SOUTH DAKOTA 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.

§ 27A-16-18. Declaration and power of attorney -- Forms. A declaration and power of attorney for mental illness treatment shall be in substantially the following form:

DECLARATION AND POWER OF ATTORNEY FOR MENTAL HEALTH TREATMENT

I, _______________, being an adult of sound mind, willfully and voluntarily make this declaration for mental illness treatment to be followed if it is determined by a court or by two physicians that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to consent to mental illness treatment. Mental illness treatment means convulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for up to thirty days. I understand that I may become incapable of giving informed consent for mental illness treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

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PSYCHOTROPIC MEDICATIONS

If I become incapable of giving informed consent for mental illness treatment, my wishes regarding psychotropic medications are as follows:

________ I consent to the administration of psychotropic medications.

Comments:
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CONVULSIVE TREATMENT

If I become incapable of giving informed consent for mental illness treatment, my wishes regarding convulsive treatment are as follows:

________ I consent to the administration of convulsive treatment.

Comments:
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ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving informed consent for mental illness treatment, my wishes regarding admission to and retention in a health care facility for mental illness treatment are as follows:

________ I consent to being admitted to a health care facility for mental illness treatment.

This directive does not provide consent to retain me in a facility for more than thirty days.
Comments:
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ADDITIONAL REFERENCES OR INSTRUCTIONS

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POWER OF ATTORNEY FOR MENTAL HEALTH TREATMENT

I hereby appoint the following person to act as my attorney-in-fact to make decisions regarding my mental illness treatment if I become incapable of giving informed consent for that treatment:

NAME____

ADDRESS____

TELEPHONE
NUMBER____

If the person named refuses or is unable to act on my behalf or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

NAME____

ADDRESS____

TELEPHONE
NUMBER____

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in my declaration for mental illness treatment or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-infact is to act in what he or she believes to be my best interests.

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(Signature of Principal/Date)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal has read the accompanying Notice to Person Making a Declaration and Power of Attorney for Mental Illness Treatment or has had the notice read and explained, that the principal signed or acknowledged the principal's signature on this declaration and power of attorney for mental illness treatment in our presence, that the principal

appears to be of sound mind and not under duress, fraud, or undue influence, that neither of us is:

A person appointed as an attorney-in-fact by this document;

The principal's attending physician or mental health service provider or a relative of the physician or provider;

The owner or operator or a relative of an owner or operator of a facility in which the principal is a patient or resident; or

A person related to the principal by blood, marriage, or adoption.
Witnessed by:

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

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

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental illness treatment for the principal. I understand that I have a duty to act in a manner that is consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental illness treatment only while the principal is incapable, as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner if the principal is capable.

____________________________________ _____________________________
(Signature of Attorney-in-fact/Date) (Printed name)

____________________________________ _____________________________
(Signature of Alternative Attorney-in-fact/Date) (Printed name)

NOTICE TO PERSON MAKING A DECLARATION AND POWER OF ATTORNEY FOR MENTAL ILLNESS TREATMENT

This is an important legal document. It creates a declaration for mental illness treatment and names an attorney-in-fact and an alternative attorney-in-fact to make mental health treatment decisions for you if you become incapable. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about three types of mental illness treatment: psychotropic medication, convulsive therapy, and shortterm (up to thirty days) admission to a treatment facility. It is very important that you declare your instructions carefully and review this document regularly. The instructions that you include in this declaration will be followed only if a court or two physicians believe that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give consent for the treatments.

You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. Preference shall be given to immediate family members in the following order: spouse, parent, adult child, and sibling. It is important that your attorney-in-fact be knowledgeable about mental illness issues and the decisions you have made. The person you appoint has a duty to act in a manner that is consistent with your desires as stated in this document. If your desires are not stated or otherwise made known to the attorney-in-fact, the attorney-in-fact has a duty to act in a manner consistent with what the person in good faith believes to be 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 attorneyin-fact at any time.

This document will continue in effect for three years unless you become incapable of participating in mental illness treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable. YOU MAY NOT REVOKE THIS DECLARATION AND POWER OF ATTORNEY WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT OR TWO PHYSICIANS. A revocation is effective when it is communicated to your attending physician or other mental health care provider.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.