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 _____.