APPENDIX B

Declaration for mental Health Treatment

ANSWERS TO QUESTIONS
and
INSTRUCTIONS FOR USE
in a

DECLARATION FOR MENTAL HEALTH TREATMENT IN IDAHO

Idaho Code 66-601 through 66-613

Mental Health Association of Idaho
and
NAMI Idaho

September 17, 1999

ANSWERS TO QUESTIONS

PLANNING FOR YOUR MENTAL HEALTH TREATMENT

1. **Can I plan now for the mental health treatment I would want if I were in crisis?**

   Yes. You can plan now for a time when you may be unable to make your own mental health decisions.

2. **How can I plan ahead?**

   Idaho has a form you can fill out and sign now to protect yourself when you may be in crisis and are unable to make your own treatment decisions. This form is called a Declaration for Mental Health Treatment,

3. **Who decides if I am unable to make my own treatment decisions?**

   Only a court or two physicians that includes a psychiatrist, or physician and a professional mental health clinician can decide if you are incapable of understanding and making decisions about your mental health treatment.

4. **When does my Declaration go into effect?**

   A Declaration form is used only when you are unable to understand and make decisions about your mental health treatment.

5. **If I make out and sign a Declaration for Mental Health Treatment, will it be good forever?**

   Yes. Unless you choose to change or revoke it.

6. **Can I change my written instructions for mental health treatment or cancel my Declaration form?**

   Yes. As long as you are capable of receiving and evaluating the information given to you about the choices that you may make for your mental health treatment, you may change your written mental health treatment instructions or cancel your Declaration form.

   Of course, in order to make sure that your wishes are followed, you must give your physician or mental health care provider a new Declaration form that includes your changes.

   However, if a court, or two physicians that includes a psychiatrist, or a physician and a professional mental health clinician decide that you are unable to understand your mental health treatment options, and you are not capable of determining your mental health treatment, you will not be permitted to change your written instructions or to make your own treatment decisions.

   But this is why you have written out your future wishes on this Declaration for Mental Health Treatment form: You want to protect yourself when you are in

crisis and are unable to make your own treatment decisions.

7) **If I move out of the state of Idaho, will my Declaration form be valid?**
It depends on where you want to go. Each state has it s own rules.

8) **Can anyone force me to make out a Declaration for Mental Health?**
No. No one, no insurer, no physician, no mental health treatment provider, nor any other person is permitted to attempt to force you to make out a Declaration form. It must be your own free choice to make out and sign the Declaration for Mental Health Treatment.

9) Who can be my agent?

a) **Suggestions For Choosing an Agent:**
We suggest that in choosing an Agent you choose someone who lives reasonably close to you and who has regular contact with you, such as:
Trusted Friend
Trusted Family Member
Employer
Fellow Church Member
Neighbor

b) **Suggestion of those who should have copies:**
Parents
Doctor
Mental Health Care Provider
Other Family Members

Make sure that you give copies of the completed form to any doctor, provider, or facility from which you expect to need treatment. If you have appointed an Agent, make sure that person also has a copy. Your instructions cannot be followed if they are not known to exist. Make sure that this is updated regularly. Your agent has to be willing to participate in your declaration and has the right to withdraw at anytime.

10) **Can the Declaration be overridden?**
In certain circumstances, as provided by law, an otherwise valid Declaration may be preempted* for reasons such as:
If the principal is committed to a treatment facility.
In cases of emergency endangering life or health.

Please NOTE: These declarations do not provide law enforcement officers or agents with the authority to enforce the terms contained within this declaration.

11) **Where can I get more information About the Declaration??**
From your Regional DHW Mental Health Center
NAMI - 1-800-572-9940

Mental Health Association of Idaho - (208) 893-9983
Mental Health Care Provider

DECLARATION FORM
INSTRUCTIONS FOR USE

ADMISSION TO AND RETENTION IN A FACILITY

In the part of the form entitled "ADMISSION TO AND RETENTION IN FACILITY," you may give or withhold consent to be kept in a health care facility for mental health treatment for up to 17 days. To do this, place a check mark in front of the statement that expresses your wishes. Fill in the blank for the numbers of days you consent to be kept in a health care facility.

If you wish to consent to inpatient treatment, for no more than 17 days or wish to specify or rule out facilities you agree to be admitted to, write these instructions on the lines at the bottom of the section after "Conditions or limitations."

ADDITIONAL REFERENCES OR INSTRUCTIONS

If there is any other information or instructions that your doctor, provider or Agent should know, write them in the section entitled "ADDITIONAL REFERENCES OR INSTRUCTIONS."

OTHER SIGNATURES

If you have appointed an Agent, "Your representative," make sure that your representative has signed the acceptance of appointment at the bottom of page 4.

Although the form doesn't say so, some people cannot act as your Agent. People who CANNOT be your Agent are:

A. Your doctor, mental health service provider, or an employee of your doctor or provider, unless you are related to that person.

B. An owner, operator, or employee of a health care facility where you live or are a patient, unless you are related to that person.

If you do not appoint an Agent or if the person you appoint does not accept appointment or is disqualified from serving, all of the other instructions in the Declaration are still valid.

DECLARATION
FOR
MENTAL HEALTH TREATMENT

Idaho Code 66-613 requires the following notice to be included in the Declaration for Mental Health Treatment.

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 to make decisions in advance about three (3) types of mental health treatment: psychotropic medication, electroconvulsive therapy, and short_term (up to seventeen (17) days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if a court, two (2) physicians that include a psychiatrist, or a physician and a professional mental health clinician believe that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

(2) You may appoint a person as your agent to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the agent, 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 agent at any time.

(3) This document will continue in effect until revoked. 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 WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT, TWO (2) PHYSICIANS THAT INCLUDE A PSYCHIATRIST, OR A PHYSICIAN AND A PROFESSIONAL MENTAL HEALTH CLINICIAN**. A revocation is effective when it is communicated to your attending physician or other provider.

(4) 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 (2) qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

DECLARATION

I,

being an adult of sound mind, willfully and voluntarily make this declaration of mental health treatment to be followed when I am unable to make decisions for myself or if it is determined by a court, two physicians that include a psychiatrist or one physician and a professional mental health clinician, that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. “Mental Health Treatment” means electroconvulsive treatment, treatment with

psychotropic medication, or short-term admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder These symptoms may include:

PSYCHOTROPIC MEDICATIONS

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

I consent to the following medications:

1. 3.
2. 4.

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

1. 3.
2. 4.

I also want it to be known that I have other health care concerns:

ADMISSION TO AND RETENTION IN A FACILITY

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

☐ I consent to being admitted to a health care facility for mental health treatment for up to _____ days for a minimum of _____days.

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

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

ADDITIONAL REFERENCE OR INSTRUCTIONS:

Include additional directions such as (what you ***want/don't want*** from family, friends, Agent, professionals; what personal business you need others to do for you; what you anticipate being able to do for yourself, but if you can't, then what you would like done)

_____
_____
_____
_____
_____
_____
_____

do not want the following people involved in my care or treatment:

_____
_____

FINANCIAL RESOURCES

The following financial resources are available for my care and treatment:

_____
_____

POWER-OF-ATTORNEY / CONSENT

__] I have also executed a general power-of-attorney or a power-of-attorney under Idaho Code, Title 66 Chapter 6, that includes the power to make decisions regarding health care services for myself. I authorize the Agent appointed under a general powers-of-attorney under Idaho Code, Title 66, Chapter 6 to serve:

[__] Jointly with consent of each other as to my mental health treatment.

[__] Separately without each other's consent as to my mental health treatment.

__] I have not executed a general power-of-attorney or a power-of-attorney under Idaho Code, Title 66, Chapter 6 that includes the power to make decisions regarding health care services for myself.

affirm the above information to be my Declaration for Mental Health Treatment.

ignature (Name of Declarant/Date)

Address)

Telephone Number)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for Mental Health Treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is a person appointed as an Agent by this document, the principal's attending physician or mental health service provider or a relative of the physician or provider; or the owner, operator, or relative of an owner or operator of a facility.

Witnessed By:

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

(Address) (Telephone Number)

Witnessed By:

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

(Address) (Telephone Number)

ATTACHMENT A (Optional)

AUTHORIZATION TO RELEASE INFORMATION

I_____,
(Name) (Address)
give my full consent to the following individual or agency:

Name:_____
Address:_____
City, State, Zip:_____

to reciprocally exchange: __verbal __written __electronic information pertinent to my physical and/or mental condition and treatment as described below (example: progress notes, admission, physical, etc.):

_____
_____
_____
_____
_____

for the purpose of:

_____
_____

with the following individual or agency:

Name:_____
Address:_____
City, State, Zip:_____

I further understand this release of information is valid only until _____, or until revoked orally or in writing by me or my Agent.

It is also my understanding that this information will be used only for professional reasons and will not be further released, published, or disseminated without my permission. I understand that I may revoke this consent either orally, or in writing at any time.

CLIENT/REPRESENTATIVE SIGNATURE: _____

"By my signature I hereby authorize the above identified individuals and agencies to release the information specified above, and release them from any responsibility and liability concerning the release of said information."

ATTACHMENT B

ACCEPTANCE OF APPOINTMENT AS AGENT

I accept this appointment and agree to serve as the Agent to make decisions about mental health treatment for the principal, (name of principal) _____.
I understand that I have a duty to act in a manner 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 health treatment on behalf of the principal only while the principal is incapable as determined by a court, two physicians that include a psychiatrist, or one physician and a professional mental health clinician. I understand my decisions must be consistent with desires the principal has expressed in the declaration.

Except to the extent these rights are limited by the declaration or any federal law, I have the same rights as the principal to receive information regarding the proposed mental health treatment and to receive, review and consent to disclosure of medical records relating to that treatment. This right of access does not waive any evidentiary privilege.

If the principal's desires are not expressed in the declaration and not otherwise known by myself, I understand I have a duty to act in what I believe in good faith to be the best interest of the principal. I also understand that I am not subject to criminal prosecution, civil liability or professional disciplinary action for an action taken in good faith under this declaration for mental health treatment. I understand that I will not, as a result of acting in this capacity, be personally liable for the cost of treatment provided to the principal.

I understand that the principal may revoke this declaration in whole or in part at any time in any manner when the principal is not incapable and that I may withdraw by giving notice to the principal. If a principal is incapable, I may withdraw by giving notice to the attending physician or provider. I may also rescind the withdrawal by executing an acceptance after the date of the withdrawal and giving notice to the principal if the principal is capable or to the principal's health care provider if the principal is incapable.

(Signature of Agent/Date)	Printed Name
(Address)	(Telephone Number)
(Signature of Agent/Date)	Printed Name
(Address)	(Telephone Number)