Chronic Disability Information Exhibit A

“Chronic disability” is defined as “a condition evidenced by a reasonable expectation, based on the person’s psychiatric history, that the person is incapable of making an informed medical decision because of a severe mental illness, is unlikely to comply with treatment as shown by a failure to comply with a prescribed course of treatment outside of an inpatient setting on two or more occasions within any continuous twelve month period, and, as a consequence, the person’s current condition is likely to deteriorate until it is probable that the person will be a danger to self or others.” SDCL 27A-1-1(4).

1. I, _________________________________ (please print clearly), believe that _________________________________ has a chronic disability, as defined above.

2. Specifically, this person’s psychiatric history shows that this person is incapable of making an informed medical decision because of a severe mental illness and is unlikely to comply with treatment as shown by a failure to comply with a course of treatment prescribed by _________________________________ (a doctor, board or court), on _________________________________ (date(s) prescribed or ordered), outside of an inpatient setting on two or more occasions within the continuous twelve month period beginning _______________________ and ending _______________________, namely on these two or more dates: (1)________________________ and (2)________________________, + _______________________________________ (specify all dates of failure to comply) and, as a consequence, this person’s current condition is likely to deteriorate until it is probable that the person will be a danger to self or others.

3. A summary of the person’s psychiatric history, mental illness, lack of capacity to make an informed medical decision, previous decompensation or deterioration and probability of dangerousness is as follows:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. I have read the foregoing Chronic Disability Information Exhibit A and know the contents of it. I swear or affirm, under penalty of perjury, under the laws of the state of South Dakota that the foregoing is true and correct.
Executed on this ___ day of _________________ (month), ______ (year), in the county of ___________________ (county name), in the state of South Dakota.

______________________________________       ______________________________________
Telephone # (required)       Signature (required)
[Please use best contact number]

______________________________________
______________________________________
______________________________________
(06-28-12)
Address (required)