SUBSTITUTE DECISION MAKING OPTIONS FOR YOUNG ADULTS WITH DISABILITIES

GUARDIANSHIP

SUPPORTED DECISION-MAKING AGREEMENTS

POWERS OF ATTORNEY

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WHAT IS "SUBSTITUE DECISION MAKING"?

- Substitute decision making is the process by which one individual is legally empowered to make decisions for another individual.

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AGE OF MAJORITY

- 18th birthday
- Young adult acquires control over their person and actions and has full decision-making authority.
- Parental rights (and responsibilities) are automatically terminated by law.
- No legal "exceptions" or "special considerations" for a child with disabilities.

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AGE OF MAJORITY – PRACTICAL CONSIDERATIONS FOR ANY YOUNG ADULT TURNING 18

- MEDICAL
- RESIDENTIAL
- EDUCATIONAL
- FINANCIAL

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AGE OF MAJORITY – YOUNG ADULT WITH A DISABILITY TURNS 18

- The fact that a young adult has a disability does not, in and of itself, mean that they cannot or should not make decisions for themselves.
- Making "bad" or ill-advised decisions does not mean that a person should not be allowed to make decisions for themselves.
- Requiring assistance in making decisions does not mean that a person should not be allowed to make decisions for themselves.

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WHAT ARE THE DIFFERENT TYPES OF SUBSTITUTE DECISION MAKING?

- Guardianship – Personal and/or Financial
  - Limited Guardianship
  - Full Guardianship
- Supported Decision-Making Agreement
  - New law in IL - became effective February 27, 2022.
- Powers of Attorney –Health and/or Property
- Declaration for Mental Health Treatment

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GUARDIANSHIP

- GUARDIANSHIP is:
  - A legal relationship
  - created by a Judge
  - between a person with a disability
  - and another individual who is given surrogate decision-making power
  - over some or all decisions
  - to be made for the person with a disability.

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GUARDINSHIP PROCESS

- A Judicial process where one person (Petitioner) alleges that another individual (Respondent) has a disability that renders them either partially incapable or totally incapable of making decisions for themselves, so that a surrogate decision-maker (Guardian) must be given the authority to make decisions for that disabled person.
- If the Petitioner can prove that:
  - The individual does, in fact, have a disability, AND
  - That disability renders that person either partially incapable or totally incapable of making personal and/or financial decisions for themselves,
- Then the Judge will appoint a Guardian and grant them some or all decision-making authority over the disabled person.
- Any authority given to the Guardian effectively takes it away from the disabled person

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TYPES OF GUARDIANSHIP – LIMITED OR FULL

LIMITED GUARDIANSHIP

- Disability impairs SOME types of decision-making, but not all.
- Judge will grant decision-making authority to a LIMITED GUARDIAN to act in specific areas only.
- Limited Guardianship must be considered first.
- No judicial determination of "legal incapacity" required.

FULL GUARDIANSHIP

- Disability impairs ALL types of decision-making,
- Judge grants full decision-making authority to the PLENARY GUARDIAN, leaving no authority to the disabled person.
- Full Guardianship considered only when Limited Guardianship is insufficient.
- Judicial determination of "legal incapacity"

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TYPES OF GUARDIANSHIPS – PERSONAL AND ESTATE

GUARDIAN OF THE PERSON

- Decisions having to do with the disabled person's physical body:
  - Medical
  - Residential
  - Educational

GUARDIAN OF THE ESTATE

- Decisions having to do with the disabled person's finances:
  - Financial decision-making
  - Contracts
  - Litigation
- Only needed if disabled person has assets in their name.
- BUT - not required if the ONLY asset/income is Social Security Benefit (SSI or SSDI). Representative Payee as potential alternative.

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GUARDIANSHIP – BASIC PROCEDURE

- PETITION – 755 ILCS 5/11a-8 – Filing Fee (Cook County currently $204)
- MEDICAL REPORT - 755 ILCS 5/11a-9 – in person visit, timing of exam
- SUMMONS / STATEMENT OF RIGHTS – timing: after 18th birthday / at least 2 weeks before hearing date
- NOTICE OF HEARING – must be mailed to immediate family over age of 18
- OATH – no surety if personal only / will need surety bond for estate
- GUARDIAN AD LITEM – can be waived in certain circumstances
- HEARING – respondent and nominated guardian(s) must be present
- LETTERS OF OFFICE
- PERSONAL GUARDIANSHIP – ANNUAL REPORT – sent to Judge every 12 months
- ESTATE GUARDIANSHIP – INVENTORY within 60 days; then ANNUAL ACCOUNT every 12 months

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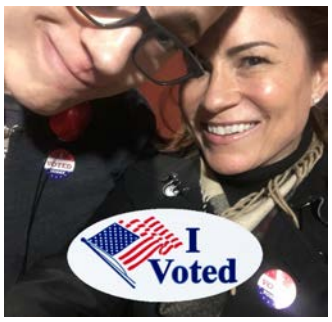
WHAT RIGHTS ARE RETAINED UNDER A GUARDIANSHIP?

- VOTING – in Illinois, this right is NOT affected by the existence of any form of Guardianship.
- DRIVING – May be retained with a Limited Guardianship.
- MARRIAGE – a contractual right
- ASSOCIATION – this right may be limited ONLY after a Guardian proves there is a need to protect the well-being of the disabled person.
- REPRODUCTION – case by case. Distinction between temporary vs permanent birth control measures.



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IS GUARDIANSHIP PERMANENT?

- Guardianship may be modified at any point by Petitioning the Court.
- Full Guardianship can be changed to Limited Guardianship.
- Limited Guardianship can be modified to adjust to the changing needs of the person with a disability.
- Guardianship can be terminated – Petition for Restoration

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GUARDIANSHIP AND MENTAL HEALTH

- When an adult has a mental health diagnosis, it is important to understand that even if the court agrees a full Guardianship is necessary (not a sure thing):
  - The Guardian CANNOT force the disabled person to stay involuntarily as an in-patient in a mental health facility - or any facility that provides psychiatric care.
  - The Guardian CANNOT force the disabled person to take psychotropic medications involuntarily.
- Absent the disabled person's voluntary cooperation, the Guardian must follow the process for involuntary treatment under the Illinois Mental Health and Developmental Disabilities Act.
- Declaration for Mental Health Treatment is a possible alternative (more later).

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SUPPORTED DECISION - MAKING AGREEMENTS

- Supported Decision-Making Agreement Act - (755 ILCS 9).
- Effective February 27, 2022
- Alternative mechanism of support for adults with disability who retain decisional capacity, so that guardianship may be too restrictive and unnecessary.
- Goal is to maximize autonomy in personal choice and self-determination.

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WHAT DOES THE SUPPORTED DECISION-MAKING AGREEMENT ACT DO?

- The Act allows:
  - An Adult
  - With Intellectual or Developmental disabilities
  - To enter into a Written Agreement
  - Between the adult with a disability (the "Principal")
  - And another adult of their choosing (the "Supporter").
- Supporter assists the adult with a disability in making decisions for themselves.
- Supporter is NOT authorized to make decisions FOR the Person with a disability.

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SUPPORTED DECISION-MAKING ACT "INTELLECTUAL OR DEVELOPMENTAL DISABILITY"

- The Act applies to individuals with ID/DD as defined by the Mental Health and Developmental Disabilities Code (405 ILCS 5):
  - Diagnosis pertaining to ID/DD, such as Down Syndrome, Autism, Cerebral Palsy, Intellectual Disability
  - Diagnosis would have been in place prior to 18
  - Individual would likely have a history of receiving services related to their diagnosis, such as early intervention, special education, therapy services, DD Adult services.
  - Can be used by person with mental health diagnosis so long as they are also diagnosed with ID/DD (dual Dx).

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SUPPORTED DECISION-MAKING AGREEMENT - "WRITTEN AGREEMENT"

- Illinois Statutory Form Supported Decision-Making Agreement (755 ILCS 9/50)
- Use of the statutory form is not required, but the agreement must substantially follow the legislated form.
- In other words – use the statutory form.
- Must be signed by:
  - Principal
  - Supporter
  - Two separate witnesses.

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WHO MAY ACT AS SUPPORTER?

- The Act specifies who is DISQUALIFIED:
  - Employer / employee of Principal, unless they are a family member;
  - Person directly providing paid support services to Principal, unless they are a family member;
  - Person who works for an Agency that is financially responsible for the care of the Principal;
  - Person listed as "ineligible to work" on the IL Healthcare Worker Registry;
  - Person subject to an Order prohibiting contact with Principal;
  - Person convicted of: sex offense, aggravated assault, fraud, theft, forgery, extortion.

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SUPPORTED DECISION-MAKING AGREEMENT – AREAS OF SUPPORT

- Obtaining food, clothing, and shelter
- Taking care of physical and emotional health
- Managing financial affairs
- Applying for public benefits
- Helping to find work
- Assisting with residential services
- Helping with school
- Helping to advocate for self
- Other

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DUTIES AS SUPPORTER

- SUPPORTER DOES NOT MAKE DECISIONS FOR PRINCIPAL
- Supporter may:
  - Assist Principal in understanding information, options, responsibilities and consequences of Principal's decision;
  - Help Principal assess, obtain, and understand information regarding a life decision;
  - Help Principal find and obtain services, make appointments for services, monitor and track services;
  - Ascertain wishes of principal, assist in communicating wishes and decisions to others, advocate to ensure Principal's wishes are implemented.

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SUPPORTER'S ACCESS TO PERSONAL INFORMATION / RECORDS

- Supporter is only authorized to assist the Principal in accessing information or records that are relevant to the specific decision identified by the Principal in the Agreement.
- To access protected information, the Principal must specifically authorize the Supporter to do so in the Agreement, AND must also execute a separate Release. Protected records include:
  - Medical records and insurance information under HIPAA
  - Confidential treatment records under Mental Health and Developmental Disability Confidentiality Act;
  - Educational Records under the Family Education Rights and Privacy Act

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THINGS A SUPPORTER CANNOT DO

- Supporter CAN'T make decisions FOR the Principal.
- Supporter CAN'T unduly influence the Principal into making a specific decision.
- Supporter CAN'T obtain information or records without the consent of the Principal.
- Supporter CAN'T use information about the Principal for any other reason than assisting the Principal in areas that are specified in the Agreement.
- Supporter CAN'T receive pay for being a Supporter.

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SUPPORTED DECISION-MAKING AT SCHOOL – BEFORE STUDENT TURNS 18

- Prior to 18th birthday, Transition Plan can include opportunities for student to practice supported decision-making with the help of the IEP team (staff and parents).
- Common transition plan goals a student can make with team support:
  - Life skills training
  - Vocational training and counseling
  - Post-secondary education
  - Supported employment
  - Graduation goals

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SUPPORTED DECISION-MAKING AT SCHOOL – AFTER STUDENT TURNS 18

After the student's 18th birthday, all parental rights terminate. Transfer of decision-making authority to the student. Parents can still be involved in planning if student signs Delegation of Rights

- Supported Decision-Making Agreement in educational setting:
  - Student should always attend meetings.
  - Supporter can also attend meetings with Student consent.
  - Supporter can assist student with:
    - Advocating for student preferences
    - Understanding information, issues, and choices
    - Selecting goals
    - Accessing educational records when necessary (need Release).

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SUPPORTED DECISION-MAKING AGREEMENT - TERMINATION

- Agreement can contain a specific termination date set by the Principal.
- Supporter can resign at any time.
- Principal can terminate at any time by:
  - Physically destroying document or instructing another person to destroy document in front of Supporter; OR
  - Execute a written document (signed and dated) indicating intent to terminate; OR
  - Verbally express intent to terminate the Agreement in front of two witnesses.
- Office of Inspector General or Adult Protective Services can terminate Agreement when there has been a substantiated allegation of abuse or neglect.

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SUPPORTED DECISION-MAKING AGREEMENTS – FINAL THOUGHTS

- The Principal ALWAYS makes the final decision.
- The Principal should be present as much as possible when information is being gathered and decisions are communicated.
- Supporter should ensure that Service Providers understand that all decisions remain with the Principal.
- The Agreement does not give the Supporter the right to stand in the shoes of the Principal, and does not give the Supporter the right to speak for the Principal. The Agreement allows the Supporter to stand behind the Principal, and helps the Principal to communicate for themselves.

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POWERS OF ATTORNEY

- A Power of Attorney is a written document that allows one person ("Principal") to name another person ("Agent") to act as a surrogate decision-maker in the event that the Principal becomes disabled.
- Two types:
  - Power of Attorney for Health Care
  - Power of Attorney for Property (finances)

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POWERS OF ATTORNEY – IN GENERAL

- A Power of Attorney is to be completed by the Principal when they have capacity to do so.
- Principal must have Contractual Capacity
- Powers of Attorney are fully revocable at any time.
- Powers of Attorney do not take away decision-making authority from the Principal.

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POWERS OF ATTORNEY – TWO TYPES

POA HEALTHCARE

- Principal names Agent to make certain health care decisions on behalf of Principal.
- The Agent's decision-making authority becomes effective ONLY when the Principal can no longer communicate their own decisions.
- Typically triggered by a Physician determining the Principal is so incapacitated that they can no longer make their own decisions.

POA PROPERTY

- Principal names Agent to conduct financial affairs on behalf of Principal.
- Durable - effective immediately upon signing) vs. Springing - effective only during such time that Principal is incapacitated.
- Principal retains all legal authority to make their own decisions even after signing.

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DECLARATION FOR MENTAL HEALTH TREATMENT

- Authorized by Statute in Illinois: Mental Health Treatment Preference Declaration Act (755 ILCS 43)
- Allows an adult with mental illness to make a written declaration of preferences or instructions indicating their consent to - or their refusal of – certain types of mental health treatment.

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DECLARATION FOR MENTAL HEALTH TREATMENT

- Document signed by an adult who has a mental illness (the "Principal"), when they are of "sound mind".
- Principal acknowledges that they have a "diagnosed mental disorder" that may cause them to become impaired to such an extent that they lack the capacity to refuse or consent to mental health treatment.
- Principal expresses their consent to or refusal of the following types of mental health treatments:
  - In-patient treatment (maximum 17 days involuntary)
  - Administration of psychotropic medications
  - Electroconvulsive therapy

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DECLARATION FOR MENTAL HEALTH TREATMENT - CONTINUED

- Declaration becomes effective when two physicians have certified that the Principal is impaired by their mental illness to the extent that they cannot make decisions for themselves.
- Principal can name one of the two Physicians in the document
- Principal names another individual (the "attorney in fact") to consent to or refuse mental health treatment on their behalf according to the terms of the Declaration.
- Valid for three years from the date of signing unless revoked.
- Principal may revoke but Revocation requires signature of Principal and a physician to attest to the fact that Principal has capacity to revoke.

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WHAT IS RIGHT FOR MY CHILD?

- Parents know their child best
- Honest assessment of child's strengths and weaknesses CURRENTLY – not aspirational.
- No checklist (sorry!)
- Consider different real-life scenarios
- Where appropriate, involve your child
- Is my child currently able to make decisions for themselves with support from another adult?
- Does my child need another person to make decisions for them?

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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT – PROBATE DIVISION

File No. _____

Estate of

_____

Alleged Person with a Disability

PETITION FOR APPOINTMENT OF GUARDIAN OF A PERSON WITH A DISABILITY

Does the Petitioner expect the Alleged Person With A Disability to appear in court? ☐ *Yes* ☐ *No*

In accordance with § 11a-8 of the Probate Act of 1975 ("Probate Act") [755 ILCS 5/11a-8] and §§ 1 - 204 of the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act ("UAGPPJA") [755 ILCS 8/201 - 204], the Petitioner, _____
[printed name of the Petitioner]
states under the penalties of perjury:

1. _____ (the "Respondent"),
[printed name of the alleged person with a disability]
whose year of birth is _____, who is 18 years or older, who resides in Cook County, and whose place of residence is _____
_____, is a person with a disability;
[address/city/county/state/zip code]
2. The relationship to and interest in the Respondent of the Petitioner is _____
*3. The reasons for the guardianship are that the Respondent is a person with a disability due to _____
_____ and because of that disability
[description of disability]
   ☐ (a) lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the care of the Respondent's person;
   ☐ (b) is unable to manage the Respondent's estate or financial affairs;
4. (a) The approximate value of the Respondent's estate is: Personal $_____ Real $_____;
   (b) The amount of the Respondent's anticipated annual gross income and other receipts are: $_____;
5. The names and post office addresses of the Respondent's Guardian, if any, or of the Respondent's agent(s) appointed under any Power of Attorney Act, if any, and of the Respondent's nearest relatives entitled to notice, are listed on Exhibit A attached to this Petition "Nearest relatives" means, in the following order, (a) the spouse (including a party to a civil union) and adult children, the parents and adult brothers and sisters or, if none, (b) the nearest adult kindred known to the Petitioner;
6. The names and post office addresses of any minor or adult who is dependent upon the Respondent are also listed on **Exhibit A** attached to this Petition.
7 The name and address of the person with whom, or the facility in which, the Respondent is residing is _____
_____
*8. ☐ (a) No Petition for the appointment of a Guardian of the Respondent is pending in any other jurisdiction;
   ☐ (b) A Petition for the appointment of a Guardian of the Respondent is pending in _____;
**9 ☐ (a) Illinois is the Respondent's "home state" as defined in §201(a)(2) of the UAGPPJA.
   ☐ (b) _____ is the Respondent's "home state", but Illinois is a "significant-connection state" as defined in §201(a)(3) of the UAGPPJA, and one of the additional requirements specified in §203(2)(A)-(B) of UAGPPJA applies.

*** Check the appropriate box or boxes**
*** Check the appropriate basis for jurisdiction**

☐ (c) Illinois is not the Respondent's "home state" or a "significant-connection state" as defined in §201(a)(2)-(3) of the UAGPPJA, but the "home state" and every "significant-connection state" have declined to exercise jurisdiction because Illinois is the most appropriate forum.

☐ (d) Illinois is not the Respondent's "home state" or a "significant-connection state" as defined in §201(a)(2)-(3) of the UAGPPJA, but the circumstances involved constitute an "emergency" as defined in §201(a)(1) of the UAGPPJA, and, as a result, the Court has "special jurisdiction" under §204(a) of the UAGPPJA.

The Petitioner asks that _____ be adjudged a person with a disability, and that
[printed name of the Respondent]

A. _____
[printed name of the proposed Guardian]

_____
[post office address/city/state/zip code]

age _____ years, _____, _____,
[relationship to the Respondent] [occupation]

who is qualified and willing to act and who _____ been convicted of a felony, be
(has) (has not)

appointed as Guardian of the _____ of the Respondent.
(estate and person) (estate only)

***B. _____
[printed name of the proposed Guardian]

_____
[post office address/city/state/zip code]

age _____ years, _____, _____,
[relationship to the Respondent] [occupation]

who is qualified and willing to act and who _____ been convicted of a felony, be
(has) (has not)

appointed as Guardian of the person only of the Respondent.

***C. _____
[printed name of the proposed Guardian]

be appointed even though _____ has been convicted of a felony because:
(he) (she)

(i) the appointment is in the Respondent's best interests, after considering the nature and date of the offense and the evidence of the proposed Guardian's rehabilitation, and

(ii) the offense is not one which, under § 1a-5(5) of the Probate Act, would prohibit the appointment.

*** Strike if not applicable.**

_____
[signature of the Petitioner]

Attorney Number _____

Name _____

_____
[address of the Petitioner]

Firm Name _____

_____
[city/state/zip code]

Attorneys for _____

Service via Email will be accepted at:

Address _____

_____

City/State/Zip _____

by consent pursuant to Ill. Sup. Court Rules 11 and 131.

Telephone _____

_____
Attorney Certification

Email _____

EXHIBIT A

Attached to and made a part of a

PETITION FOR APPOINTMENT OF GUARDIAN OF A PERSON WITH A DISABILITY

List the names and post office addresses (i) of the persons entitled to receive notice under paragraph 5, and (ii) of the minors or adults who are dependent upon the Respondent under paragraph 6, of the Petition to which this **Exhibit A** is attached.

I. Respondent's Guardian(s) or agent(s) appointed under the Illinois Power of Attorney Act

Has a Court appointed a Guardian for the Respondent? ☐ Yes ☐ No ☐ Unknown

Has the Respondent executed a Power of Attorney for Property? ☐ Yes ☐ No ☐ Unknown

Has the Respondent executed a Power of Attorney for Health Care? ☐ Yes ☐ No ☐ Unknown

Provide the following information with respect to each Guardian and agent:

_____ [name] _____ [address] _____ [city/state/zip] _____ [relationship to the Respondent] _____ [telephone] _____ [email]	_____ [name] _____ [address] _____ [city/state/zip] _____ [relationship to the Respondent] _____ [telephone] _____ [email]
Type of guardianship: ☐ Adult ☐ Minor ☐ Person ☐ Estate Type of Power of Attorney: ☐ Property ☐ Health Care	Type of guardianship: ☐ Adult ☐ Minor ☐ Person ☐ Estate Type of Power of Attorney: ☐ Property ☐ Health Care

If the Respondent has one or more additional Guardian(s) or agent(s), provide the above information with respect to each on an additional page.

II. Respondent's Nearest Relatives Entitled to Notice

A. Does the Respondent have a spouse (by marriage or civil union) and adult children, parents and adult brothers and sisters living?

If "No" or "Unknown", proceed to paragraph B below.

If "Yes", provide the following information with respect to each:

Spouse	**Adult Child**
_____ [name] _____ [address] _____ [city/state/zip] _____ [telephone] _____ [email]	_____ [name] _____ [address] _____ [city/state/zip] _____ [telephone] _____ [email]

Adult Child

[name]

[address]

[city/state/zip]

[telephone] [email]

Adult Child

[name]

[address]

[city/state/zip]

[telephone] [email]

If the Respondent has one or more additional adult children living, provide the above information with respect to each on an additional page.

Parent

[name]

[address]

[city/state/zip]

[telephone] [email]

Parent

[name]

[address]

[city/state/zip]

[telephone] [email]

Adult Brother or Sister

[name]

[address]

[city/state/zip]

[telephone] [email]

Adult Brother or Sister

[name]

[address]

[city/state/zip]

[telephone] [email]

If the Respondent has one or more additional adult brothers and sisters living, provide the above information with respect to each on an additional page.

B. If the Respondent has no spouse, no adult child, no parent and no adult brother or sister, provide the following information with respect to each nearest adult relative:

[name] [relationship]

[address]

[city/state/zip]

[telephone] [email]

[name] [relationship]

[address]

[city/state/zip]

[telephone] [email]

[name] [relationship] [address] [city/state/zip] [telephone] [email]	[name] [relationship] [address] [city/state/zip] [telephone] [email]

If the Respondent has one or more additional adult relatives living, provide the above information with respect to each on an additional page.

III. Minor(s) and Adult(s) Dependent Upon the Respondent

Does the Respondent have one or more minors or adults who are dependent upon the Respondent?

☐ Yes ☐ No ☐ Unknown

If "Yes", provide the following information with respect to each:

Dependent ☐ **Minor** ☐ **Adult** **Dependent** ☐ **Minor** ☐ **Adult**

[name] [relationship] [address] [city/state/zip] [telephone] [email]	[name] [relationship] [address] [city/state/zip] [telephone] [email]

If the Respondent has one or more additional adult relatives living, provide the above information with respect to each on an additional page.

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, PROBATE DIVISION

File No. _____

Estate of

_____

Alleged Person with a Disability

REPORT OF PHYSICIAN

_____, a licensed physician, submits the following Report on
[printed name of the physician]

_____, an alleged person with a disability (the "Respondent"), based
[printed name of the alleged person with a disability]

upon evaluations of the Respondent performed on _____.

NOTE: The evaluations upon which this Report is based must have been performed within three (3) months of the date the Petition for guardianship is filed.

1. The following is a description of the nature and type of the Respondent's disability and an assessment of how the disability impacts on the ability of the Respondent to make decisions or to function independently, including an underlying diagnosis and a description of the manifestations of the disability:

_____

_____

_____

_____

2. The following is an analysis and the results of evaluations of the Respondent's mental and physical condition, and (if appropriate) a description of the Respondent's educational condition, adaptive behavior and social skills:

_____

_____

_____

_____

3. The following is my opinion as to whether guardianship is needed, the type and scope of the guardianship needed, and the reasons for my opinion, including whether the Respondent is **totally** or only **partially** incapable of making **personal** and **financial** decisions and if only **partially**, the kinds of decisions which the Respondent can and cannot make:

_____

_____

_____

_____

4. The following is my recommendation as to the most suitable living arrangement for the Respondent and (if appropriate) the treatment or habilitation plan for the Respondent, and the reasons for my recommendation:

_____

_____

_____

_____

If the description of the Respondent's mental, physical and educational condition, adaptive behavior or social skills is based upon evaluations by other professionals, all professionals preparing evaluations must also sign this Report.

5. The following are the names, addresses, certifications, licenses or other credentials, and signatures of each other person who performed an evaluation upon which this Report is based:

a. Name _____

Address _____

License (state and number)_____

Certification _____

Other credentials _____

Signature _____

b. Name _____

Address _____

License (state and number)_____

Certification _____

Other credentials _____

Signature _____

* _____

[signature of the physician preparing this Report]

_____

[license (state and number)]

_____

[address of the physician]

_____

[city/state/zip]

_____

[physician's telephone]

Certification _____

Other credentials _____

***This Report must be signed by a licensed physician.**

Illinois Supported Decision-Making Agreement
Appointment of a Supporter

I, _____(insert Principal's name), make this agreement of my own free will. I agree and designate that the following individual as my Supporter:

Name: _____
Address: _____
Phone Number: _____
Email Address: _____

My Supporter is to help me make decisions for myself and may help with making everyday life decisions relating to the following (<u>only items initialed by Principal</u>):

_____ Obtaining food, clothing, and shelter.
_____ Taking care of my physical and emotional health.
_____ Managing my financial affairs.
_____ Applying for public benefits.
_____ Helping me find work.
_____ Assisting with residential services.
_____ Helping me with school.
_____ Helping me advocate for myself.
_____ Other, describe: _____

<u>My Supporter is not allowed to make decisions for me.</u> 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, housing and treatment records;

2) help me understand my options so that I can make an informed decision; and

3) help me communicate my decision to appropriate persons.

I want my Supporter to have (<u>only items initialed by principal</u>):

_____ A release allowing my supporter to see protected health information under the Health Insurance Portability and Accountability Act of 1996, and/or confidential information under the Mental Health and Developmental Disabilities Confidentiality Act, and/or to see substance abuse records under Confidentiality of Alcohol and Drug Abuse Patient Records regulations is attached.

_____A release allowing my supporter to see educational records under the Family Educational Rights and Privacy Act of 1974 and the Illinois School Records Act is attached.

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____

_____ _____

(Signature of Principal) **(Printed Name of Principal)**

Consent of Supporter

Important Information for the Supporter: Duties

If you agree to provide support to the Principal, 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.

I, _____(name of supporter), consent to act as a supporter under this agreement.

_____ _____

(Signature of Supporter) **(Printed Name of Supporter)**

Witness Signatures

_____ _____

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

_____ _____

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

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 ADULT PROTECTIVE SERVICES HOTLINE:

1-866-800-1409 OR 1-888-206-1327 (TTY)

This form is not intended to exclude other forms or agreements that identify the principal, supporter, and types of support.

Release of Information for Supporter Involvement (School Related Support)

This disclosure of information is necessary to accomplish the statutory purposes of the Supported Decision-Making Act. The Principal under a Supported Decision-Making Agreement is requesting the disclosure of educational information pursuant to 740 ILCS 110/5, 105 ILCS 10/5 and 10/6 and 34 C.F.R 99.30.

I, _____
(Name of Principal in a Supported Decision- Making Agreement which should accompany this release),

Authorize:

_____
(Name of School District or Special Education Program to release information)

To Release Information To:

_____
(Name of Supporter in a Supported Decision-Making Agreement)

For the purpose of carrying out Supporter duties under a Supported Decision-Making Agreement. List the types of information to be released to the Supporter (such as academic records, evaluations, psychological testing, IEPs):

_____

I understand that I may revoke this consent at any time and that the above-named person authorized to receive this information has the right to limit, consent, inspect, copy and challenge information in the records to be disclosed. It has been explained to me that if I refuse to consent to this release of information, the supporter will not receive information about my education.

_____	**_____**
(Witness Signature)	**(Signature of Principal/Student age 18 or over)**
_____	**_____**
(Date)	**(Date)**

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Act, you may not redisclose any information unless the person who consented to this disclosure specifically consents to such redisclosure.

Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorization for such redisclosure.

Release of Information for Supporter Involvement (Non-School Related Support)

This disclosure of information is necessary to accomplish the statutory purposes of the Supported Decision-Making Act.

I, _____
(Name of Principal in a Supported Decision- Making Agreement which should accompany this release),

Authorize:

_____
(Name of Entity to release information)

To Release Information To:

_____
(Name of Supporter in a Supported Decision-Making Agreement)

For the purpose of carrying out Supporter duties under a Supported Decision-Making Agreement. Specific information to be released (list types of information to be released to the Supporter such as financial, medical or psychological information):

_____

I understand that I may revoke this consent in writing at any time and that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person/agency otherwise authorized to disclose records and communications. I Understand that the above-named person authorized to receive this information has the right to inspect and copy information to be disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA regulations (45 CFR 160; 164). I understand that the records and communications to be disclosed may include sensitive information such as evaluations, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse, sickle cell anemia and sexually transmitted diseases or HIV/AIDS unless specifically designated for exclusion:_____

It has been explained to me and I understand that my refusal to consent to this release of information will prevent information from being released and reviewed by my Supporter in a Supported Decision-Making Agreement. I understand that entities may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. This authorization is valid for 12 months following the date of signature.

_____ **_____**
(Witness Signature) **(Signature of Principal)**

_____ **_____**
(Date) **(Date)**

Standards for Privacy of Personally Identifiable Information under 45 CFR 160 and 164 state that information used or disclosed by this authorization may be subject to redisclosure by the recipient of the information. Federal Confidentiality Rules under 42 CFR 2 prohibit further disclosure of drug or alcohol information unless further disclosure is permitted by written consent of the person it pertains to or as otherwise permitted under 42 CFR 1.

Declaration for Mental Health Treatment

I_____, born on_____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by two physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

_____

_____

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

_____ I consent to the administration of the following medications:

_____

_____ I do not consent to the administration of the following medications:

_____

Conditions or limitations: _____

_____

_____

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

_____ I consent to the administration of electroconvulsive treatment.

_____ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations:_____

_____

_____

_____

(continued)

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

_____ I consent to being admitted to a health care facility for mental health treatment.

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations:_____

_____

_____

SELECTION OF PHYSICIAN *(optional)*

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose Dr. _____ of _____ to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

_____

_____

_____

Conditions or limitations: _____

_____

ATTORNEY-IN-FACT

I hereby appoint:

NAME_____

ADDRESS _____

TELEPHONE# _____

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

(continued)

ATTORNEY-IN-FACT *(continued)*

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

NAME_____

ADDRESS_____

TELEPHONE# _____

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interest.

_____

(Signature of Principal/Date)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

A person appointed as an attorney-in-fact by this document;

The principal's attending physician or mental health service provider or a relative of the physician or provider;

The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or

A person related to the principal by blood, marriage or adoption.

Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

_____ _____

(Signature of Attorney-in-fact/Date) (Printed Name of Witness)

_____ _____

(Signature of Attorney-in-fact/Date) (Printed Name of Witness)

(continued)

NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about three types of mental health treatment: psychotropic medication, electroconvulsive therapy, and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if two physicians or the court believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time.

This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to your attending physician in writing and is signed by you and a physician. The revocation may be in a form similar to the following:

REVOCATION

I,_____, willfully and voluntarily revoke my declaration for mental health treatment as indicated

[ ] I revoke my entire declaration

[ ] I revoke the following portion of my declaration

_____

_____

_____

Date _____ Signed _____
(Signature of principal)

I, Dr. _____, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

Date _____ Signed _____
(Signature of physician)

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

History
(Source: P.A. 89-439, § 75.)