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How to Complete Your Pennsylvania Mental Health Advance Directive

Combined Mental Health Care Declaration and Power of Attorney • 20 Pa.C.S. Chapter 58

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This form lets you state your mental health treatment preferences in advance (the declaration) and name an agent to make mental health care decisions you have not covered (the power of attorney), in case a mental health crisis leaves you unable to decide. It lasts two years unless you are incapable when it would expire.

1. **Choose when it becomes effective (Part II-A)**
   Usually when you are found incapable of making mental health decisions.
2. **Mark your treatment preferences (Part II-B)**
   Facility, medications, ECT, and research studies. Add anything that helps in a crisis.
3. **Name your agent and alternate (Part III)**
   Each agent signs to accept the appointment.
4. **Limit your agent's authority (Part III-D)**
   Mark whether your agent may consent to medications, ECT and studies.
5. **Sign before two adult witnesses and a notary**
   Do not sign ahead of time. Bring a current photo ID.

Signing requirements: Two witnesses, age 18 or older. A person signing for you cannot be a witness, and your mental health care provider generally should not sign for you or serve as your agent. Notarizing it as well helps it be accepted.

After It's Signed

- Give copies to your agent, your psychiatrist and treatment team, and your preferred facility.
- Write the expiration date (two years from signing) on your calendar so you can renew it.

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Have questions about your Mental Health Advance Directive? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**.

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COMBINED MENTAL HEALTH CARE DECLARATION AND POWER OF ATTORNEY

Commonwealth of Pennsylvania • 20 Pa.C.S. Chapter 58 • Form under § 5808

PART I. INTRODUCTION

Declarant / principal full name

I, the person named above, 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.

PART II. MENTAL HEALTH DECLARATION

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.

☐ When the following condition is met:

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 and address of facility

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

Name and address of facility

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 exception, preference or limitation (list medication and reason). The exception, preference or limitation applies to generic, brand name and trade name equivalents. I understand that dosage instructions are not binding on my physician.

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

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

3. Preferences regarding electroconvulsive therapy (ECT).

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

4. Preferences for experimental studies or drug trials.

- ☐ 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.
- ☐ 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.

5. Additional instructions or information. Examples: activities that help or worsen symptoms; type of intervention preferred in 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; other matters of importance.

C. Revocation. 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 combined mental health declaration and power of attorney; or (3) two years after the date this document was executed.

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.

Termination date (two years from signing)

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, address and telephone 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.

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PART III. 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 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.

Agent name

Telephone

Agent address

Agent's acceptance: I hereby accept designation as mental health care agent for the declarant named in this document.

X

Agent signature

Date

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:

Alternative agent name

Telephone

Alternative agent address

Alternative agent's acceptance: I hereby accept designation as alternative mental health care agent for the declarant named in this document.

X

Alternative agent signature

Date

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.
- ☐ 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 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) 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) Electroconvulsive therapy (ECT).

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

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

(3) Experimental studies or drug trials.

☐ 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.

☐ 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.

E. Revocation. 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: (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 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.

PART IV. SIGNATURES

I am making this combined declaration and power of attorney on (day, month, year)

X _____

Declarant / principal signature

My address and telephone number

If the principal is unable to sign, another individual may sign on behalf of and at the direction of the principal:

X _____ Date

Signature of person signing on my behalf

Name, address and telephone number

Witnesses

Each of us is 18 years of age or older and witnessed the signing of this document. Neither of us signed on behalf of the declarant. (20 Pa.C.S. §§ 5822 and 5832.) Please include telephone numbers with addresses.

X _____ Date

Witness 1 signature

Witness 1 printed name

Witness 1 address

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X _____ Witness 2 signature

Date

Witness 2 printed name

Witness 2 address

NOTARIZATION (RECOMMENDED)

ACKNOWLEDGMENT

COMMONWEALTH OF PENNSYLVANIA

COUNTY OF

This record was acknowledged before me on _____ (date) by _____ (name(s) of individual(s)).

X _____ Signature of notarial officer

(Notary seal)

Title of office (e.g., Notary Public)

My commission expires

Commission number

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