For the most part, you can name anyone you would like to be your Attorney-in-fact for Mental Health Care. It is helpful to name someone to be your Attorney-in-fact for Mental Health Care who you trust and who will be easy for your care providers to contact. This person does not have to be a lawyer, and there are some state laws to consider as you select the person to name as your Attorney-in-fact for Mental Health Care. Listed below are people who cannot be your Attorney-in-fact for Mental Health Care, depending on the laws of the state in which you live.

For Both Nebraska and Iowa Residents

» Your treating health care provider cannot be named as your Attorney-in-fact for Mental Health Care.

» A nonrelative employee of your treating health care provider or the facility where you receive care cannot be named as your Attorney-in-fact for Mental Health Care.

For Nebraska Residents Only

» A nonrelative owner or operator of a community care facility where you are a patient or resident cannot be named as your Attorney-in-fact for Mental Health Care.

» A nonrelative who, at the time you complete your Durable Power of Attorney for Mental Health Care documents, is currently serving as an Attorney-in-fact for ten or more people cannot be named as your Attorney-in-fact for Mental Health Care.

Will my Attorney-in-fact for Mental Health Care always make decisions about my mental health care and treatment?

No. The person who is your Attorney-in-fact for Mental Health Care will only be responsible for making decisions on your behalf about your mental health care and treatment needs when it is determined that you do not have the capacity to make those decisions for yourself.

Who determines if I have the capacity to make my own decisions?

Your professional, licensed mental health care provider (or your other doctors, if you are not being treated by a mental health care provider) will examine you to determine if you have the capacity to make decisions about your mental health care and treatment needs. They will work with you, your Attorney-in-fact for Mental Health Care, and others involved in your care, and will record your capacity to make decisions in your medical records. If they determine that you do not have the capacity to make decisions for yourself, your Attorney in fact for Mental Health Care can begin making decisions on your behalf. If there is considerable disagreement about your capacity for decision-making, this determination may be left up to a judge.

How will my Attorney-in-fact for Mental Health Care and mental health care providers know about my Advance Directives documents and my preferences for my care?

It is important to talk with your mental health care providers and the person you name as your Attorney-in-fact for Mental Health Care about your values, beliefs and preferences, and about any information you include in your Advance Directives documents. The documents included in this packet have a place for both your mental health care providers, other physicians, and the person or people you name to be your Attorney-in-fact for Mental Health Care to sign to acknowledge that they have talked with you about your preferences.

If I include information and directions about my mental health care and treatment in my Advance Directives documents, will they be followed?

Your Attorney-in-fact for Mental Health Care and your mental health care providers will do their best to follow your directions for your mental health care and treatment. It may not always be possible, however, to follow your directions exactly as you have written them if there are legal, technical or ethical concerns related to your directions, or if they believe your directions place you at risk for causing harm to yourself or others. That is why it is important to talk with the person or people you name as your Attorney-in-fact for Mental Health Care and your mental health care providers and other physicians about your directions as you complete your Durable Power of Attorney for Mental Health Care documents.

Will my Attorney-in-fact for Mental Health Care make decisions as he or she thinks I would make them, or will my Attorney-in-fact for Mental Health Care make decisions based on their own ideas and wishes?

Your Attorney-in-fact for Mental Health Care has an obligation to make decisions that reflect your preferences, values, and beliefs when those are known. This is known as the "substituted judgment standard" for decision making. If your preferences are not known, or if following your directions as you have written them would place you at risk for harming yourself or others, your Attorney-in-fact for Mental Health Care and your health care providers will make decisions about your mental health care and treatment needs based on what they believe is in your best interest. This is known as the "best interest standard" for decision-making.

Can anyone else be given information about my mental health care and treatment?

You can give your Attorney-in-fact for Mental Health Care directions about who you want (or do not want) to receive information about your mental health care and treatment using the documents in this packet. Specific mental health care facilities or places where you are receiving care may require you or your Attorney-in-fact for Mental Health Care to complete additional forms (called HIPAA Authorization forms) in order to release your Protected Health Information and to protect your privacy.

What if I have already completed documents that provide information about my preferences for my mental health care and treatment?

Some people have already completed documents that provide information about their mental health care and treatment preferences. These documents (such as the Wellness Action Recovery Plan, or "WRAP") can be referenced in the Durable Power of Attorney for Mental Health Care form included in this packet, and provide additional information to those making decisions about your mental health care and treatment on your behalf.

Do I need an attorney to prepare my Durable Power of Attorney for Mental Health Care documents?

There are no legal requirements in Iowa or Nebraska that says you have to have an attorney prepare your Durable Power of Attorney for Mental Health Care documents. Some people do find an attorney helpful, however. You do not need to consult with an attorney to complete the documents that are provided in this packet. Be sure to follow the directions for having your documents witnessed or notarized if you complete your Durable Power of Attorney for Mental Health Care documents on your own.

Who can serve as a witness for me as I complete my Durable Power of Attorney for Mental Health Care documents?

The laws vary from state to state regarding who can and cannot serve as your witness.

» In Iowa, your witness cannot be your attending health care provider, an employee of your health care provider or the person you have named as your Attorney-in-fact for Mental Health Care.

» In Nebraska, your witness cannot be an employee of your life or health insurance provider. In addition, in Nebraska only one of your witnesses may be an employee of a health care provider who is caring for or treating you.

You may wish to have these documents notarized by an official Notary instead of witnessed.

What should I do with my Durable Power of Attorney for Mental Health Care documents and other Advance Directives documents?

You should keep a copy of your Durable Power of Attorney for Mental Health Care documents and other Advance Directives documents in a safe place. It is helpful to give a copy of your Durable Power of Attorney for Mental Health Care to the person you name as your Attorney-in-fact for Mental Health Care, and to your mental health care providers. You may also wish to give copies to your primary care physician and to others close to you.

Should I talk with other people in addition to the person or people I name as my Attorney-in-fact for Mental Health Care and my mental health care providers and other physicians about my wishes for my mental health care and treatment needs?

It may be helpful to talk with other family members, friends, or emergency contacts about your wishes for your mental health care and treatment so they can help support you and your Attorney-in-fact for Mental Health Care. This may help prevent any future conflicts that may come up at the time decisions about your mental health care and treatment are being made on your behalf.

Can I change my Durable Power of Attorney for Mental Health Care documents once they are completed if my wishes and preferences change?

You can change your Durable Power of Attorney for Mental Health Care documents if your wishes and preferences change by updating your current documents or completing new documents. Remember to give copies of your updated or new documents to your health care providers and those named in your Advance Directives documents.

Can I revoke, or cancel, my Durable Power of Attorney for Mental Health Care documents?

You are able to revoke, or cancel, your Durable Power of Attorney for Mental Health Care document under certain circumstances defined by state law.

» For Nebraska Residents: You can revoke your Durable Power of Attorney for Mental Health Care document when you have the capacity to make your decisions by telling your care provider and your Attorney-in-fact for Mental Health Care verbally or in writing.

» For Iowa Residents: You can revoke your Durable Power of Attorney for Mental Health Care documents at any time regardless of your decision-making capacity, by telling your care provider and your Attorney-in-fact for Mental Health Care verbally or in writing.

- The documents in this packet, however, give you the option of indicating that you want to be able to revoke your Durable Power of Attorney for Mental Health Care documents only when you have the capacity to make your own decisions.

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 <u>have not</u> 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 <u>have</u> 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: _____

Supplemental Information For My Mental Health Care and Treatment (Page 1 of 2)

I, _____ , would like to provide the following information to my Attorney(s) in-fact for Mental Health Care and my mental health care provider(s) and other physicians, and ask that these be followed if possible when making mental health care and treatment decisions on my behalf. I understand that my care providers will do their best to comply with my information and directions to the extent they are technically, ethically and legally able, and as long as they do not risk causing harm to myself or others in the opinion of my Attorney(s)-in-fact for Mental Health Care and my mental health care provider(s) and other physicians.

Information about medication for my mental health care and treatment needs:

Information about where I would like to receive care for my mental health care and treatment needs:

Information about the types of treatment I would like to receive for my mental health care and treatment needs *(e.g., group therapy, seclusion, and restraint options, electroconvulsive therapy):*

Additional information that may be helpful when making decisions about my mental health care and treatment needs *(e.g., things I find comforting, activities I enjoy, things that tend to upset me, things that have helped me in the past):*

Other information related to my mental health care and treatment needs:

Please complete both sides of this document

Supplemental Information For My Mental Health Care and Treatment (Page 2 of 2)

I recognize that it is important to discuss the information in this document with the people who will be involved in making decisions on my behalf related to my mental health care and treatment needs if I cannot make them myself. Because of that, I have (check any of the following that apply):

☐ Discussed this information with my Attorney(s)-in-fact for Mental Health Care, who is (are):

_____

☐ Discussed this information with the following physicians and/or mental health care providers:

_____

☐ Discussed this information with the following people (for example, other family members, friends, or emergency contacts who may be present as decisions regarding your mental health care and treatment are made on your behalf):

_____

My Printed Name: _____ Date: _____

My Signature: _____

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(s) of Physician(s) and/or Mental Health Care Provider(s): _____

_____

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: _____

Please complete both sides of this document

Person completing this form initial _____ Date: _____

Wallet Cards

Cut out and complete the cards below. Put one card in the wallet or purse you carry most often, along with your driver's license or health insurance card. You may keep the other cards on your refrigerator, in your motor vehicle glove compartment, a spare wallet or purse, or other easy-to-find place.

Attn: Healthcare Providers

My name is _____

I have created the following Advance Directives:
(Check one or more, as appropriate)

____ Durable Power of Attorney for Health Care
____ Living Will Declaration
____ Durable Power of Attorney for Mental Health Care
____ Other: _____

(FOLD HERE)

Please Contact: _____
(Name)

at _____ for more information.
(Telephone)

_____
(Signature) *(Date)*

Attn: Healthcare Providers

My name is _____

I have created the following Advance Directives:
(Check one or more, as appropriate)

____ Durable Power of Attorney for Health Care
____ Living Will Declaration
____ Durable Power of Attorney for Mental Health Care
____ Other: _____

(FOLD HERE)

Please Contact: _____
(Name)

at _____ for more information.
(Telephone)

_____
(Signature) *(Date)*

Attn: Healthcare Providers

My name is _____

I have created the following Advance Directives:
(Check one or more, as appropriate)

____ Durable Power of Attorney for Health Care
____ Living Will Declaration
____ Durable Power of Attorney for Mental Health Care
____ Other: _____

(FOLD HERE)

Please Contact: _____
(Name)

at _____ for more information.
(Telephone)

_____
(Signature) *(Date)*

Attn: Healthcare Providers

My name is _____

I have created the following Advance Directives:
(Check one or more, as appropriate)

____ Durable Power of Attorney for Health Care
____ Living Will Declaration
____ Durable Power of Attorney for Mental Health Care
____ Other: _____

(FOLD HERE)

Please Contact: _____
(Name)

at _____ for more information.
(Telephone)

_____
(Signature) *(Date)*

Notes

Notes

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