Health Care Provider's Certificate of Medical Examination

Revised December 4, 2024

In the Matter of the Guardianship of
_____,
an Alleged Incapacitated Person

For Court Use Only
Court Assigned: _____

To the Physician, Psychologist, or Advanced Practice Registered Nurse

This form is to enable the Court to determine whether the individual identified above is incapacitated according to the legal definition (on page 4), and whether that person should have a guardian appointed.

1. General Information

Examining Health Care Provider's Name _____ Phone: (_____)_____
Office Address _____
_____

Select one: ☐ I am a physician currently licensed to practice in the State of Texas;
☐ I am a psychologist currently licensed in the State of Texas or certified by HHSC; or
☐ I am an advanced practice registered nurse acting under a physician's delegation authority and supervision in accordance with Chapter 157, Occupations Code.

☐ YES ☐ NO I have experience examining individuals with the physical or mental condition resulting in the Proposed Ward's incapacity; or

☐ YES ☐ NO I have an established patient-provider relationship with the Proposed Ward

Proposed Ward's Name _____
Date of Birth _____ Age_____ Gender ☐ M ☐ F
Proposed Ward's Current Residence: _____
_____

I last examined the Proposed Ward on _____, 20_____at:
☐ a Medical facility ☐ the Proposed Ward's residence ☐ Other: _____

☐ YES ☐ NO The Proposed Ward is under my continuing treatment.

☐ YES ☐ NO Before the examination, I informed the Proposed Ward that communications with me would not be privileged.

☐ YES ☐ NO A mini-mental status exam was given. If "YES," please attach a copy.

2. Evaluation of the Proposed Ward's Physical Condition *(required to be completed by physician or APRN only, not psychologist)*

Physical Diagnosis: _____

a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis: _____
c. Treatment/Medical History: _____

3. Evaluation of the Proposed Ward's Mental Functioning

Mental Diagnosis: _____

a. Severity: ☐ Mild ☐ Moderate ☐ Severe
b. Prognosis: _____
c. Treatment/Medical History: _____

If the mental diagnosis includes dementia, answer the following:

☐ YES ☐ NO----- It would be in the Proposed Ward's best interest to be placed in a secured facility for the elderly or a secured nursing facility that specializes in the care and treatment of people with dementia.

☐ YES ☐ NO----- It would be in the Proposed Ward's best interest to be administered medications appropriate for the care and treatment of dementia.

☐ YES ☐ NO----- The Proposed Ward currently has sufficient capacity to give informed consent to the administration of dementia medications.

d. Possibility for Improvement:

☐ YES ☐ NO----- Is improvement in the Proposed Ward's physical condition and mental functioning possible?

If "YES," after what period should the Proposed Ward be reevaluated to determine whether a guardianship continues to be necessary? _____

4. Cognitive Deficits

a. The Proposed Ward is oriented to the following (check all that apply):

☐ Person ☐ Time ☐ Place ☐ Situation

b. The Proposed Ward has a deficit in the following areas (check all areas in which Proposed Ward has a deficit):

☐--- Short-term memory
☐--- Long-term memory
☐--- Immediate recall
☐--- Understanding and communicating (verbally or otherwise)
☐--- Recognizing familiar objects and persons
☐--- Solve problems
☐--- Reasoning logically
☐--- Grasping abstract aspects of his or her situation
☐--- Interpreting idiomatic expressions or proverbs
☐--- Breaking down complex tasks down into simple steps and carrying them out

c. ☐ YES ☐ NO -- The Proposed Ward's periods of impairment from the deficits indicated above (if any) vary substantially in frequency, severity, or duration.

5. Ability to Make Responsible Decisions

Is the Proposed Ward able to initiate and make responsible decisions concerning himself or herself regarding the following:

☐ YES ☐ NO----- Make complex business, managerial, and financial decisions
☐ YES ☐ NO----- Execute a medical power of attorney (see Attachment 1)
☐ YES ☐ NO----- Execute a durable power of attorney (see Attachment 2)
☐ YES ☐ NO----- Execute a supported decision-making agreement (see Attachment 3)
☐ YES ☐ NO----- Manage a personal bank account

If "YES," should amount deposited in any such bank account be limited? ☐ YES ☐ NO

If "YES," delineate the amount deposited in any such bank account? $_____ / month

☐ YES ☐ NO----- Safely operate a motor vehicle
☐ YES ☐ NO----- Vote in a public election
☐ YES ☐ NO----- Purchase, use or possess firearms or ammunition
☐ YES ☐ NO----- Make decisions regarding marriage
☐ YES ☐ NO----- Determine the Proposed Ward's own residence
☐ YES ☐ NO----- Administer own medications on a daily basis
☐ YES ☐ NO----- Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, toileting) without supports and services
☐ YES ☐ NO----- Attend to basic activities of daily living (ADLs) (e.g., bathing, grooming, dressing, walking, toileting) with supports and services
☐ YES ☐ NO----- Attend to instrumental activities of daily living (e.g., shopping, cooking, traveling, cleaning)
☐ YES ☐ NO----- Consent to medical and dental treatment at this point going forward
☐ YES ☐ NO----- Consent to psychological and psychiatric treatment at this point going forward

6. Developmental Disability

☐ YES ☐ NO----- Does the Proposed Ward have developmental disability?
If "NO," skip to number 7 below.
If "YES," answer the following question and look at the next page.

Is the disability a result of the following? (Check all that apply)

☐ YES ☐ NO----- Intellectual Disability?
☐ YES ☐ NO----- Autism?
☐ YES ☐ NO----- Static Encephalopathy?
☐ YES ☐ NO----- Cerebral Palsy?
☐ YES ☐ NO----- Down Syndrome?
☐ YES ☐ NO ---- Other? Please explain _____

Answer the questions in the "Determination of Intellectual Disability" box below only if both of the following are true:

(1) The basis of a proposed ward's alleged incapacity is intellectual disability.
and
(2) **You are making a "Determination of Intellectual Disability" in accordance with rules of the executive commissioner of the Health and Human Services Commission governing examinations of that kind**.

If you are not making such a determination, please skip to number 7 below.

DETERMINATION OF INTELLECTUAL DISABILITY

Among other requirements, a Determination of Intellectual Disability must be based on an interview with the Proposed Ward and on a professional assessment that includes the following:

1) a measure of the Proposed Ward's intellectual functioning;
2) a determination of the Proposed Ward's adaptive behavior level; and
3) evidence of origination during the Proposed Ward's developmental period.

You may use a previous assessment, social history, or relevant record from a school district, another physician, a psychologist, an authorized provider, a public agency, or a private agency if you determine that the previous assessment, social history, or record is valid.

1. Check the appropriate statement below. If neither statement is true, skip to number 7 below.
   - ☐ **I examined the proposed ward in accordance with rules of the executive commissioner of the Health and Human Services Commission governing Intellectual Disability examinations**, and my written findings and recommendations include a determination of an intellectual disability.
   - ☐ **I am updating or endorsing in writing a prior determination of an intellectual disability** for the proposed ward made in accordance with rules of the executive commissioner of the Health and Human Services Commission by a physician or psychologist licensed in this state or an authorized provider certified by the Health and Human Services Commission to perform the examination.
2. What is your assessment of the Proposed Ward's level of intellectual functioning and adaptive behavior?
   ☐ Mild (IQ of 50-55 to approx. 70) ☐ Moderate (IQ of 35-40 to 50-55)
   ☐ Severe (IQ of 20-25 to 35-40) ☐ Profound (IQ below 20-25)
3. ☐ Yes ☐ No ---- Is there evidence that the intellectual disability originated during the Proposed Ward's developmental period?

Note to attorneys: *If the above box is filled out because a determination of intellectual disability has been made in accordance with rules of the executive commissioner of the Health and Human Services Commission governing examinations of that kind, a Court may grant a guardianship application if (1) the examination is made not earlier than 24 months before the date of the hearing or (2) a prior determination of an intellectual disability was updated or endorsed in writing not earlier than 24 months before the hearing date. If a physician's or NPRN's diagnosis of intellectual disability is not made in accordance with rules of the executive commissioner — and the above box is not filled out — the court may grant a guardianship application only if the Physician's Certificate of Medical Examination is based on an examination the physician performed within 120 days of the date the application for guardianship was filed. See Texas Estates Code § 1101.104(a)(1).*

7. Definition of Incapacity

For purposes of this certificate of medical examination, the following definition of incapacity applies:

An "**Incapacitated Person**" is an adult who, because of a physical or mental condition, is substantially unable to: (a) provide food, clothing, or shelter for himself or herself; (b) care for the person's own physical health; or (c) manage the person's own financial affairs. Texas Estates Code § 1002.017.

8. Evaluation of Capacity

☐ YES ☐ NO----- Based upon my last examination and observations of the Proposed Ward, it is my opinion that the Proposed Ward is incapacitated **according to the legal definition in section 1002.017 of the Texas Estates Code, set out in the box above.**

If you indicated that the Proposed Ward is incapacitated, indicate the level of incapacity:

☐ **Total ----------** The Proposed Ward is totally without capacity (1) to care for himself or herself and (2) to manage his or her property.

☐ **Partial ----------** The Proposed Ward lacks the capacity to do some, but not all, of the tasks necessary to care for himself or herself or to manage his or her property.

Evaluation of Capacity (continued)

If you indicated the Proposed Ward's incapacity is partial, what specific powers or duties of the guardian should be limited if the Proposed Ward receives supports and services? _____

_____

_____

If you answered "NO" to all of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **partially** incapacitated, please explain: _____

_____

_____

If you answered "YES" to any of the questions regarding decision-making in Section 5 (on page 2) and yet still believe the Proposed Ward is **totally** incapacitated, please explain: _____

_____

_____

9. Ability to Attend Court Hearing

☐ YES ☐ NO----- The Proposed Ward would be able to attend, understand, and participate in the hearing.

☐ YES ☐ NO----- Because of the Proposed Ward's incapacities, I recommend that the Proposed Ward not appear at a Court hearing.

☐ YES ☐ NO----- Does any current medication taken by the Proposed Ward affect the demeanor of the Proposed Ward or his or her ability to participate fully in a court proceeding?

10. What is the least restrictive placement that you consider is appropriate for the Proposed Ward:

☐---------- Nursing home level of care ☐--- Assisted Living Facility

☐---------- Group Home ☐--- Memory care unit

☐---------- Own Home or with family ☐--- Other _____

11. Additional Information of Benefit to the Court: If you have additional information concerning the Proposed Ward that you believe the Court should be aware of or other concerns about the Proposed Ward that are not included above, please explain below or on an additional page.

12. <u>Signature of Physician, Psychologist or Advanced Practice Registered Nurse and Supervising Physician:</u>

Physician/Psychologist/Advanced Practice Registered Nurse's Signature	Date
Physician/Psychologist/Advanced Practice Registered Nurse's Name Printed	License Number

If the examination was conducted by an Advanced Practicing Registered Nurse, the supervising physician shall sign below:

Supervising Physician's Signature	Date
Supervising Physician's Name Printed	License Number

Medical Power of Attorney Designation of Health Care Agent (MPOA)

Advance Directives Act (see §166.164, Health and Safety Code)

I, _____ (insert your name) appoint:

Name: _____

Address: _____

Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

Limitations On The Decision-Making Authority Of My Agent Are As Follows:

_____

_____

_____

_____

Designation Of An Alternate Agent:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: _____

Address: _____

Phone: _____

Second Alternate Agent

Name: _____

Address: _____

Phone: _____

The original of the document is kept at _____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

Attachment 1

Duration

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(If Applicable) This power of attorney ends on the following date: _____

Prior Designations Revoked

I revoke any prior medical power of attorney.

Disclosure Statement

This Medical Power Of Attorney Is An Important Legal Document. Before Signing This Document, You Should Know These Important Facts:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life- sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not allow a person to serve as both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent to make health care decisions for you.

This Power Of Attorney Is Not Valid Unless:

(1) You Sign It And Have Your Signature Acknowledged Before A Notary Public; Or
(2) You Sign It In The Presence Of Two Competent Adult Witnesses.

The Following Persons May Not Act As One Of The Witnesses:

(1) the person you have designated as your agent;
(2) a person related to you by blood or marriage;
(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
(4) your attending physician;
(5) an employee of your attending physician;
(6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
(7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

(You Must Date And Sign This Power Of Attorney. You May Sign It And Have Your Signature Acknowledged Before A Notary Public Or You May Sign It In The Presence Of Two Competent Adult Witnesses.)

Signature Acknowledged Before Notary

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

_____
(City and State)

_____
(Signature)

_____
(Print Name)

State of Texas

County of _____

This instrument was acknowledged before me on _____ (date) by _____ (name of person acknowledging).

_____
Notary Public, State of Texas

Notary's printed name:

SEAL

_____

My commission expires:

_____

OR

Signature In Presence Of Two Competent Adult Witnesses

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

_____
(City and State)

_____
(Signature)

_____
(Print Name)

Statement Of First Witness

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____

Printed Name: _____ Date: _____

Address: _____

Statement Of Second Witness

Signature: _____

Printed Name: _____ Date: _____

Address: _____

STATUTORY DURABLE POWER OF ATTORNEY

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE DURABLE POWER OF ATTORNEY ACT, SUBTITLE P, TITLE 2, ESTATES CODE. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO. IF YOU WANT YOUR AGENT TO HAVE THE AUTHORITY TO SIGN HOME EQUITY LOAN DOCUMENTS ON YOUR BEHALF, THIS POWER OF ATTORNEY MUST BE SIGNED BY YOU AT THE OFFICE OF THE LENDER, AN ATTORNEY AT LAW, OR A TITLE COMPANY.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until:

(1) you die or revoke the power of attorney;
(2) your agent resigns, is removed by court order, or is unable to act for you; or
(3) a guardian is appointed for your estate.

I, _____ (insert your name and address), appoint _____ (insert the name and address of the person appointed) as my agent to act for me in any lawful way with respect to all of the following powers that I have initialed below. (YOU MAY APPOINT CO-AGENTS. UNLESS YOU PROVIDE OTHERWISE, CO-AGENTS MAY ACT INDEPENDENTLY.)

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (O) AND IGNORE THE LINES IN FRONT OF THE OTHER POWERS LISTED IN (A) THROUGH (N).

TO GRANT A POWER, YOU MUST INITIAL THE LINE IN FRONT OF THE POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF THE POWER. YOU MAY, BUT DO NOT NEED TO, CROSS OUT EACH POWER WITHHELD.

_____ (A) Real property transactions;
_____ (B) Tangible personal property transactions;
_____ (C) Stock and bond transactions;
_____ (D) Commodity and option transactions;
_____ (E) Banking and other financial institution transactions;
_____ (F) Business operating transactions;
_____ (G) Insurance and annuity transactions;
_____ (H) Estate, trust, and other beneficiary transactions;
_____ (I) Claims and litigation;
_____ (J) Personal and family maintenance;
_____ (K) Benefits from social security, Medicare, Medicaid, or other governmental

Attachment 2

programs or civil or military service;

_____ (L) Retirement plan transactions;

_____ (M) Tax matters;

_____ (N) Digital assets and the content of an electronic communication;

_____ (O) ALL OF THE POWERS LISTED IN (A) THROUGH (N). YOU DO NOT HAVE TO INITIAL THE LINE IN FRONT OF ANY OTHER POWER IF YOU INITIAL LINE (O).

SPECIAL INSTRUCTIONS:

Special instructions applicable to agent compensation (initial in front of one of the following sentences to have it apply; if no selection is made, each agent will be entitled to compensation that is reasonable under the circumstances):

____ My agent is entitled to reimbursement of reasonable expenses incurred on my behalf and to compensation that is reasonable under the circumstances.

____ My agent is entitled to reimbursement of reasonable expenses incurred on my behalf but shall receive no compensation for serving as my agent.

Special instructions applicable to co-agents (if you have appointed co-agents to act, initial in front of one of the following sentences to have it apply; if no selection is made, each agent will be entitled to act independently):

____ Each of my co-agents may act independently for me.

____ My co-agents may act for me only if the co-agents act jointly.

____ My co-agents may act for me only if a majority of the co-agents act jointly.

Special instructions applicable to gifts (initial in front of the following sentence to have it apply):

_____ I grant my agent the power to apply my property to make gifts outright to or for the benefit of a person, including by the exercise of a presently exercisable general power of appointment held by me, except that the amount of a gift to an individual may not exceed the amount of annual exclusions allowed from the federal gift tax for the calendar year of the gift.

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

_____

_____

_____

_____

_____

_____

_____

UNLESS YOU DIRECT OTHERWISE BELOW, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT TERMINATES.

CHOOSE ONE OF THE FOLLOWING ALTERNATIVES BY CROSSING OUT THE ALTERNATIVE NOT CHOSEN:

(A) This power of attorney is not affected by my subsequent disability or incapacity.

(B) This power of attorney becomes effective upon my disability or incapacity.

YOU SHOULD CHOOSE ALTERNATIVE (A) IF THIS POWER OF ATTORNEY IS TO BECOME EFFECTIVE ON THE DATE IT IS EXECUTED.

IF NEITHER (A) NOR (B) IS CROSSED OUT, IT WILL BE ASSUMED THAT YOU CHOSE ALTERNATIVE (A).

If Alternative (B) is chosen and a definition of my disability or incapacity is not contained in this power of attorney, I shall be considered disabled or incapacitated for purposes of this power of attorney if a physician certifies in writing at a date later than the date this power of attorney is executed that, based on the physician's medical examination of me, I am mentally incapable of managing my financial affairs. I authorize the physician who examines me for this purpose to disclose my physical or mental condition to another person for purposes of this power of attorney. A third party who accepts this power of attorney is fully protected from any action taken under this power of attorney that is based on the determination made by a physician of my disability or incapacity.

I agree that any third party who receives a copy of this document may act under it. Termination of this durable power of attorney is not effective as to a third party until the third party has actual knowledge of the termination. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney. The meaning and effect of this durable power of attorney is determined by Texas law.

If any agent named by me dies, becomes incapacitated, resigns, or refuses to act, or is removed by court order, or if my marriage to an agent named by me is dissolved by a court decree of divorce or annulment or is declared void by a court (unless I provided in this document that the dissolution or declaration does not terminate the agent's authority to act under this power of attorney), I name the following (each to act alone and successively, in the order named) as successor(s) to that agent:

_____.

Signed this _____ day of _____,_____.

_____

(your signature)

State of _____
County of _____

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

_____

(name of principal)

_____
(signature of notarial officer)

(Seal, if any, of notary)

_____
(printed name)

My commission expires: _____

IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, you establish a "fiduciary" relationship with the principal. This is a special legal relationship that imposes on you legal duties that continue until you resign or the power of attorney is terminated, suspended or revoked by the principal or by operation of law. A fiduciary duty generally includes the duty to:

(1) act in good faith;
(2) do nothing beyond the authority granted in this power of attorney;
(3) act loyally for the principal's benefit;
(4) avoid conflicts that would impair your ability to act in the principal's best interest; and
(5) disclose your identity as an agent when you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

(Principal's Name) by (Your Signature) as Agent

In addition, the Durable Power of Attorney Act (Subtitle P, Title 2, Estates Code) requires you to:

(1) maintain records for each action taken or decision made on behalf of the principal;
(2) maintain all records until delivered to the principal, released by the principal, or discharged by a court; and
(3) if requested by the principal, provide an accounting to the principal that, unless directed by the principal or otherwise provided in the Special Instructions, must include:
    (A) the property belonging to the principal that has come to your knowledge or into your possession;
    (B) each action taken or decision made by you as agent;
    (C) a complete account of receipts, disbursements, and other actions of you as agent that includes the source and nature of each receipt, disbursement or action, with receipts of principal and income shown separately;
    (D) a listing of all property over which you have exercised control that includes an adequate description of each asset and the asset's current value, if known to you;
    (E) the cash balance on hand and the name and location of the depository at which the cash balance is kept;
    (F) each known liability;
    (G) any other information and facts known to you as necessary for a full and definite understanding of the exact condition of the property belonging to the principal; and
    (H) all documentation regarding the principal's property.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn or any event that terminates or suspends this power of attorney or your authority under this power of attorney. An event that terminates this power of attorney or your authority to act under this power of attorney includes:

(1) the principal's death;
(2) the principal's revocation of this power of attorney or your authority;
(3) the occurrence of a termination event stated in this power of attorney;

(4) if you are married to the principal, the dissolution of your marriage by court decree of divorce or annulment or declaration that your marriage is void, unless otherwise provided in this power of attorney;
(5) the appointment and qualification of a permanent guardian of the principal's estate unless a court order provides otherwise; or
(6) if ordered by a court, your removal as agent (attorney in fact) under this power of attorney. An event that suspends this power of attorney is the appointment and qualification of a temporary guardian unless a court order provides otherwise.

Liability of the Agent

The authority granted to you under this power of attorney is specified in the Durable Power of Attorney Act (Subtitle P, Title 2, Estates Code). If you violate the Durable Power of Attorney Act or act beyond the authority granted, you may be liable for any damages caused by the violation or subject to prosecution for misapplication of property by a fiduciary under Chapter 32 of the Texas Penal Code.

THE AGENT, BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

SUPPORTED DECISION-MAKING AGREEMENT

Important Information For Supporter: Duties

When you agree to provide support to an adult with a disability under this supported decision-making agreement, you have a duty to:

(1) act in good faith;

(2) act within the authority granted in this agreement;

(3) act loyally and without self-interest; and

(4) avoid conflicts of interest.

Appointment of Supporter

I,_____ (insert the name of the person with the disability), 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:

Y ___ N ___ obtaining food, clothing, and shelter

Y ___ N ___ taking care of my physical health

Y ___ N ___ 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.

Y ___ N ___ 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.

Y ___ N ___ 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.

_____ _____

(signature of supporter) (printed name of supporter)

Signature of Person Designating Supporter

_____ _____

(my signature) (my printed name)

Witness Signatures

_____ _____

(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 this _____ day of _____, 20___, by

_____ and _____.
(name of adult with disability) (name of supporter)

_____
(signature of notarial officer)

{SEAL}

_____
(printed name)

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.