



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;



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166 ___ When the following event happens: _____
167

168 **Third Party Rights Under the Supported Health Care Decision-Making Agreement**
169

170 I agree that anyone who receives a copy of this document may act consistent with it and respect
171 my supporter's authority to help me make my own health care decisions, except when that person has
172 actual notice that I have cancelled this agreement or want to cancel it.
173

174 **Successor Supporter**
175

176 If my supporter dies, becomes unable to act as my supporter, resigns as my supporter, or refuses
177 to act as my supporter, I want the following person to become my supporter:
178

179 Name:

180 Address:

181 Phone Number:
182

183 **Consent of Supporter**
184

5 I consent to act as a supporter.
186

187
188 (signature of supporter)

(printed name of supporter)

189
190 **Signature**
191

192
193 (your signature)

(your printed name)

194
195
196 (witness signature)

(printed name of witness)
197

Signed this _____ day of _____, 20____

(your signature)

State of _____

County of _____

198
199 This document was acknowledged before me on
200

201 _____ (date) by _____



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202
203

(name of adult with a disability)

(signature of notary)

(seal, if any, of notary)

(printed name)

My commission expires: _____

204
205

WARNING: PROTECTION FOR THE ADULT WITH A DISABILITY

206
207
208
209
210
211

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 _____.