***SUPPORTED DECISION-MAKING AGREEMENT EXAMPLE***

Appointment of Supporter I, (insert your name), 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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                         (My Signature)                                                              (My Printed Name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

             (Witness 1 Signature)                                                      (Printed Name of Witness 1)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                (Witness 2 Signature)                                                     (Printed Name of Witness 2)

This document was acknowledged before me on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date)

by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

              (Name of Adult with Disability)                                             (Name of Supporter)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

             (Signature of Notarial Officer)                                         (Printed Name of Notarial Officer)

(Seal, if any of notary)

My commission expires:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WARNING:  PROTECTION FOR THE ADULT WITH 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.](http://www.txabusehotline.org./)