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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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123 3. Help me make appointments with doctors, dentists, therapists, case managers, or other health care
124 providers;
125 4. Help me keep track of information about my health care, including my medical records, and
126 whether I have had recommended medical check-ups, tests and vaccines;
127 5. Help me with my health care plan, including, but not limited to, taking medications, monitoring
128 blood sugar, administering insulin, and refilling prescriptions;
129 6. Help me understand information about health care decisions I have to make, now or in the future,
130 so that I can make my own decisions about my health care;
131 7. Communicate or assist me in communicating my decision to other persons.
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133 I DO DO NOT give my supporter permission to talk to doctors when I am not present or when I am
134 temporarily unable to communicate.
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136 I DO DO NOT give my supporter permission to access psychotherapy notes or other information
137 about conversations I have had during mental health counseling, substance abuse counseling, or group or
138 family therapy.
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140 This agreement does not give my supporter the authority to make decisions about my health care for me,
141 or to influence me to make decisions that do not reflect my expressed wishes and preferences. My
142 supporter's consent to providing or withholding treatment is not a substitute for my consent.
143

144 Additional Authority or Limitations 145

146 ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR
147 ADDING TO THE RIGHTS GRANTED TO YOUR SUPPORTER.
148

149 _____
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157 Effective Date of Supported Health Care Decision-Making Agreement 158

159 This agreement takes effect:

160 Immediately
161 On the following date: _____
162

163 This agreement ends:

164 When I cancel it
165 On the following date: _____



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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**

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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:

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179 Name:

180 Address:

181 Phone Number:

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183 **Consent of Supporter**

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5 I consent to act as a supporter.

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187

188 (signature of supporter)

189 (printed name of supporter)

190

191 Signature

192

193

194 (your signature)

195 (your printed name)

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198 (witness signature)

199 (printed name of witness)

200 Signed this _____ day of _____, 20_____

201 _____
(your signature)

202 State of _____

203 County of _____

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202 (name of adult with a disability)
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(signature of notary)

(seal, if any, of notary)

(printed name)

My commission expires: _____

204 WARNING: PROTECTION FOR THE ADULT WITH A DISABILITY
205

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