SUPPORTED DECISION-MAKING AGREEMENT

Appointment of Supporter

I, _____, make this agreement of my own free will.

I agree and designate that: _____

Name: _____

Address: _____

Phone Number: _____

E-mail address: _____

is my supporter. My supporter may help me with making everyday life decisions relating to the following:

(Yes) /(No) obtaining food, clothing, shelter.

(Yes) /(No) taking care of my physical health.

(Yes) /(No) managing my financial affairs.

My supporter is not allowed to make decisions for me. To help me with my decisions, my supporter may:

1. Help me access, collect, or obtain information that is relevant to a decision, including medical, psychological, financial, educational, or treatment records;

2. Help me understand my options so I can make an informed decision; or

3. Help me communicate my decision to appropriate persons.

(Yes /No) A release allowing my supporter to see protected health information under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) is attached.

(Yes /No) A release allowing my supporter to see educational records under the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. Section 1232g) is attached.

Effective Date of Supported Decision-Making Agreement

This supported decision-making agreement is effective immediately and will continue until (insert date) or until the agreement is terminated by my supporter or me or by operation of law.

Signed this _____ day of _____, 20___.

Consent of Supporter

I, (name of supporter), consent to act as a supporter under this agreement in exchange for the opportunity to meaningfully participate in the life of this person and the person's pursuit of independent living.

_____ _____

(Signature of supporter) (Printed name of supporter)

Signature

_____ _____

(My signature) (My printed name)

_____ _____

(Witness 1 signature) (Printed name of witness 1)

_____ _____

(Witness 2 signature) (Printed name of witness 2)

State of _____

County of _____

This document was acknowledged before me on
_____(date) by
_____ and _____.

(name of adult with disability) (name of supporter)

_____

Notary Public

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 DEPARTMENT OF ECONOMIC SERVICES, ADULT PROTECTIVE SERVICES BY CALLING _____ OR ONLINE AT _____.