Psychological Declaration/Certification Regarding Capacity

I, _____, declare and state as follows:

1. I am competent to testify to the matters set forth herein, and testify based on my personal knowledge, education, information and belief.

2. I am a licensed clinical psychologist and consult to _____. I have consulted to _____ since _____. I received my degree in _____ from _____ in _____.

3. I have known _____ since _____. I have provided services to him/her since _____. In that regard, I have seen _____ on numerous occasions, with the most recent psychological assessment completed on _____. I have also reviewed his/her records and discussed him/her with other interdisciplinary team members. Based on my observations, my assessment, my review of the record and my discussion with other staff, it is my opinion that his/her cognitive functioning falls within the _____ range of intellectual disability and adaptive functioning falls within the _____ range of intellectual disability.

4. _____'s most recent psychological assessment is attached and discusses his/her present mental health condition and treatment plan.

5. It is my clinical opinion that because of his/her mental condition as evidenced above, _____ is unable to receive and evaluate information effectively, or his/her ability to communicate decisions is impaired to such an extent that he/she lacks the capacity to take actions to: *(please check appropriate boxes)*
   - [ ] obtain, administer, and dispose of real and personal property, intangible property, business property, benefits and income; AND/OR
   - [ ] provide health care, food, shelter, clothing, personal hygiene, and other care without which serious physical injury or illness is more likely than not to occur; AND/OR
   - [ ] acquire and maintain those life skills that enable him/her to cope more effectively with the demands of his/her own person and of his/her own environment, and to raise the level of his/her physical, intellectual, social, emotional, and economic efficiency or meet all or some of essential requirements for his/her therapeutic needs; AND/OR
   - [ ] grant, refuse or withdraw consent to any medical treatment.

6. It is my clinical opinion that _____ is, with proper explanation, at a level suitable to his/her functioning *(please check one of the boxes)*:
   - [ ] ABLE to choose the person he/she desires to make decisions for him/her, and could execute a durable power of attorney.
   - [ ] NOT ABLE to understand and execute a durable power of attorney.

7. I have examined this person within 24 hours or one day of my certification therein.

8. I declare under penalty of perjury that the foregoing statements are true and correct to the best of my information, knowledge and belief. Executed on _____, 20__.

_____ _____

Licensed Psychologist's Signature Street Address, City, State and Zip Code

_____ _____

Psychologist's Name *(printed)* Phone Number/Pager Number