Mental Health Power of Attorney

Pursuant to 20 Pa.C.S.A. §5831, et. seq.

NOTICE

THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR "AGENT") BROAD POWERS TO HANDLE YOUR PROPERTY, WHICH MAY INCLUDE POWERS TO SELL OR OTHERWISE DISPOSE OF ANY REAL OR PERSONAL PROPERLY WITHOUT ADVANCE NOTICE TO YOU OR APPROVAL BY YOU.

THIS POWER OF ATTORNEY DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS, BUT WHEN POWERS ARE EXERCISED, YOUR AGENT MOST USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS POWER OF ATTORNEY.

YOUR AGENT MAY EXERCISE THE POWERS GIVEN HERE THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME INCAPACITATED, UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THESE POWERS OR YOU REVOKE THESE POWERS OR A COURT ACTING ON YOUR BEHALF TERMINATES YOUR AGENT'S AUTHORITY.

YOUR AGENT MUST KEEP YOUR FUNDS SEPARATE FROM YOUR AGENT'S FUNDS.

A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS YOUR AGENT IS NOT ACTING PROPERLY.

THE POWERS AND DUTIES OF AN AGENT UNDER A POWER OF ATTORNEY ARE EXPLAINED MORE FULLY IN 20 PA.C.S. CH. 56.

IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER OF YOUR OWN CHOOSING TO EXPLAIN IT TO YOU.

I HAVE READ OR HAD EXPLAINED TO ME THIS NOTICE AND I UNDERSTAND ITS CONTENTS.

_____ _____

(PRINCIPAL) (DATE)

(D) ACKNOWLEDGMENT EXECUTED BY AGENT. — AN AGENT SHALL HAVE NO AUTHORITY TO ACT AS AGENT UNDER THE POWER OF ATTORNEY UNLESS THE AGENT HAS FIRST EXECUTED AND AFFIXED TO THE POWER OF ATTORNEY AN ACKNOWLEDGMENT IN SUBSTANTIALLY THE FOLLOWING FORM:

I, _____, HAVE READ THE ATTACHED POWER OF ATTORNEY AND AM THE PERSON IDENTIFIED AS THE AGENT FOR THE PRINCIPAL. I HEREBY ACKNOWLEDGE THAT IN THE ABSENCE OF A SPECIFIC PROVISION TO THE CONTRARY IN THE POWER OF ATTORNEY OR IN 20 PA.C.S. WHEN I ACT AS AGENT:

I SHALL EXERCISE THE POWERS FOR THE BENEFIT OF THE PRINCIPAL.

I SHALL KEEP THE ASSETS OF THE PRINCIPAL SEPARATE FROM MY ASSETS.

I SHALL EXERCISE REASONABLE CAUTION AND PRUDENCE.

I SHALL KEEP A FULL AND ACCURATE RECORD OF ALL ACTIONS, RECEIPTS AND DISBURSEMENTS ON BEHALF OF THE PRINCIPAL.

_____ _____
(AGENT) (DATE)

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:

_____
(Insert name of designated person)

Signed:

_____

_____
(My name, address and telephone number)

_____ _____
(Witness signature) (Witness signature)

_____ _____

_____ _____
(Address, telephone number of witness) (Address, telephone number of witness)

Agent's Acceptance:

I hereby accept designation as mental health care agent for _____.

_____
(Signature of Agent)

_____

_____
(Address and telephone number of designated person)

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)

Signed:

_____
(My name)

_____	_____
(Witness signature)	(Witness signature)
_____	_____
_____	_____
(Address, telephone number of witness)	(Address, telephone number of witness)

Alternative Agent's Acceptance:

I hereby accept designation as alternative mental health care agent for ____ _____.

_____
(Signature of Alternative Agent)
_____
_____
(Address and telephone number of designated person)

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 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.

E. 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:

_____

(_____) In the event that I require commitment to a psychiatric treatment facility, I do *not* wish to be committed to the following 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 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 exception or limitation:

_____

This exception or limitation applies to generic, brand name and trade name equivalents.

(_____) My agent is not authorized to consent to the use of any medications.

3. 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.

4. Preferences for 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 my 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.

5. Additional information and instructions.

_____

Examples of other 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 release or disclosure of mental health records.
Other matters of importance.

F. 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 mental health care power of attorney; or

(3) two years after the date this document is executed.

G. 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 the power of attorney would expire.

H. 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 pursuant to 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, telephone 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.

I am making this power of attorney on the _____ day of ____ _____, 20_____.

My signature: _____

Witnesses' signatures:

_____	_____
(Witness signature)	(Witness signature)
_____	_____
_____	_____
(Address, telephone number of witness)	(Address, telephone number of witness)

If the principal making this power of attorney 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 signing
_____
_____
(Address and phone number)