*Model Affidavit of Supporting Professional Supporting Voting Rights of Person under Guardianship*

**IN THE \_\_\_\_\_\_\_\_\_\_\_\_\_\_ COURT FOR THE STATE OF [STATE NAME]**

**FOR THE COUNTY OF [COUNTY NAME]**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In the Guardianship of** **)**

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**JOHN DOE,** **)** **Case No. \_\_\_\_\_\_\_\_\_**

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**An Incapacitated Person.**  **)**

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**AFFIDAVIT OF [SUPPORTING PROFESSIONAL]**

NAME OF AFFIANT, being duly sworn, deposes and says:

1. I am a [list professional qualifications: [**licensed physician, psychiatrist, psychologist, geriatrician, social worker, occupational therapist]** in the State of **[state name]** and I make this Affidavit in support of the Motion dated **[date]** of John Doe so as to explicitly acknowledge in Mr. Doe’s Guardianship Order that Mr. Doe should be considered competent to vote.

2. [Affiant’s educational background and licensing information:] I obtained my **[insert name of degree]** from **[insert name of school]** in **[insert year**]. **[Include information about residency/fellowship training.]** I have been licensed to practice **[insert specialty]** in the State of **[state name]** since **[insert year]**.

3. My curriculum vita is attached hereto and is an accurate representation of my professional background. **[Attach a copy of resume as Exhibit A.]**

4. [If appropriate:] I have experience with guardianship proceedings **[or capacity determinations]**. **[Provide examples of instances when medical professional was involved in guardianship proceeding or in making capacity determinations, e.g., I have previously testified in courts of law as to the capacity of the subjects of guardianship proceedings, specifically where the capacity to vote has been addressed, and I have served as an expert witness in such proceedings.]**

5. I have treated John Doe, a **[insert age, gender]** since **[insert year]**. Mr. Doe resides with **[identify people who live with Mr. Doe]** at **[insert address, including if applicable name of facility, and describe nature of facility, i.e., a skilled nursing facility, assisted living facility]**.

6. I have in the past and continue to work with Mr. Doe for **[insert diagnosis or specific needs, for example, Bi-Polar Disorder, Manic Depression, Parkinson’s Disease, Depression, Schizophrenia, Alzheimer’s, Alcoholic Dementia, Traumatic Brain Injury, support relating to Intellectual/Developmental Disability, development of independent living skills]**. **[Include a brief description of movant’s condition and current status. For example, if Mr. Doe’s functional and decisional abilities are intermittently affected by a mental health impairment, Affiant could discuss the current state of his condition. If Mr. Doe’s condition is Alzheimer’s or dementia, Affiant can specify the ways in which the condition does (and does not) currently affect his functioning. If a developmental disability, Affiant can describe the level of Mr. Doe’s functioning and community participation, e.g., holds a job, volunteers, takes classes.]**

7. During the course of my relationship with Mr. Doe, I have had discussions with him regarding his desire to vote. Mr. Doe is aware that he is currently not allowed to vote under **[state name]** law, but he would like to have his right to vote restored.

8. I **[examined or spoke with]** Mr. Doe on **[date]**. I concluded then that Mr. Doe is competent to vote in local, state, and federal elections. Mr. Doe understands the electoral process and understands the nature and effect of voting. Mr. Doe also has the capacity to make his own decisions regarding candidates and questions on the ballot. Mr. Doe has opinions about elections that he holds entirely on his own without undue outside influence. Mr. Doe has communicated that he has a desire to participate in the voting process.

9. Mr. Doe requires accommodations in order to demonstrate his capacity and desire to vote, and to complete the voting process, that may include: **[describe here accommodations such as personal helper, supported decision-making, adapted materials, assistive technology, transportation, etc. If person has voted previously, describe supports or accommodations used]**. I understand that Mr. Doe will receive these accommodations through [**working with guardian or other individual, using understandable voting materials provided through self-advocacy organizations, using assistive technology in his possession, etc.]**

10. I have reached my opinions based on my education and training, my **[number]** years of experience as a [**medical]** professional, my regular treatment of Mr. Doe over the past **[number]** years, and my recent examination of Mr. Doe on **[date]**.

11. I declare under penalty of perjury under the laws of the state of **[state name]** that the foregoing is true and correct.

Dated: \_\_\_\_\_\_\_\_\_, 2022 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Affiant