Psychological Affidavit/Certification Regarding Capacity

I, _________________________________, being first duly sworn, depose and say the following:

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.

________________________________	____
Licensed Psychologist's Signature	Street Address, City, State and Zip Code
________________________________	________________________________
Psychologist's Name *(printed)*	Phone Number/Pager Number

Sworn and subscribed before me the ______day of _____________, 20____.

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Notary Public
My Commission Expires: