NEW JERSEY MENTAL HEALTH POWER OF ATTORNEY FORM

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions for you (the principal). Your agent will be able to make decisions and act on your behalf, whether or not you are able to act for yourself.

This power of attorney does not authorize the agent to make health care decisions for you. Such powers are governed by applicable laws for Advance Directives.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

The following forms are available from the National Resource Center on Psychiatric Advance Directives.

N.J.S.A. 26:2H-108 et seq.

Name: D.O.B.: Phone:

Address:

I, _____, being a legal adult of sound mind, voluntaril
make this declaration for mental health treatment.

Please select and initial one of the following statements:

_____ I want this declaration to be followed if I am incapable of making a decision or decis
about my care, as defined in New Jersey Statutes Annotated 26:2H-109.

_____ In the absence of a declaration of incapacity, I want this declaration to be followed a
I am incapable of making a decision or decisions about my care, as defined in New Jersey
Statutes Annotated 26:2H-109, when signs and symptoms listed in PART 2 are evident.

Please select and initial one of the following statements:

_____ I can revoke this plan at any time as permitted by law.

_____ I do not wish to exercise my right to revoke this plan once it has been activated.

If it is determined that I am unable to make informed health care decisions for myself, I wa
the following person to act as my primary mental health care representative:

Name	Relationship to self	Phone 1 Phone 2
Address		Email

I would like the following person to be my alternate mental health care representative:

Name	Relationship to self	Phone 1 Phone 2
Address		Email

_____ I do not wish to appoint a mental health care representative.

*Adapted from the Wellness and Recovery Action Plan (WRAP®) Crisis Plan. Copyright by Mary Ellen Copel
PO Box 301, W. Dummerston, VT 05357 Phone: (802) 254-2092 www.mentalhealthrecovery.com

your representative, do not complete this page.

A) Authority and Limitation of Authority of Mental Health Care Representative
I want my representative to make decisions about my treatment in the following way:
(Please select and initial one of the following statements.)

_____ Make decisions about my care based on what is in this document or, if not specifical expressed, as are otherwise known to my representative. If my wishes are unknown or are specifically addressed in this document, make decisions based on what he/she believes wou be the decision I would make.

_____ Make decisions about my care based on what is in this document or, if not specifical expressed, as are otherwise known to my representative. If my wishes are unknown or are specifically addressed in this document, make decisions about my care that he/she thinks would be in my best interest, taking into consideration my preferences and consultation w providers and supporters as indicated in this document.

B) Please select and initial one of the following statements:

____ I consent to giving my representative the authority to admit me to an inpatient or pa psychiatric hospitalization program for up to _____days.

Optional: Describe the conditions under which you would agree to be hospitalized:

_____

_____

_____

____ I do not consent to give my representative the authority to admit me to an inpatient partial psychiatric hospitalization program.

The following are my wishes regarding my mental health care treatment in the event of a mental health crisis, including hospitalization:

Part 1. The following words describe me when I am feeling well:

Part 2. **Symptoms**

The following signs and symptoms will indicate that I am in a mental health crisis:

Substance Use (Street Drugs/Alcohol/Prescription Medications)

Without admitting to current use of substances, I offer the following information:

This is the substance(s) that I am or was most likely to use:

I feel and behave this way after taking this drug(s):

addition to any representatives named.

Name	Relationship to self	Phone 1 Phone 2
Name	Relationship to self	Phone 1 Phone 2
Name	Relationship to self	Phone 1 Phone 2

I do not want the following people notified or involved in my care or treatment in any wa

Name	I do not want them involved because: (Optiona
Name	I do not want them involved because: (Optiona

If I am admitted to a hospital, I will need assistance with the following tasks:

I need (Name) _____ To (tasks) _____

I need (Name) _____ To (tasks) _____

I need (Name) _____ To (tasks) _____

I need (Name) _____ To (tasks) _____

I need (Name) _____ To (tasks) _____

I am a caretaker of the following person(s) at home:

The following person should be contacted to arrange substitute care:

Name	Phone 1 Phone 2

Primary Care Physician		Phone
Psychiatrist		Phone
Therapist		Phone
Case Manager		Phone
Pharmacy		Phone
Insurance Carrier	ID #	Phone

I would like the following health care providers to be notified and consulted about my care

I have the following medical conditions:

Medications/Supplements/OTC (Over the Counter) preparations I am currently using:

Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose

Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose
Name	Dosage	Purpose

Medications that I do not consent to or wish to avoid:

Name or type of medication	Reason Why
Name or type of medication	Reason Why
Name or type of medication	Reason Why
Name or type of medication	Reason Why

Medications that I am allergic to:

Name	Reaction
Name	Reaction

Part 5: Help from my supporters and hospital staff

Please do the following things that would help reduce my symptoms, make me more comfortable, and keep me safe:

Part 6. Home care/Community care/Respite center

If possible, follow this care plan instead of hospitalization:

Part 7. Hospital or other Treatment Facilities

If I am being admitted to a hospital or treatment facility, I prefer the following facilities in order of preference:

1.	Name	Reason I prefer it
2.	Name	Reason I prefer it

AVOID using the following hospital or treatment facilities:

1.	Name	Reason to avoid it
2.	Name	Reason to avoid it

Name	When to use this therapy
Name	When to use this therapy

Treatments and Interventions that I do not consent to:

Name	Reason why
Name	Reason why

I would like to be permitted to use the following wellness techniques to help me in my recovery:

Part 9: Inactivating the Plan

The following signs, lack of symptoms or actions indicate that my supporters no longer nee use this plan and I am able to make decisions on my own behalf:

I, _____, being a legal adult of sound mind, voluntarily make this declaration for mental health treatment.

Signature _____ Date _____

Print Name _____

Any Mental Health Care Advance Directive plan signed with a more recent date takes precedence over this one.

_____This plan has been registered with the state of New Jersey.

Witness:

I attest that the declarant signed this document (or asked another to sign this document on his o her behalf) in my presence, and that the declarant appears to be of sound mind and free of dure and undue influence. I am 18 years of age or older. I am not designated by this or any other document as the person's mental health care representative, nor as an alternate mental health c representative. At the time this document is being executed, I am not the responsible mental h care professional responsible, or directly involved with, the declarant's care.

Witnessed by _____ Date _____

Print Name _____

Second Witness:
(A second witness is required if the first witness is related to the declarant by blood, marriage o adoption, or is the declarant's domestic partner or otherwise shares the same home with the declarant; is entitled to any part of the declarant's estate by will or by operation of law at the ti the advance directive is being executed; or is an operator, administrator, or employed of a roor or boarding or residential health care facility in which the declarant resides.)

I attest that the declarant signed this document (or asked another to sign this document on his o her behalf) in my presence, and that the declarant appears to be of sound mind and free of dure and undue influence. I am 18 years of age or older. I am not designated by this or any other document as the person's mental health care representative, nor as an alternate mental health c representative. At the time this document is being executed, I am not the responsible mental h care professional responsible, or directly involved with, the declarant's care.

Witnessed by: _____ Date: _____

Print Name _____