Disability Rights TEXAS

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SUPPORTED DECISION-MAKING AGREEMENTS

Most people with disabilities can manage their own affairs with assistance and guidance from a person whom they trust and do not need a guardian. There are many alternatives to guardianship that give people with disabilities support to make decisions without taking away their rights. During the 84th Texas Legislative Session in 2015, legislators passed new laws that make Texas the first state to have laws recognizing supported decision-making agreements as an alternative to guardianship.

What is Supported Decision-Making?

Supported decision-making allows individuals to make their own decisions and stay in charge of their lives, while receiving the help and assistance they need to do so. All people need and use support to make important life decisions. Even if a person with a disability needs extra help to make significant life decisions, their right to make their own choices should not be taken away. Using a supported decision-making agreement, a person with a disability chooses someone they trust to serve as their supporter.

Under a supported decision-making agreement, the supporter **CAN** help a person with a disability:

- Understand the options, responsibilities, and consequences of their decisions.
- Obtain and understand information relevant to their decisions.
- Communicate their decisions to the appropriate people.

Under a supported decision-making agreement, the **supporter CANNOT** make a decision for a person with a disability.

Who Can Enter Into the Agreement?

A supported decision-making agreement may be entered into by an adult with a disability, defined as "a physical or mental impairment that substantially limits one or more major life activities." The adult with a disability must voluntarily agree to the supported decision-making agreement and cannot be pressured into entering a supported decision-making agreement.

The law does not establish a specific level of capacity required for an individual to enter into a supported decision-making agreement. The individual should have the ability to understand that he or she needs assistance in making particular decisions, to choose a trusted friend or trusted family to be his or her supporter and be able to make decisions with the help of the supporter.

Who Can Be the Supporter?

Any adult may be a supporter. Usually it is a family member or friend. The adult with a disability must choose who will serve as his or her supporter. The individual should pick someone they trust. A supported decision-making agreement is based on trust. An adult with a disability cannot be told whom to select as his or her supporter.

What does the Agreement do?
The adult with a disability may allow his or her supporter to help gather information needed for a life decision, support the decision-making process by helping the adult evaluate and understand the options and consequences, and communicate that decision to other parties. The agreement may be established for one specific decision or for many decisions. The agreement may be customized to fit the situation as long as it is substantially similar to the statutory form.

What Authority Does The Supporter Have?
The supporter has no authority to make the decisions for the adult with a disability. The supporter is only allowed to assist the individual with whatever is specified in the agreement. The supporter helps the individual gather information and understand that information in order to make an informed decision. The supporter can also assist the person with a disability in communicating the decision to the necessary third parties. The supporter merely assists the individual—the individual with a disability is "the decider."

What Rights Are Maintained By The Adult With a Disability?
The adult maintains the right to make the decisions, including where to live, with whom to live, where to work, and what supports and services they want. The individual can reject the advice of the supporter or make life decisions without the assistance of the supporter..

How Does It Differ From a Power of Attorney?
A power of attorney grants another person the authority to make decisions and handle matters without input from the individual. A supported decision-making agreement does not give the supporter the power to make decisions. The person with a disability retains right to make decisions for himself or herself.

Can Supported Decision-Making Be Used With Guardianship And Other Alternatives?
A Supported decision-making agreement could be used in conjunction with other alternatives to guardianship such as powers of attorney and representative payee. The use of other alternatives to guardianship with a supported decision-making agreement should be consistent with the goal of promoting self-determination of the person with a disability and avoiding a full guardianship.

For more information or assistance in getting a Supported Decision-Making Agreement contact Disability Rights Texas at 1-800-252-9108 or go to intake.DRTx.org to submit a request online.

This handout is available in Braille and/or on audio tape upon request.

Disability Rights Texas strives to update its materials on an annual basis, and this handout is based upon the law at the time it was written. The law changes frequently and is subject to various interpretations by different courts. Future changes in the law may make some information in this handout inaccurate. This handout is not intended to and does not replace an attorney's advice or assistance based on your particular situation.

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 the individual wants to live, the services, supports, and medical care the individual wants to receive, whom the individual wants to live with, 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 Supporter)_____ to be my Supporter.

Supporter's Address: _____

Phone Number: _____

E-mail Address: _____

My Supporter 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 Supporter does not make decisions for me. To help me make decisions, my Supporter 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 Supporter 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 Supporter 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 Supporter 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)

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.**

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

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION UNDER A SUPPORTED DECISION-MAKING AGREEMENT

NAME OF ADULT WITH A DISABILITY

_____
Last First Middle

DATE OF BIRTH_____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

PHONE (_____)_____ **ALTERNATE PHONE** (_____)_____

I ALLOW THE FOLLOWING PERSON, PROVIDER OR ORGANIZATION TO RELEASE MY INFORMATION, WHICH MAY INCLUDE PROTECTED HEALTH INFORMATION:

Name _____
Address _____
City _____ State _____ Zip _____
Phone (_____)_____ Fax (_____)_____

Name of Supporter Who Can Receive the Confidential Information?

Name _____
Address _____
City _____ State _____ Zip _____
Phone (_____)_____ Fax (_____)_____

REASON FOR RELEASE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Legal Purposes
- ☐ School
- ☐ Employment
- ☐ Other_____

WHAT INFORMATION CAN BE RELEASED? Complete the following by choosing those items that you want released. Check one of the following:

1. HEALTH/MENTAL HEALTH INFORMATION

- ☐ All health/mental health information:
- ☐ Only the following health/mental health information: _____

Your initials are required to release the following information:

___ Psychotherapy Notes
___ HIV/AIDS Test Results/Treatment
___ Drug, Alcohol, or Substance Abuse Records

2. CASE-RELATED INFORMATION

- ☐ My entire case file/records
- ☐ Only the following case-related information: _____

3. EDUCATION/SPECIAL EDUCATION INFORMATION

- ☐ All education/special education records
- ☐ Only the following education/special education records: _____

4. EMPLOYMENT INFORMATION

- ☐ All employment records
- ☐ Only the following employment information: _____

5. FINANCIAL/PROPERTY INFORMATION

☐ All financial/property records

☐ Only the following financial/property information: _____

_____

_____

6. HOUSING INFORMATION

☐ All housing records

☐ Only the following housing information: _____

_____

_____

7. SUPPORTS AND SERVICES

☐ All records related to any supports and services provided to me

☐ Only the following supports and services information: _____

_____

_____

PURPOSE OF AUTHORIZATION: I have entered a supported decision-making agreement with my supporter. I only authorize the release of my confidential information to my supporter so that my supporter can help me obtain a copy of the confidential information, help me understand the information contained in this confidential information and help me communicate my decisions based on this confidential information. My supporter shall ensure that my confidential information is kept privileged and confidential and is not subject to unauthorized access, use or disclosure. My supporter may only release my confidential information to any other person, provider or organization with my permission. I also retain the right to obtain my confidential information on my own without the help of my supporter.

EFFECTIVE TIME PERIOD. This authorization is valid until my death; the end of my supported decision-making agreement; my permission is withdrawn; or until (date): Month _____ Day ____ Year ____.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to release information to my supporter.

SIGNATURE AUTHORIZATION: I agree to the release of my confidential information to my supporter. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that I cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. I have read and agree with how my confidential information may be used and shared with my supporter.

SIGNATURE _____ _____

Signature of Adult with Disability **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Developed Pursuant Texas Health & Safety Code § 181.154(d)
Effective October 1, 2015

This authorization is based on a standard Authorization to Disclose Protected Health Information adopted by the Attorney General of Texas in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities must obtain a signed authorization form from the individual or the individual's legally authorized representative to electronically release that individual's protected health information.

The authorization provided by use of this form means that the organization, entity or person authorized can release, communicate, or send the named individual's protected health information to the organization, entity or person identified on this form, including through the use of any electronic means.

Definitions – In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 C.F.R. §164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health/Mental Health Information to be Released – If "All Health/Mental Health Information" is selected for release, health/mental health information includes, but is not limited to, all records and other information regarding health/mental health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health/mental health information. As indicated on this form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Psychotherapy notes.
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.

Note on Release of Health Records – This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a physician or mental health professional makes such a determination, DRTx will advise the individual about how the individual may seek access to these records under state or federal law.

Limitations of this form – This authorization form should only be used for the release of psychotherapy notes when the individual specifically requests the release of psychotherapy notes. **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 C.F.R. Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges – Some covered entities may charge a retrieval/processing fee and for copies of medical records (Tex. Health & Safety Code § 241.154).

Right to Receive Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.