MAKING MY OWN CHOICES

An Easy-to-Follow Guide on Supported Decision-Making Agreements

About Disability Rights Texas

Beginning in 1975, Congress created a national network of protection and advocacy organizations to help secure and advance the rights of people with disabilities. Disability Rights Texas is the federally mandated legal protection and advocacy agency for people with disabilities in Texas. Our mission is to help people with disabilities understand and exercise their rights under the law, ensuring their full and equal protection in society. Our lawyers and advocates fulfill this mission through individual advocacy, legal representation, policy work, and systems reform initiatives.

www.DRTx.org
Statewide Intake Phone Line for New Callers
9 am – 4 pm, Monday – Friday
1 (800) 252-9108

Online Intake (Available 24/7)
intake.drtx.org

Statewide Video Toll Free Phone Line
1 (866) 362-2851

Main Office
2222 West Braker Lane
Austin, TX 78758
(512) 454-4816 (Voice)
(512) 323-0902 (Fax)

The information in this publication does not substitute for the advice of an attorney.

Financial support for this publication was provided by the Texas Council for Developmental Disabilities with federal funds made available by the US Department of Health and Human Services Administration on Intellectual and Developmental Disabilities. The views contained herein do not necessarily reflect the position or policy of the funding agencies.

Making My Own Choices

An Easy-to-Follow Guide on Supported Decision-Making Agreements

What's Inside This Guide:

- What is self-determination? 1
- What is guardianship? 2
- What are alternatives to guardianship? 3
- What are supports and services? 4
- What is supported decision-making? 5
- How does supported decision-making work? 6
- Decision-making worksheet 7
- How do I fill out a supported decision-making agreement? 8
  - Step 1 8
  - Step 2 9
  - Step 3 10
  - Step 4 11
  - Step 5 12
  - Step 6 13
  - Step 7 14
  - Step 8 15
  - Step 9 16
  - Step 10 17
  - Step 11 18
- Sample Forms 19

An Easy-to-Follow Guide on Supported Decision-Making Agreements

What is self-determination?

Self-determination is making your own choices. You have a right to make your own decisions.
You make decisions every day. You choose things like:

- What to wear
- Where to work
- Which friends or family members to spend time with
- And more!

All people need help to make important decisions. You have the right to make your own choices, even if you need help. Your right to make choices should not be taken away just because you need help.

What is guardianship?

Guardianship is when a judge decides that a person with a disability cannot make their own decisions. The judge chooses a guardian. A guardian is someone who makes decisions for you.

Under guardianship, you can lose your rights to:

- Choose where you live
- Make medical decisions
- Choose where you work
- Drive
- Vote
- Get married
- And more

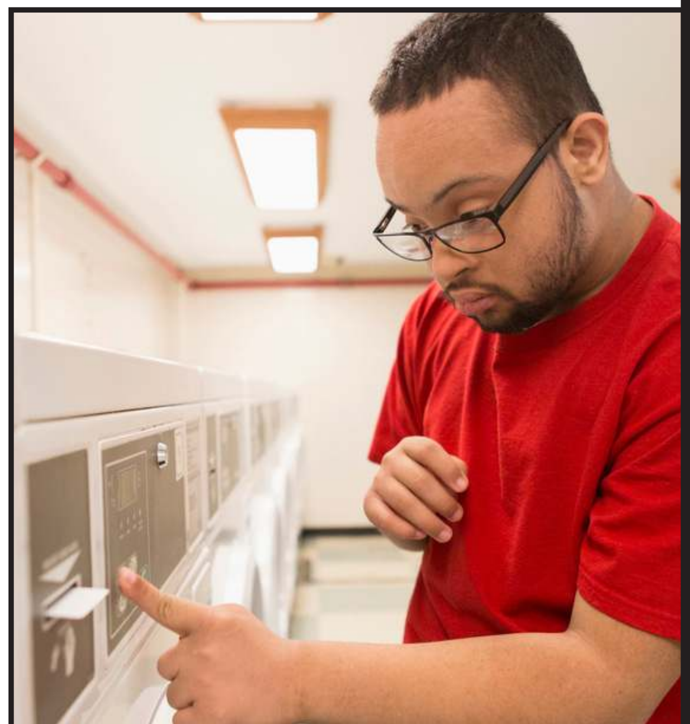
Full guardianship means the guardian makes every decision. Limited guardianship means the guardian only makes certain decisions.

What are alternatives to guardianship?

Alternatives to guardianship are ways that can help you make life decisions and get support without having your rights taken away. Here are a few alternatives to guardianship:

- **Supported Decision-Making:** This is when someone you trust helps you make choices.
- **Power of Attorney:** You give someone else permission to make some decisions for you, but you still keep your right to make decisions without this person. These could be medical, school, money, or other kinds of decisions.
- **Representative Payee:** If you receive SSI or other social security, someone will keep track of and manage your money.
- **Special Needs Trust:** A trust is an account where you and others save money for your benefit, and you will not lose your Medicaid or SSI benefits.
- **ABLE Account:** This is a special bank account you have control over. You can save money in an ABLE Account and still get all of your Medicaid or SSI benefits.
  More information at www.texasable.org.
- **Joint Bank Account:** This is an account you and someone else share. You and the other person can both put money in and take money out.
- **Person-Centered Planning:** This is when people you choose help you plan for your future. They help you decide what is important to you.
  They also ask what helps keep you safe and healthy. With people you trust, you can make goals for your life. They help you make decisions about what you want.

For more information on these options, call Disability Rights Texas at 1-800-252-9108 or visit www.DRTx.org, call The Arc of Texas at 1-800-252-9729 or visit www.arcoftexas.org, or talk to someone you trust.



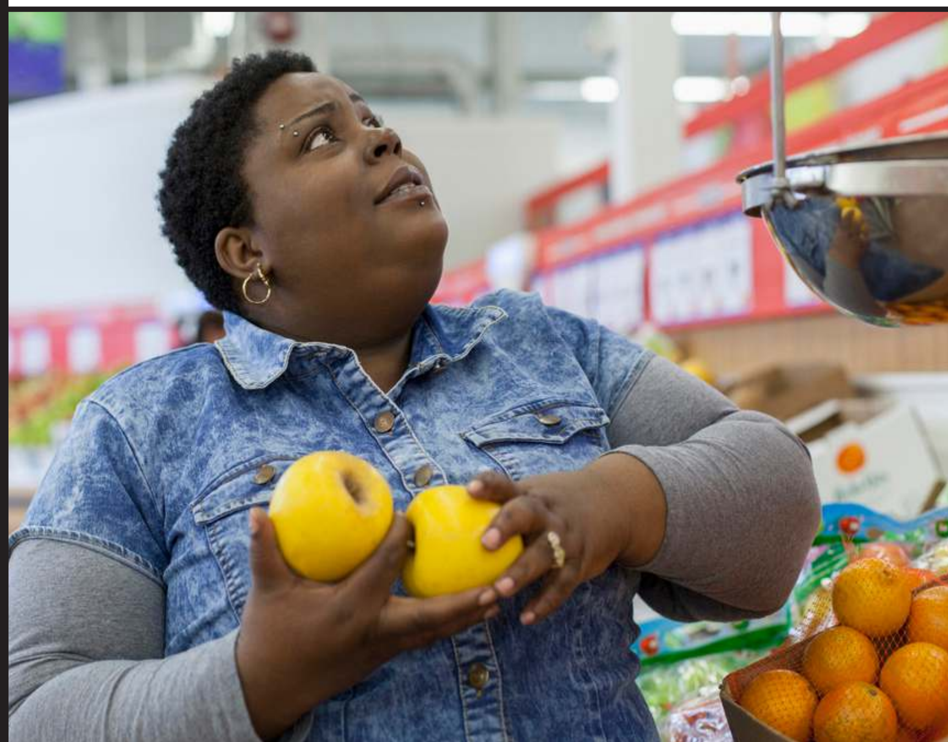
What are supports and services?

You can get supports and services to help you make life choices instead of getting a guardian. For example, a friend or family member may help you pay your bills. Or an attendant could help you get dressed and cook food.

Many people with disabilities also get help through something called a Medicaid waiver. Medicaid waivers have waiting lists, so be sure to get on an interest list.

To find out more about Medicaid waivers, call 1-855-937-2372 or go to hhs.texas.gov/laws-regulations/policies-rules/waivers.

Another thing you can use is supported decision-making.



What is supported decision-making?

Supported decision-making means choosing someone you trust to help you make decisions. Your helper, or supporter, can be someone like your parents or a good friend.

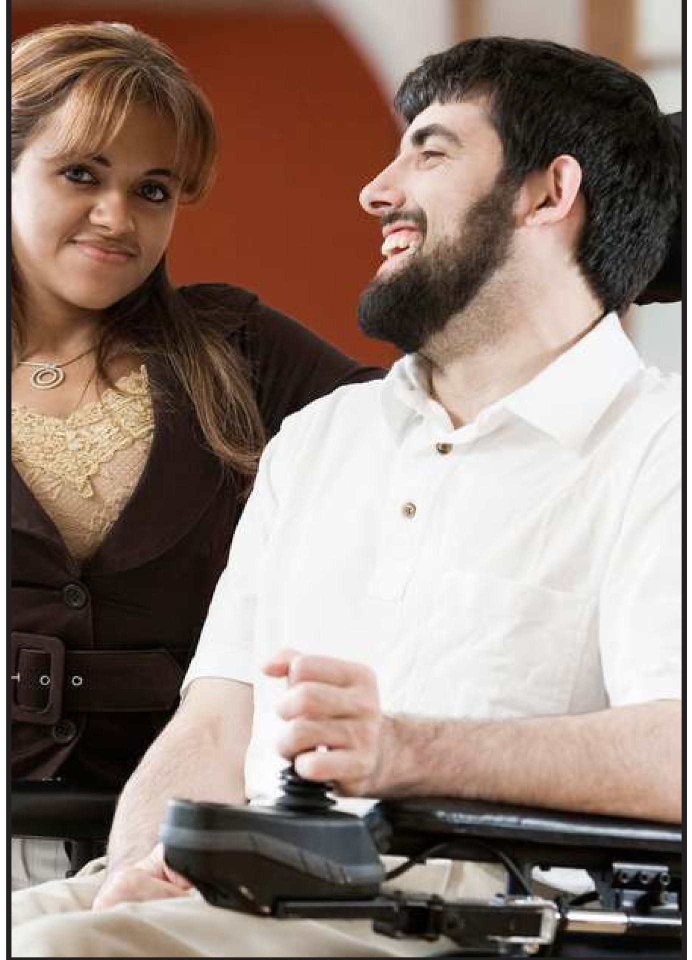
Your supporter CANNOT make decisions for you. Your supporter CAN, however:

- Help you understand your choices and decisions
- Help you get and understand information to help you make your decisions
- Help you tell your decisions to other people
- With supported decision-making, you make your own choices with help. This lets you be more independent

How does supported decision-making work?

If you want to use supported decision-making, follow the steps below.

- Choose people you trust to help you make decisions.
- Ask them to be your supporter(s). You can change your mind and say you don't want this person to support you whenever you want.
- Think about what decisions you need help making. Your supporter can help you choose things like where to live, where to work, what medical help you want, and more.
- Create a written plan called a supported decision-making agreement.



When you need to make a decision and want help, you can ask your supporter(s) to help you. You can also take your agreement with you to the doctor, to school, when looking at places to live, and more!

You can use the worksheet on the next page to help you think about the decisions you make and who can help you make them. After the worksheet, you will find step-by-step help on how to fill out a supported decision-making agreement. You can find a copy of a blank supported decision-making agreement that you can use in the Sample Forms section of this guide.

Decision-Making Worksheet

Choices I Make	Do I need Help?			Who Could Help Me?
	Yes	No	Sometimes	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

How do I fill out a supported decision-making agreement?

Before filling out a supported decision-making agreement, you will need the following:

- Your supporter(s)
- A blank copy of the supported decision-making agreement (see Sample Forms section of this guide.
- Two people over age 14 (called witnesses) OR a notary public
- Your decision-making worksheet, if you filled one out

STEP 1: WHAT IS A SUPPORTED DECISION-MAKING AGREEMENT?

The first paragraph in the agreement explains what supported decision-making is, and that it is in the law. Your supporter can help explain this paragraph to you if it is confusing.

> *"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."*

STEP 2: WHO IS MAKING THE AGREEMENT?

It says "Appointment of Supporter." This means you are choosing someone to help you make decisions.

You should write your name on the next line. Write your name after "I (Name of Adult with Disability)".

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

On the next lines, your supporter will write her/his name. The supporter also puts her/his address, phone number, and email address.

I choose (Name of Supporter) _____________________ ____________________ to be my Supporter. *Supporter's Address:* ____ *Phone Number:* ____ *E-mail Address:* ____

STEP 3: WHAT DECISIONS DO YOU WANT HELP WITH?

Put an X in the boxes for the types of decisions you want your supporter to help with. You can check yes or no for each type of decision. For example, if you want your supporter to help with decisions about your medical care, you would check yes on the second line, before "my physical health." You can write other kinds of decisions on the last line.

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:____

STEP 4: WHAT PRIVATE INFORMATION ABOUT YOU DO YOU WANT TO SHARE WITH OTHERS?

The lines below have to do with your private information. The first one asks if your supporter can see your private medical records. The second one asks if your supporter can see your private school records.

You can check yes or no for these questions. The decision is up to you. If you say "yes," your supporter will use the private information to help you make choices. If you say "no", you will decide what information you need to share with your supporter to help you make decisions.

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.**

* If you want your supporter to get your records for you, you must sign the Authorization to Release Confidential Information form found in the last section of this guide.

STEP 5: WHEN DOES THE AGREEMENT START AND END?

The next part says that the agreement starts when you and your supporter sign it. You or your supporter can end the agreement whenever either of you want. You can also pick a day for the agreement to end. If you want the agreement to end on a certain day, you write it in the space below.

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.

STEP 6: YOU SIGN THE AGREEMENT.

At the bottom of the first page, you put the date that you signed the agreement and sign and print your name. By signing, you are saying that you want your supporter to help you make decisions.

Signed this ____________ (day) of _______________________ (month), ______________ (year)

(Signature of Adult with Disability) ______________________________

(Printed Name of Adult with Disability) ______________________________

STEP 7: INFORMATION FOR SUPPORTERS.

This part says that your supporter must help you in ways that are best for you and not the supporter or anyone else.

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

STEP 8: YOUR SUPPORTER SIGNS THE AGREEMENT.

Your supporter signs the top of the second page where it says, "I (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)*

STEP 9: WITNESSES SIGN THE AGREEMENT.

In the middle of page 2, two people over 14 years old sign and write out their names. These people are called witnesses. If you don't have two witnesses, you can have someone called a "notary public" sign. They also put a stamp on the agreement. A notary public might be at your bank.

This agreement must be signed in front of two witness 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 Person with Disability) *(Name of Supporter)*

______________________________	___________________________________
(Signature of Notary)	*(Printed Name of Notary)*

(Seal (if any) of Notary) *My commission expires:* _________________________________

STEP 10: PROTECTION FROM HARM.

This part says that your supporter should not hurt you or take advantage of you. If your supporter is hurting or taking advantage of you, you can call the Texas Department of Family and Protective Services Abuse Hotline at 1-800-252-5400 for help.

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.

STEP 11: RELYING ON THE AGREEMENT.

The last part tells doctors, teachers, providers and other people who get the agreement that they should accept it. They won't get in trouble for letting your supporter help you. If you have problems with people letting you use your supported decision-making agreement, please call Disability Rights Texas at 1-800-252-9108 or The Arc of Texas at 1-800-252-9729.

> *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.*

With supported decision-making, you make your own choices. You make decisions with help from people you trust. You can use this tool to live the life you want! ■

Sample Forms

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 Supporter)____ to be my Supporter.

Supporter's Address:____State______ Zip____________

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___ managing my money or property

Yes ___ No___ getting an education or other training

Yes ___ No___ choosing and maintaining my services and supports

Yes ___ No___ Other: ____

Yes ___ No___ my physical health

Yes ___ No___ my mental health

Yes ___ No___ finding a job

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

- Help me get the information I need to make medical, psychological, financial, or educational decisions;
- Help me understand my choices so I can make the best decision for me; or
- 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)*

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)*

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

____ ____

(Signature of Witness 1) *(Signature of Witness 2)*

____ ____

(Printed Name of Witness 1) *(Printed Name of Witness 2)*

OR

Notary Public

State of ______________________________ County of ____

This document was acknowledged before me on this ___________(day) of ____________________________ (month), ____________________ (year)

By ____ and

____

(Name of Adult with 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 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
- ☐ Legal Purposes
- ☐ Employment
- ☐ Personal Use
- ☐ School
- ☐ 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** ____
- ☐ **Drug, Alcohol, or Substance Abuse Records** ____
- ☐ **HIV/AIDS Test Results/Treatment** ____

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 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.

What's Inside

Information about:

- Self-determination
- Guardianship
- Alternatives to guardianship
- Supports and services
- Supported decision-making
- Supported decision-making worksheet
- Sample Forms

www.DRTx.org

April 2018 Edition