SAMPLE SUPPORTED DECISION-MAKING AGREEMENTS

- **Sample Supported Decision-Making Agreement**
  - Includes space for multiple supporters
  - Includes separate forms for financial support and all other types of support
  - Requires a monitor if supporters are authorized to help with finances
  - Includes reference to other alternatives to conservatorship, including HIPAA authorization and authorization to share educational information
  - Developed by ACLU/Quality Trust
- **Disability Rights Texas Supported Decision-Making Agreement**
  - Based on Texas Supported Decision-Making Statute (passed into law in 2015)
  - Default of only one supporter
  - Allows person with a disability to choose which areas they want assistance in
  - Includes reference to other alternatives to guardianship/conservatorship including HIPAA and FERPA
- **ASAN Supported Health Care Decision-Making Agreement**
  - Default of only one supporter (but notes additional forms can be filled out for additional supporters)
  - Focuses on supported decision-making in healthcare decisions
  - Includes option of successor supporter
  - Developed by the Autistic Self Advocacy Network
- **Nonotuck Resource Associates, Center for Public Representation Supported Decision-Making Agreement**
  - Includes options for what type of help the supporters will provide
  - Includes space for multiple supporters
  - Allows supporters to be identified to provide support in only certain areas, and to be excluded from providing help in other areas
  - Allows supporters to work jointly or successively
  - Developed by Nonotuck Resource Associates and Center for Public Representation

Supported Decision-Making Agreement

This agreement must be read out loud or otherwise communicated to all parties to the agreement in the presence of a notary. The form of communication shall be appropriate to the needs and preferences of the person with a disability.

My name is: _____.

Today's date is: _____

I want to have people I trust help me make decisions. The people who will help me are called **supporters.** I can say what kind of help my supporters will give me. If I want supporters to help me make choices about money, I will sign a different agreement, called "Supported Decision-Making Agreement for Finances."

Supporters

My supporter(s) are:

Supporter #1

Name: _____

Address: _____

Phone Number: _____

Email address: _____

I want this person to help me with:
(*check as many boxes as you want*)

- ☐ Making choices about food, clothing, and where I live
- ☐ Making choices about my health
- ☐ Making choices about how I spend my time
- ☐ Making choices about where I work

Supporter #2

Name: _____

Address: _____

Phone Number: _____

Email address: _____

I want this person to help me with:
(*check as many boxes as you want*)

- ☐ Making choices about food, clothing, and where I live
- ☐ Making choices about my health
- ☐ Making choices about how I spend my time
- ☐ Making choices about where I work

Supporter #3

Name: _____

Address: _____

Phone Number: _____

Email address: _____

I want this person to help me with:
(*check as many boxes as you want*)

- ☐ Making choices about food, clothing, and where I live
- ☐ Making choices about my health
- ☐ Making choices about how I spend my time
- ☐ Making choices about where I work

My supporters are not allowed to make choices for me. To help me with my choices, my supporters may:

- Help me find out more about my choices;
- Help me understand my choices so I can make a good decision for me;
- Help me tell other people about my decision

I am including the following forms to this agreement:

(*circle yes or no for each choice below)*

Yes / No A form that lets my supporters to see my medical records (*HIPAA Authorization*)

Yes / No A form that lets my supporters see my school information (*Authorization to Disclose Educational Information*)

This supported decision-making agreement starts right now and will continue until the agreement is stopped by me or my supporters.

Signature of adult with a disability

I am signing this supported decision-making agreement because I want people to help me make choices. I know that I do not have to sign this agreement. I know that I can change this agreement at any time.

My signature: _____

My printed name: _____

My address: _____

My phone number: _____

My email address: _____

Consent of Supporters

I, _____ consent to act as _____'s supporter under this agreement. I understand that my job as a supporter is to honor and express his/her wishes. My support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; and helping this person communicate his/her choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith.

_____

Signature of supporter

_____

Date

I, _____ consent to act as _____'s supporter under this agreement. I understand that my job as a supporter is to honor and express his/her wishes. My support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; and helping this person communicate his/her choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith.

_____

Signature of supporter

_____

Date

I, _____ consent to act as _____'s supporter under this agreement. I understand that my job as a supporter is to honor and express his/her wishes. My support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; and helping this person communicate his/her choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith.

_____

Signature of supporter

_____

Date

Signature of Notary

State of California County of _____.

On _____ (*date*), before me _____ (*name of notary*), personally appeared _____

_____ (*names of all signers*), who proved to me on the basis of satisfactory evidence of identification to be the people whose names are signed on this Supported Decision-Making agreement.

The text of this agreement was communicated to the person with a disability in my presence by:

- ☐ Reading the full agreement aloud
- ☐ Otherwise communicating the agreement to the person with a disability (*describe communication used*): _____ _____.

Seal of notary: My commission expires:

Supported Decision-Making Agreement for Finances

This agreement must be read out loud or otherwise communicated to all parties to the agreement in the presence of a notary. The form of communication shall be appropriate to the needs and preferences of the person with a disability.

My name is: _____.

I want to have people I trust help me make decisions about my money. The people who will help me are called **supporters.** I can say what kind of help my supporters will give me. If I want supporters to help me make other choices, I will also sign a different agreement, called "Supported Decision-Making Agreement."

I want my supporters to help me make choices about how I spend and save my money.

Supporters

My supporter(s) are:

Supporter #1

Name: _____

Address: _____

Phone Number: _____

Email address: _____

Supporter #2

Name: _____

Address: _____

Phone Number: _____

Email address: _____

Monitor

I must also choose someone to make sure my supporters are being honest and using good judgment in helping me with my money. This person is called a monitor. The monitor cannot also be a supporter.

My monitor is:

Name: _____

Address: _____

Phone Number: _____

Email address: _____

My supporters are not allowed to make choices for me. To help me with my choices, my supporters may:

- Help me find out more about my choices;
- Help me understand my choices so I can make a good decision for me;
- Help me tell other people about my decision

This supported decision-making agreement starts right now and will continue until the agreement is stopped by me or my supporters.

Signature of adult with a disability

My signature: _____

My printed name: _____

My address: _____

My phone number: _____

My email address: _____

Today's date is: _____

Consent of Supporters

I, _____ consent to act as _____'s supporter for financial decisions under this agreement. I agree to provide financial records to the supported decision-making monitor (listed below) every month. I understand that my job as a supporter is to honor and present the wishes of the person with a disability. I understand that my support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; communicating the person's choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith.

_____

Signature of supporter

_____

Date

I, _____ consent to act as _____'s supporter for financial decisions under this agreement. I agree to provide financial records to the supported decision-making monitor (listed below) every month. I understand that my job as a supporter is to honor and present the wishes of the person with a disability. I understand that my support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; communicating the person's choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith.

_____

Signature of supporter

_____

Date

Consent of Monitor

A monitor must be appointed to oversee financial supporters.

I, _____ consent to act as a monitor for financial decisions under this agreement. I agree to review the financial records of the person with a disability when provided by the supporters every month. I agree to make reasonable efforts to ensure that the supporters under this agreement are acting honestly, in good faith, and in accordance with the choices of the person with a disability. If I suspect financial abuse, misuse of funds, bad faith, or failure to comply with the decisions of the person with a disability, I will require the supporters to explain their actions. If the supporter fails to provide this information or if I continue to have reason to believe that the supporter is abusing or failing to comply with the wishes of the person with a disability, I will promptly inform Adult Protective Services.

Monitor's signature: _____

Date: _____

Signature of Notary

State of California County of _____

On _____ (*date*), before me _____
(*name of notary*), personally appeared _____

_____
(*names of all signers*), who proved to me on the basis of satisfactory evidence of identification to be the people whose names are signed on this Supported Decision-Making agreement.

The text of this agreement was communicated to the person with a disability in my presence by:

- ☐ Reading the full agreement aloud
- ☐ Otherwise communicating the agreement to the person with a disability (*describe communication used*): _____
  _____.

Seal of notary: My commission expires:

SDM Agreement Created by Disability Rights Texas

Supported Decision-Making Agreement

This agreement is governed by the Supported Decision-Making Act, Chapter 1357 of the Texas Estates Code. This supported decision-making agreement is to support and accommodate an individual with a disability to make life decisions, including decisions related to where and with whom the individual wants to live, the services, supports, and medical care the individual wants to receive, and where the individual wants to work, without impeding the self-determination of the individual with a disability. This agreement may be revoked by the individual with a disability or his or her supporter at any time. If either the individual with a disability or his or her supporter has any questions about the agreement, he or she should speak with a lawyer before signing this supported decision-making agreement.

Appointment of Supporter:

I (Name of Adult with Disability), _____ am entering into this agreement voluntarily.

I choose (Name of Supporter)_____ to be my Supporter.

Supporter's Address: _____

Phone Number: _____

E-mail Address: _____

My Supporter may help me with life decisions about:

Yes ___ No___ obtaining food, clothing and a place to live

Yes ___ No___ my physical health

Yes ___ No___ my mental health

Yes ___ No___ managing my money or property

Yes ___ No___ getting an education or other training

Yes ___ No___ choosing and maintaining my services and supports

Yes ___ No___ finding a job

Yes ___ No___ Other:_____

My Supporter does not make decisions for me. To help me make decisions, my Supporter may:

1. Help me get the information I need to make medical, psychological, financial, or educational decisions;
2. Help me understand my choices so I can make the best decision for me; or
3. Help me communicate my decision to the right people.

Yes____ No____ My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996. I will provide a signed release.

Yes____ No____ My Supporter may see my educational records under the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. Section 1232g). I will provide a signed release.

This agreement starts when signed and will continue until _____ (date) or until my Supporter or I end the agreement or the agreement ends by law.

Signed this _____ (day) of _____ (month), _____ (year)

_____ _____

(Signature of Adult with Disability) (Printed Name of Adult with Disability)

CONSENT OF SUPPORTER

I (Name of Supporter), _____ consent to act as a Supporter under this agreement.

_____ _____
(Signature of Supporter) (Printed Name of Supporter)

This agreement must be signed in front of two witnesses or a Notary Public.

_____ _____
(Witness 1 Signature) (Printed Name of Witness 1)

_____ _____
(Witness 2 Signature) (Printed Name of Witness 2)

OR

Notary Public

State of _____

County of _____

This document was acknowledged before me on _____ (date)

By _____ and _____
(Name of Adult with a Disability) (Name of Supporter)

_____ _____
(Signature of Notary) (Printed Name of Notary)

(Seal, if any, of notary) My commission expires: _____

WARNING: PROTECTION FOR THE ADULT WITH A DISABILITY

If a person who receives a copy of this agreement or is aware of the existence of this agreement has cause to believe that the adult with a disability is being abused, neglected, or exploited by the supporter, the person shall report the alleged abuse, neglect, or exploitation to the Department of Family and Protective Services by calling the Abuse Hotline at **1-800-252-5400** or online at **www.txabusehotline.org**.

DUTY OF CERTAIN PERSONS WITH RESPECT TO AGREEMENT

A person who receives the original or a copy of a supported decision-making agreement shall rely on the agreement. A person is not subject to criminal or civil liability and has not engaged in professional misconduct for an act or omission if the act or omission is done in good faith and in reliance on a supported decision-making agreement

Nothing about us without us!

SUPPORTED HEALTH CARE DECISION-MAKING AGREEMENT

Notice of Rights: to be read aloud or otherwise communicated, in the presence of the notary, to all parties to the agreement. The form of communication shall be appropriate to the needs of the individual with the disability, including that individual's language and sensory processing wants or needs.

This is a form that you can use to appoint a person to help you make health care decisions.

You have the right to make your own health care decisions and the right to decide who helps you make those decisions. If you do not want the person named in this form to help you make health care decisions, you do not have to sign this agreement.

If you sign this agreement, you still have the right to make the final decision about your health care. Your health care supporter cannot force you to accept health care that you do not want, or take away health care that you do want.

You can add another supporter by signing a new form appointing the other supporter.

You can cancel this agreement at any time. You can cancel this agreement in writing or by otherwise making it clear to the supporter that you want the agreement to be canceled.

Appointment of Supporter

I, _____ (insert your name), agree that:
Name:
Address:
Phone Number:

is my supporter.

Authority of Supporter

My supporter has my permission to do the following things, except for the ones I have crossed out:

1. Access or obtain any information that will help me make health care decisions, including, but not limited to, medical, psychological, financial, educational, or treatment records or research, as my personal representative under the Health Insurance Portability and Accountability Act (HIPAA), 42 C.F.R. § 164.502;
2. Help me access or obtain any information that will help me make health care decisions, including, but not limited to, medical, psychological, financial, educational, or treatment records or research;

3. Help me make appointments with doctors, dentists, therapists, case managers, or other health care providers;
4. Help me keep track of information about my health care, including my medical records, and whether I have had recommended medical check-ups, tests and vaccines;
5. Help me with my health care plan, including, but not limited to, taking medications, monitoring blood sugar, administering insulin, and refilling prescriptions;
6. Help me understand information about health care decisions I have to make, now or in the future, so that I can make my own decisions about my health care;
7. Communicate or assist me in communicating my decision to other persons.

I __DO __DO NOT give my supporter permission to talk to doctors when I am not present or when I am temporarily unable to communicate.

I __DO __DO NOT give my supporter permission to access psychotherapy notes or other information about conversations I have had during mental health counseling, substance abuse counseling, or group or family therapy.

This agreement does not give my supporter the authority to make decisions about my health care for me, or to influence me to make decisions that do not reflect my expressed wishes and preferences. My supporter's consent to providing or withholding treatment is not a substitute for my consent.

Additional Authority or Limitations

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR ADDING TO THE RIGHTS GRANTED TO YOUR SUPPORTER.

_____
_____
_____
_____
_____
_____

Effective Date of Supported Health Care Decision-Making Agreement

This agreement takes effect:
__ Immediately
__ On the following date: _____

This agreement ends:
__ When I cancel it
__ On the following date: _____

__ When the following event happens: _____

Third Party Rights Under the Supported Health Care Decision-Making Agreement

I agree that anyone who receives a copy of this document may act consistent with it and respect my supporter's authority to help me make my own health care decisions, except when that person has actual notice that I have cancelled this agreement or want to cancel it.

Successor Supporter

If my supporter dies, becomes unable to act as my supporter, resigns as my supporter, or refuses to act as my supporter, I want the following person to become my supporter:

Name:
Address:
Phone Number:

Consent of Supporter

I consent to act as a supporter.

(signature of supporter) **(printed name of supporter)**

Signature

(your signature) **(your printed name)**

(witness signature) **(printed name of witness)**

Signed this _____ day of _____, 20___

_____
(your signature)

State of _____

County of _____

This document was acknowledged before me on

_____ (date) by _____

(name of adult with a disability)

_____
(signature of notary)

(seal, if any, of notary)

_____
(printed name)

My commission expires: _____

WARNING: PROTECTION FOR THE ADULT WITH A DISABILITY

IF A PERSON WHO RECEIVES A COPY OR IS AWARE OF THE SUPPORTED HEALTH CARE DECISION-MAKING AGREEMENT HAS REASON TO BELIEVE THAT THE ADULT WITH A DISABILITY IS SUFFERING FROM ABUSE, NEGLECT, OR EXPLOITATION CAUSED BY THE SUPPORTER, THE PERSON MAY REPORT THE ALLEGED ABUSE, NEGLECT OR EXPLOITATION TO THE [DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES] BY CALLING THE ABUSE HOTLINE AT _____ OR BY EMAIL AT _____.

Nonotuck Resource Associates and
Center for Public Representation
Supported Decision-Making Agreement

This is the Supported Decision-Making Agreement of

Name : _____ Date of birth: _____

Address: _____

Telephone: _____ Email:_____

A. I need supporter(s) to help me make decisions about:

☐ Taking care of my financial affairs, like banking

☐ Hiring a lawyer if I need one and working with the lawyer

☐ My health care, including large and small health care decisions

☐ Personal care (like where I live, the support services I need, managing the people who work with me, my diet, exercise, education, safety and activities)

☐ Other matters: _____

B. I expect my supporter(s) to help me in the following ways:

☐ Giving me information in a way I can understand

☐ Discussing the good things and bad things (pros and cons) that could happen if I make one decision or another

☐ Telling other people my wishes

☐ _____

C. I express myself and show what I want in the following ways:

- ☐ Telling people my likes and dislikes.
- ☐ Telling people what I do and do not want to do.
- ☐ _____
- ☐ _____

D. I designate the following individual(s) to be part of my Supported Decision-Making Network to assist me in making decisions.

Network Supporter #1

Name: _____ Date of birth: _____

Address: _____

Telephone: _____ Email: _____

Relationship: _____

Areas of Assistance for Supporter #1: *Check all that apply*:

☐ **Finances** ☐ **Healthcare** ☐ **Living Arrangements**

☐ **Relationships/Social** ☐ **Employment** ☐ **Legal Matters**

☐ **Other** (*please specify)*:

Areas I don't want Supporter #1 to assist me with:

Network Supporter #2

Name: _____ Date of birth: _____

Address: _____

Telephone: _____ Email: _____

Relationship: _____

Areas of Assistance for Supporter #2: *Check all that apply*:

☐ **Finances** ☐ **Healthcare** ☐ **Living Arrangements**

☐ **Relationships/Social** ☐ **Employment** ☐ **Legal Matters**

☐ **Other** (*please specify)*:

Areas I don't want Supporter #2 to assist me with:

Network Supporter #3

Name: _____ Date of birth: _____

Address: _____

Telephone: _____ Email: _____

Relationship: _____

Areas of Assistance for Supporter #3: *Check all that apply*:

☐ **Finances** ☐ **Healthcare** ☐ **Living Arrangements**

☐ **Relationships/Social** ☐ **Employment** ☐ **Legal Matters**

☐ **Other** (*please specify)*:

Areas I don't want Supporter #3 to assist me with:

Use the reverse side of this document to list additional supporters.

E. **If I have more than one Supporter** (Optional, but if you do not fill out this section, your Supporters will act "Successively".)

My Supporters will act (*choose one*)

☐ Jointly (work together to help me)

OR

☐ Successively (For example: Supporter #2 helps me if Supporter #1 is not available)

F. I understand I can contact the Supported Decision-Making Project at any time to end this agreement or to add, replace or remove a network supporter.

_____ _____

Signature Date

G. Notary Certification

Commonwealth of Massachusetts, County of _____

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document in my presence.

_____

(seal) Notary Public Signature

The Supported Decision-Making Project can be reached at 413-586-6024.

H. Network Supporters' Statements

Network Supporter #1

I understand that as _____'s supporter, my job is to honor and present his/her expressed wishes. In the event I cannot perform my job under this agreement, I will contact the Supported Decision-Making Coordinator.

_____ _____

Signature Date

Network Supporter #2

I understand that as _____'s supporter, my job is to honor and present his/her expressed wishes. In the event I cannot perform my job under this agreement, I will contact the Supported Decision-Making Coordinator.

_____ _____

Signature Date

Network Supporter #3

I understand that as _____'s supporter, my job is to honor and present his/her expressed wishes. In the event I cannot perform my job under this agreement, I will contact the Supported Decision-Making Coordinator.

_____ _____

Signature Date