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.