State of Ohio
Declaration for Mental Health Treatment

An Introduction

In October 2003, a law permitting a Declaration for Mental Health Treatment became effective. This mental health declaration allows you to state your own preferences regarding your mental health treatment and to name a person to make mental health care decisions for you when you cannot make these important decisions for yourself. You can name any adult, except your mental health treatment provider, but it should be a person that you know and trust, because that person will need to agree to make decisions for you.

Before the law allowing for a Declaration for Mental Health Treatment went into effect, the only document that could be used to name someone to make health decisions for another person was the durable health care power of attorney (DPOA). The DPOA addresses both mental and physical health issues, and still is sufficient for many Ohioans. However, the DPOA does not address mental health issues in any detailed way. Unlike some other health care issues, mental health issues can be more complex and their specific treatments (e.g. medication therapies) generally are not addressed in durable health care powers of attorney. If you have a mental illness or have been diagnosed with a mental illness in the past, and you already have a durable health care power of attorney, you also may wish to have a mental health declaration to address issues that might arise and are not specifically covered by your health care DPOA. The mental health declaration lets health care professionals know your own preferences regarding mental health care treatment. It also allows the person you have named in the declaration (your "proxy") to advocate for your stated choices and make other decisions in your best interest if you have not stated any preferences.

The mental health declaration:

- allows you to name an individual you know and trust to make decisions about your mental health treatment when you are unable to make them yourself;
- specifies when and how the declaration is used;
- specifically outlines the duties and rights of the person you designated to make your mental health decisions when you cannot and protects that person from liability;
- provides that your mental health declaration designee (proxy) cannot be overridden by the designee of any other durable health care power of attorney regarding decisions about your mental health;
- specifies that, if you have lost your capacity to make informed decisions about your mental health treatment, you will not be able to revoke or cancel the mental health declaration;
- stipulates that, if you have a living will (a document that conveys your wishes about your treatment during an end-of-life situation when you cannot make those decisions yourself), the living will overrides the mental health declaration.

Those who would benefit from having such a document include people who have been diagnosed with mental illness and people who find themselves or may find themselves in circumstances that would warrant a mental health declaration (including those of advanced age or those who have developed an illness that likely will include a mental component as it progresses).

Before you make any decisions, it would be wise to contact your legal professional and discuss the options available. Your legal professional also can help you complete the necessary form for a mental health declaration. It is also important that you discuss your treatment preferences with any mental health professional providing services to you. Additional information can be obtained from the Ohio Advocates for Mental Health or Ohio Legal Rights Service. The Mental Health Care Declaration form follows.

Ohio Hospice & Palliative Care Organization

Ohio State Bar Association EST 1880

OLRS Ohio Legal Rights Service

Ohio Advocates for Mental Health AMH

State of Ohio
Notice to Person Making
a Declaration for Mental Health Treatment

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

1) This document allows you, the "disclaimant" to make decisions in advance about your mental health treatment including: psychotropic medication, electroconvulsive therapy, and admission to a treatment facility. The instructions that you include in this declaration will be followed only when your designated physician or psychiatrist and one other mental health treatment provider who have examined you determine that you do not have the capacity to consent to mental health treatment decisions. At least one of the two persons who make this determination shall not currently be involved in your treatment at the time of the determination. If these two persons do not find you to lack the capacity, you will be considered to have capacity to make your own mental health treatment decisions.

2) This document also allows you to appoint an adult person as your proxy to make these treatment decisions for you if you lose the capacity to make mental health treatment decisions. You do not need to name a proxy for this document to be valid. If you do choose to appoint a proxy, it is advisable to choose a person you know and trust. The person you appoint has a duty to act consistently with your desires stated in this document, or, if your desires are not stated or otherwise made known to the proxy, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your proxy at any time. Any discrepancies may need to be resolved by a court. Pursuant to federal law, your proxy is considered your personal representative when the declaration is operative, and will be treated as if he or she were you for purposes of having access to your health care records and other related information.

3) When properly signed, this document that expresses mental health treatment preferences will remain valid for three (3) years unless it is properly revoked. If the declaration is not operative at the end of three (3) years, it will expire. However, it may be renewed one (1) time for another three (3) years if no changes are made. Regardless of when the declaration is set to expire, once the declaration is operative, it continues in effect until you regain the capacity to consent to mental health treatment decisions. If used only to appoint a proxy, this document will remain permanently in effect until otherwise revoked.

4) You have the right to revoke this document at any time you have the capacity to consent to mental health treatment decisions. Any revocation shall be in writing, signed by you, and dated. <u>The revocation shall be effective upon its communication to your mental health treatment provider.</u>

5) You may complete all sections of this form, or only those that apply directly to your situation. Should you leave any sections blank, please include the mark "N/A" to indicate they do not apply to your situation. Your preferences will be honored unless in conflict with reasonable medical practices or available resources, or in emergency situations, or where there are court orders to the contrary.

6) This declaration will not be valid unless signed by two (2) qualified witnesses who are present when you sign or acknowledge your signature, ***or*** this declaration is acknowledged by a Notary Public. A qualified witness may not be your mental health treatment provider or a relative or employee of your mental health treatment provider; the owner, the operator, or a relative of the owner or operator of a health care facility in which you are a patient or resident; a person related to you by blood, marriage, or adoption; or a person named as a proxy in your declaration.

If there is anything in this document that you do not understand, you should seek clarification from a lawyer or other knowledgeable person.

State of Ohio
Declaration for Mental Health Treatment

I, _____, being an adult person, voluntarily execute this declaration for mental health treatment. I understand and accept the consequences of this action.

I name _____ as my DESIGNATED PHYSICIAN and assign this physician the primary responsibility for my mental health treatment.

This declaration only becomes operative when both of the following apply:

1) This declaration is communicated to my mental health treatment provider.
2) a) My designated physician or a psychiatrist and b) one other mental health treatment provider who have examined me determine that I do not have the capacity to consent to mental health treatment decisions. At least one of the two persons who make this determination shall not be involved in my treatment at the time of the determination.

In the event that this declaration becomes operative, the following constitutes my intentions for treatment.

Psychotropic Medications

If I lack capacity to consent to mental health treatment decisions, my wishes regarding psychotropic medications are as follows:

I consent to the administration of the following medications:

_____

_____

I do not consent to the administration of the following medications:

_____

_____

Conditions or limitations:

_____

_____

Electro-convulsive Treatment

If I lack capacity to consent to mental health treatment decisions, my wishes regarding electro-convulsive treatment are as follows:

_____ I consent to the administration of electro-convulsive treatment.

_____ I do not consent to the administration of electro-convulsive treatment.

Conditions or limitations:

_____

_____

Admission To And Retention In A Facility

If I lack capacity to consent to mental health treatment decisions, my wishes regarding admission to and retention in a facility are as follows:

NOTE : Admission to and retention in a facility may be mandated for other than voluntary admissions.

_____ I consent to being admitted to a health care facility for mental health treatment for as long as my physician or psychiatrist deem appropriate.

_____ I consent to being admitted to a health care facility for mental health treatment for up to ____ days.

_____ I do not consent to being admitted to a health care facility for mental health treatment.

Conditions or limitations:

_____

_____

Treatment Preferences Or Instructions

I understand that the following preferences and instructions are provided to guide mental health treatment providers and/or my proxy in determining, within reason, a course of treatment most beneficial to me.

[ ] I have a Wellness Recovery Action Plan (WRAP) or other crisis intervention plan that is:

[ ] attached to this document
[ ] in the following location: _____

[ ] I do not have a Wellness Recovery Action Plan or other written crisis intervention plan.

I consent to be treated by the following physician(s) and/or mental health therapist(s):

Name Telephone Number (if known)

_____

_____

_____

I prefer not to be treated by the following physician(s) and/or mental health therapist(s):

Name Telephone Number (if known)

_____

If I am hospitalized, I consent to be hospitalized at the following institution(s):

_____

If I am hospitalized, I prefer *not* to be hospitalized at the following institution(s):

_____

I prefer that the following people *not* visit me:

I authorize the following person(s) to care for any relative or pet for whom I am responsible or for any property for which I am responsible.

Name Telephone Number

It is strongly recommended that the authorized person is made aware of and agrees to these responsibilities, and is notified that legal authority may be needed to fulfill these roles.

Additional conditions, instructions or limitations (include, for example, information about what may cause a mental health crisis, what may help avoid a hospitalization, any reactions to hospitalization or medications, and how mental health treatment staff can help):

Proxy Designation

I hereby appoint

Name: _____
Address: _____
Telephone Number: _____

to act as my proxy to make decisions regarding my mental health treatment if I lack the capacity to consent to mental health treatment decisions. If the person above refuses or is unable to act on my behalf, I authorize the following person to act as my proxy:

Name: _____
Address: _____
Telephone Number: _____

My proxy is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, are otherwise known to my proxy. If my wishes are not expressed and are not otherwise known by my proxy, my proxy is to act in what my proxy believes to be in my best interest.

Acceptance Of Appointment As Proxy

I accept this appointment and agree to serve as proxy to make decisions about mental health treatment for the declarant. I understand that I have a duty to act in a manner consistent with the desires of the declarant as expressed in this declaration or otherwise made known to me. If no preferences are expressed by the declarant, I have a duty to act in what I believe is the declarant's best interests. I understand that this document gives me authority to make decisions about mental health treatment only while the declarant lacks the capacity to consent to mental health treatment decisions as determined by the declarant's designated physician or a psychiatrist, and one other mental health treatment provider who has examined the declarant. At least one of the two persons who make this determination shall not be involved in the declarant's treatment at the time of the determination.

I understand that the declarant may revoke this declaration at any time the declarant has the capacity to consent to mental health treatment decisions. I understand that any revocation shall be in writing, signed by the declarant, and dated. I understand that the revocation shall be effective upon its communication to the declarant's mental health treatment provider or the health care facility providing services to the declarant. I understand that, as a proxy, I may withdraw from a declaration before the declaration becomes operative by giving notice to the declarant. If the declaration is operative, I may withdraw by giving written notice to the declarant's mental health treatment provider or the health care facility providing services to the declarant.

I acknowledge that I am not the declarant's mental health treatment provider, or an employee of the declarant's mental health treatment provider, nor am I the owner, operator, or employee of a health care facility in which the declarant is a patient receiving its services or a resident, any of which would make me ineligible to serve as a proxy for a declarant, unless I am related to the declarant by blood, marriage or adoption.

_____ _____

(Signature of Proxy/Date) (Printed Name)

_____

(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____

(Telephone Number)

_____ _____

(Signature of Alternate Proxy/Date) (Printed Name)

_____

(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____

(Telephone Number)

Affirmation Of Witnesses

We affirm that the proxy/alternate proxy is personally known to us, that the proxy/alternate proxy signed or acknowledged the proxy's/alternate proxy's signature on this declaration for mental health treatment in our presence, and that neither of us is: the declarant's mental health treatment provider or a relative or employee of the declarant's mental health treatment provider; the owner, the operator, or a relative of the owner or operator of a health care facility in which the declarant is a patient or resident; a person related to the declarant by blood, marriage, or adoption; or a person named as a proxy in the declarant's declaration. Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____

(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____

(Telephone Number)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____

(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____

(Telephone Number)

— or —

Notary Acknowledgment

State of Ohio
County of _____ss.

On _____, 20___, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person(s) whose name(s) is/are subscribed to the above Declaration for Mental Health Treatment as the proxy/alternate proxy, and who has acknowledged that (s)he/they executed the same for the purposes expressed therein. I attest that such person(s) appear to be of sound mind and not under or subject to duress, fraud or undue influence.

_____

Notary Public
My Commission Expires:_____

Signature Of Declarant

This declaration will not be valid unless signed by two (2) qualified witnesses who are present when you sign or acknowledge your signature, OR this declaration is acknowledged by a Notary Public.

I understand the purpose and effect of this document and sign my name to this Declaration for Mental Health Treatment on _____,

20_____, at _____ Ohio.

_____ _____

(Signature of Declarant) (Printed Name)

[It is suggested that you inform important people in your life about this declaration. While this is not mandatory, it will help. If you choose to do so, you are responsible for telling members of your family and your designated physician or psychiatrist about this document and the name of your proxy(ies). You also may wish to tell your religious advisor and your lawyer that you have signed a Declaration for Mental Health Treatment. You may wish to give a copy of the document to each person notified.]

Affirmation Of Witnesses

We affirm that the declarant is personally known to us, that the declarant signed or acknowledged the declarant's signature on this declaration for mental health treatment in our presence, that the declarant appears to be of sound mind to consent to mental health treatment decisions and is not under or subject to duress, fraud or undue influence and that neither of us is: the declarant's mental health treatment provider or a relative or employee of the declarant's mental health treatment provider; the owner, the operator, or a relative of the owner or operator of a health care facility in which the declarant is a patient or resident; a person related to the declarant by blood, marriage, or adoption; or a person named as a proxy in the declarant's declaration. Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____

(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____

(Telephone Number)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____

(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____

(Telephone Number)

— *or* —

Notary Acknowledgment

State of Ohio
County of _____ss.

On _____, 20___, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to the above Declaration for Mental Health Treatment as the Declarant, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Declarant appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

_____
Notary Public
My Commission Expires:_____

Revocation

Sign this only if you wish to revoke your mental health declaration.

You have the right to revoke this document at any time you have the capacity to consent to mental health treatment decisions. Any revocation shall be in writing, signed by you, and dated. The revocation shall be effective upon its communication to your mental health treatment provider.

The revocation may be in a form similar to the following:

I, _____, willfully and voluntarily revoke my declaration for mental health treatment.

Date _____ Signed _____
(Signature of Declarant)

If, and only if, this declaration has become operative, a designated physician or psychiatrist and a mental health treatment provider must signify that the declarant is capable of making mental health treatment decisions.

I, Dr. _____ and _____ have evaluated the declarant and determined that he or she has the capacity to make mental health treatment decisions.

Date _____ Signed _____
(Signature of Designated Physician or Psychiatrist)

Date _____ Signed _____
(Signature of Mental Health Treatment Provider who has examined Declarant)

Renewal
I understand that:

a) I may renew this declaration one (1) time for another three (3) years if no changes are made.

b) Regardless of when the declaration is set to expire, once the declaration is operative, it continues in effect until I regain the capacity to consent to mental health treatment decisions.

I, _____, willfully and voluntarily renew my declaration for mental health treatment for an additional three (3) years.

Date _____ Signed _____
(Signature of Declarant)

Affirmation Of Witnesses
We affirm that the declarant is personally known to us, that the declarant signed or acknowledged the declarant's signature on this renewal of the declaration for mental health treatment in our presence, that the declarant appears to be of sound mind to consent to mental health treatment decisions and is not under or subject to duress, fraud or undue influence and that neither of us is: the declarant's mental health treatment provider or a relative or employee of the declarant's mental health treatment provider; the owner, the operator, or a relative of the owner or operator of a health care facility in which the declarant is a patient or resident; a person related to the declarant by blood, marriage, or adoption; or a person named as a proxy in the declarant's declaration.
Witnessed By:

_____ _____
(Signature of Witness/Date) (Printed Name of Witness)

_____
(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____
(Telephone Number)

_____ _____
(Signature of Witness/Date) (Printed Name of Witness)

_____
(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____
(Telephone Number)

— or —

Notary Acknowledgment

State of Ohio
County of _____ss.

On _____, 20___, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to the above Declaration for Mental Health Treatment as the Declarant, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Declarant appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

_____
Notary Public
My Commission Expires:_____

_____ _____
(Signature of Proxy/Date) (Printed Name)

_____
(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____
(Telephone Number)

_____ _____
(Signature of Alternate Proxy/Date) (Printed Name)

_____
(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____
(Telephone Number)

Affirmation Of Witnesses

We affirm that the proxy/alternate proxy is personally known to us, that the proxy/alternate proxy signed or acknowledged the proxy's/alternate proxy's signature on this declaration for mental health treatment in our presence, and that neither of us is: the declarant's mental health treatment provider or a relative or employee of the declarant's mental health treatment provider; the owner, the operator, or a relative of the owner or operator of a health care facility in which the declarant is a patient or resident; a person related to the declarant by blood, marriage, or adoption; or a person named as a proxy in the declarant's declaration. Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____

(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____

(Telephone Number)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____

(Address) (City) (State) (ZIP)

(_____) _____–_____ (_____) _____–_____

(Telephone Number)

— *or* —

Notary Acknowledgment

State of Ohio
County of _____ss.

On _____, 20___, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person(s) whose name(s) is/are subscribed to the above Declaration for Mental Health Treatment as the proxy/alternate proxy, and who has acknowledged that (s)he/they executed the same for the purposes expressed therein. I attest that such person(s) appear to be of sound mind and not under or subject to duress, fraud or undue influence.

_____

Notary Public
My Commission Expires:_____

HIPAA Release Notice

I intend for the person named as my proxy in the attached State of Ohio Declaration for Mental Health Treatment to be my personal representative and therefore, treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health and mental health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accounting Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize any physician, health care professional, mental health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered healthcare provider, any insurance company and the Medical Information Bureau, Inc., or other healthcare clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my proxy, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition. The authority given my proxy shall supersede any prior agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information. The authority given my proxy has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider.

Date _____ Signed _____

(Signature of Declarant)