SUPPORTED DECISION-MAKING AGREEMENT

Delaware Code Title 16, Chapter 94A, Section 9401A

This form is to be read aloud or otherwise communicated, in the presence of the witnesses and parties to the agreement. The form of communication shall be appropriate to the needs of the individual with the disability, that individual's language (an interpreter must be present for foreign languages and alternative forms of communication) and sensory processing wants or needs.

This form is to be used for the appointment of a person(s) to help me make decisions. A Supported Decision-Making Agreement is a written agreement between me and my appointed person(s). The person(s) I appoint helps me make decisions. **My appointed person(s) does not make decisions for me.** A Supported Decision-Making Agreement is effective if I am at least 18 years of age and able to understand the nature and effect of this agreement. I can revoke this agreement at any time and with notice to the appointed Supported Decision-Maker(s). This agreement takes effect as soon as it is signed by all the required individuals. This agreement supersedes any other Supported Decision-Making Agreement made by me. This agreement is not durable and would not survive a determination of incapacity under Delaware Code.

1. This is the Supported Decision-Making Agreement of:

Name_____ Date of Birth_____
Address_____
Phone_____
Email_____

2. My Supported Decision-Maker

I appoint the following person(s) to be my Supported Decision-Maker(s):

Supported Decision-Maker:

Name_____
Address_____
Phone (wk)_____ (hm)_____(cell)_____
Email_____

3. Alternate Supported Decision-Maker (Optional) – if there is no Alternate, please cross out this section.

If my Supported Decision-Maker named above declines to help me or is unable or unavailable to help me within a reasonable time period, I want the following person to help me as my Supported Decision-Maker:

Name_____
Address_____
Phone (wk)_____ (hm)_____(cell)_____
Email_____

4. Areas I Want My Supported Decision-Maker to Help Me

I want my Supported Decision-Maker(s) to help me make decisions in the following areas:

a) Health Affairs ☐ _____initials

Access or obtain any information that will help me make decisions. Help me make appointments with health care providers. Help me keep track of information about my health care, including my medical records and help me with creating my health care plan and activities of daily living. Help me understand information about health care decisions I have to make, now or in the future, so that I can make my own decisions about my health care. Communicate or assist me in communicating my decision to other persons. My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996, and I will provide a signed release.

Add any additional information:

_____

_____

_____

b) Supportive Services ☐ _____initials

Defined as a coordinated system of social and others services supplied by private, state, institutional, or community providers designed to help maintain the independence of an adult. Communicate or assist me in communicating my decision to other persons. For more specifics see DE Code, Title 16, Ch. 94A. Access or obtain any information that will help me make decisions. My Supporter may see my educational records under the Family Education Rights and Privacy Act of 1974 (20 U.S.C. Section 1232g), and I will provide a signed release.

Add any additional information:

_____

_____

_____

c) Financial Affairs ☐ _____initials

Access or obtain any information that will help me make decisions. Help me obtain information and understand information about financial affairs, including but not limited to assets and resources and their use and management for my clothing, support, care, comfort, education, health care and shelter. Communicate or assist me in communicating my decision to other persons.

Add any additional information:

_____

_____

_____

5. Areas I DO NOT Want My Supported Decision-Maker(s) To Help Me (if any)

I do not want my Supported Decision-Maker(s) to help me in making these kinds of decisions:

_____

_____

_____

6. Signatures (me, my Supported Decision-Maker(s) and the witnesses must sign together at the same time)

Adult
I am at least 18 years of age and I understand the nature and effect of this agreement.

_____	_____	_____
Print Name	Signature	Date

Supported Decision-Maker #1

_____	_____	_____
Print Name	Signature	Date

Alternate Supported Decision-Maker (optional) - <u>if there is no Alternate, please cross out this section.</u>

_____	_____	_____
Print Name	Signature	Date

Witnesses
Two adults must witness my signature and the signature(s) of my Supported Decision-Maker(s) and sign together in my presence. The witnesses CANNOT be a Supported Decision-Maker of the adult. They also CANNOT be an employee or an agent of the Supported Decision-Maker. As well, they CANNOT be a spouse, child or parent of the Supported Decision-Maker or an employee of the Supported Decision-Maker.

_____	_____	_____
Print Name	Witness Signature	Date

_____	_____	_____
Print Name	Witness Signature	Date

Concerns about adults who may be in need of protective services should be evaluated and reported in accordance with Title 31 chapter 39.

A person, who in good faith acts in reliance on an authorization in a supported decision-making agreement, or who in good faith declines to honor an authorization in a supported decision-making agreement, is not subject to civil or criminal liability or to discipline for unprofessional conduct.

For further guidance please see Title 16, chapter 94A.

SUPPORTED DECISION-MAKING AGREEMENT DECLARATION

My relationship to the Adult is
_____.

I am willing to act as a supporter.

I acknowledge the duties of a supporter under DE Code Title 16, Chapter 94A.

Supported Decision-Maker #1

_____	_____	_____
Print Name	Signature	Date

Alternate Supported Decision-Maker (optional) <u>if there is no Alternate, please cross out this section.</u>

_____	_____	_____
Print Name	Signature	Date