

## Supported Decision-Making Agreement

This agreement is governed by the Supported Decision-Making Act, Chapter 1357 of the Texas Estates Code. This supported decision-making agreement is to support and accommodate an individual with a disability to make life decisions, including decisions related to where and with whom the individual wants to live, the services, supports, and medical care the individual wants to receive, and where the individual wants to work, without impeding the self-determination of the individual with a disability. This agreement may be revoked by the individual with a disability or his or her supporter at any time. If either the individual with a disability or his or her supporter has any questions about the agreement, he or she should speak with a lawyer before signing this supported decision-making agreement.

Appointment of Supporter:

I (Name of Adult with Disability), \_\_\_\_\_ am entering into this agreement voluntarily.

I choose (Name of Supporters) \_\_\_\_\_ to be my Supporter.

Supporters' Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

My Supporters may help me with life decisions about:

Yes \_\_\_ No \_\_\_ obtaining food, clothing and a place to live

Yes \_\_\_ No \_\_\_ my physical health

Yes \_\_\_ No \_\_\_ my mental health

Yes \_\_\_ No \_\_\_ managing my money or property

Yes \_\_\_ No \_\_\_ getting an education or other training

Yes \_\_\_ No \_\_\_ choosing and maintaining my services and supports

Yes \_\_\_ No \_\_\_ finding a job

Yes \_\_\_ No \_\_\_ Other: \_\_\_\_\_

My Supporters do not make decisions for me. To help me make decisions, my Supporters may:

1. Help me get the information I need to make medical, psychological, financial, or educational decisions;
2. Help me understand my choices so I can make the best decision for me; or
3. Help me communicate my decision to the right people.

Yes \_\_\_ No \_\_\_ My Supporters may see my private health information under the Health Insurance Portability and Accountability Act of 1996. I will provide a signed release.

Yes \_\_\_ No \_\_\_ My Supporters may see my educational records under the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. Section 1232g). I will provide a signed release.

This agreement starts when signed and will continue until \_\_\_\_\_ (date) or until my Supporters or I end the agreement or the agreement ends by law.

Signed this \_\_\_\_\_ (day) of \_\_\_\_\_ (month), \_\_\_\_\_ (year)

\_\_\_\_\_  
(Signature of Adult with Disability)

\_\_\_\_\_  
(Printed Name of Adult with Disability)

**IMPORTANT INFORMATION FOR SUPPORTERS:**

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 loyally and without self-interest; and
3. Avoid conflicts of interest.

**CONSENT OF SUPPORTER**

I (Name of Supporter), \_\_\_\_\_ consent to act as a Supporter under this agreement.

\_\_\_\_\_  
(Signature of Supporter)

\_\_\_\_\_  
(Printed Name of Supporter)

**CONSENT OF SUPPORTER**

I (Name of Supporter), \_\_\_\_\_ consent to act as a Supporter under this agreement.

\_\_\_\_\_  
(Signature of Supporter)

\_\_\_\_\_  
(Printed Name of Supporter)

**This agreement must be signed in front of two witnesses or a Notary Public.**

\_\_\_\_\_  
(Witness 1 Signature)

\_\_\_\_\_  
(Printed Name of Witness 1)

\_\_\_\_\_  
(Witness 2 Signature)

\_\_\_\_\_  
(Printed Name of Witness 2)

OR

Notary Public

State of \_\_\_\_\_

County of \_\_\_\_\_

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

By \_\_\_\_\_ and \_\_\_\_\_  
(Name of Adult with a Disability) (Name of Supporter)

\_\_\_\_\_  
(Signature of Notary)

\_\_\_\_\_  
(Printed Name of Notary)

(Seal, if any, of notary)

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](http://www.txabusehotline.org)**.

## **DUTY OF CERTAIN PERSONS WITH RESPECT TO AGREEMENT**

A person who receives the original or a copy of a supported decision-making agreement shall rely on the agreement. A person is not subject to criminal or civil liability and has not engaged in professional misconduct for an act or omission if the act or omission is done in good faith and in reliance on a supported decision-making agreement