SUPPORTED DECISION-MAKING

WEST VIRGINIA

EMPOWERED & ABLE!

AGREEMENT

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This program is being implemented by Astrive Advocacy, Inc.

This Document Was Developed Using a Combination of Components and Adaptations from the Following Resources:

- **Disability Rights Texas Supported Decision-Making Agreement**
  www.disabilityrightstx.org/en/publication/supported-decision-making-agreement-sample-form
- **ASAN (Autistic Self Advocacy Network) Supported Health Care Decision-Making Agreement**
  supporteddecisionmaking.org/sites/default/files/asan-sdm-agreement.pdf
- **Nonotuck Resource Associates, Center For Public Representation Supported Decision-Making Agreement**
  supporteddecisions.org/wp-content/uploads/2015/09/SDM-Representation-Agreement-pdf.pdf
- **ACLU/Quality Trust Sample Supported Decision-Making Agreement**
  www.aclu.org/other/aclu-supported-decision-making-agreement
- **The South Carolina Supported Decision-Making Project**
  scsupporteddecisionmaking.org/wp-content/uploads/2017/07/SDM-Representation-Agreement7.28.17.pdf
- **Indiana Sample Agreement - Wings – Working Interdisciplinary Networks Of Guardianship Stakeholders**
  www.in.gov/idr/sdm/files/SDM-Form-v.9-20190523.pdf

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This agreement is a sample of a Supported Decision-Making Agreement. West Virginia does not currently have a law that specifically says that a Supported Decision Making Agreement can be enforced, but there is no law that says that an individual with a disability cannot develop and utilize a Supported Decision-Making Agreement to support and accommodate an individual with a disability to make life decisions without impeding the self-determination of the individual with a disability.

The West Virginia Guardianship and Conservatorship Act [§44A-2-10(a)] states that ***"In making the determination, the court shall consider the suitability of the proposed guardian or conservator, the limitations of the alleged protected person, the development of the person's maximum self-reliance and independence, the availability of less restrictive alternatives including advance directives and the extent to which it is necessary to protect the person from neglect, exploitation, or abuse."*** This supports that premise that guardians are charged with placing the least possible restrictions on the person's ability to make choices, be part of the community, and identify and honor the individual's preferences.

Furthermore, the American Bar Association adopted a Resolution August 14, 2017, encouraging the use of Supported Decision-Making as an alternative to guardianship, and specifically urged states to revise their statutes to include supported decision-making as a legally recognized option.

DECISION-MAKER
The individual with a disability who will be making the final decision

SUPPORTER
The person(s) who will help the Decision-Maker understand their choices and help them make their decisions

Supported Decision-Making Agreements can address decisions related to where and with whom the individual wants to live, the services, supports, medical care the individual wants to receive, employment, education, relationships, finances, legal matters, etc.

Having this sample document is not a substitute for seeking legal advice from an attorney. If you have questions about your legal rights, please talk with an attorney.

This agreement should be reviewed by all parties to the agreement, and t*his agreement must be read out loud or otherwise communicated to all parties to the agreement in the presence of a notary. The form of communication shall be appropriate to the needs and preferences of each party,* **including each individual's language and sensory processing wants or needs.** Each Supporter will acknowledge by signature his/her/their role as determined by the Decision-Maker.

This document is not intended to create an agency agreement between the adult and any Supporters listed in this document. Supporters do not owe a fiduciary duty to the Decision-Maker subject to the agreement, and have no authority to make decisions for the person with a disability.

SUPPORTED DECISION-MAKING AGREEMENT

My name is: _____

My address is: _____

My phone number is: _____

My email address is: _____

I want to have people I trust help me make decisions. The people who will help me are called Supporters. I can say what kind of help my Supporters will give me.

I am entering into this agreement voluntarily and I understand that:

- ☐ **I can talk to an attorney before I sign this agreement.**
- ☐ **I do not have to sign this agreement.**
- ☐ **This agreement is because I want supporters to help me make decisions.**
- ☐ **My supporter cannot make decisions for me.**
- ☐ **I can end this agreement when I want it to.**
- ☐ **I can change this agreement when I want to.**
- ☐ **If I end this agreement or change this agreement, I must let my supporters know about the change. Anyone with a copy of the agreement needs to get a copy of the change in writing.**
- ☐ **I can change my list of supporters when I want to.**
- ☐ **My supporter(s) can quit if they want to.**
- ☐ **If I have more than one Supporter in any area, those Supporters will work jointly (together) unless I note otherwise.**
- ☐ **My Supporter(s) is not liable for any consequences or decisions I make unless my Supporter's actions or omissions amount to fraud, misrepresentation, recklessness, or willful or wanton misconduct.**

My supporters are not allowed to make choices for me. To help me with my choices, my supporters may:

1. **Help me find out more about my options and what choices I have by giving me information in a way I can understand**
2. **Help me understand what the choices are so I can make a good decision for me by discussing both the good things and bad things (pros and cons) that could happen if I make one decision or another**
3. **Help me communicate or tell other people about my decision so the right people know what I want**

This supported decision-making agreement starts right now and will continue until the agreement is stopped by me or my supporters, or the agreement ends by law.

_____ _____

Signature of Decision-Maker Date (Month/Day/Year

APPOINTMENT OF SUPPORTER(S)

SUPPORTER #1

Name: _____

Address: _____

Phone Number: _____

Email address: _____

Relationship: _____

I want this person to help me with making choices about: *(check as many boxes as you want)*

- ☐ **Buying or obtaining food and clothing**
- ☐ **Where I live and who I live with**
- ☐ **My personal relationships, including friendships, dating. sex, and marriage**
- ☐ **How I spend my time, hobbies, and activities**
- ☐ **My education or trainings, including what classes I will take and what accommodations I will have**
- ☐ **If I work and/or where I work, and what accommodations I will have**
- ☐ **Choosing the level of services and supports and managing the people who work with me**
- ☐ **Hiring a lawyer if I need one and working with the lawyer**
- ☐ **My physical health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My mental health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My financial affairs, like banking and budgeting (if ☑ the Finance Addendum must be completed)**
- ☐ **Other:** _____

I express myself and show what I want in the following ways:

Telling people my likes and dislikes.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Telling people what I do and do not want to do.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Areas I specifically do not want Supporter #1 to assist me with:

☐ Finances ☐ Healthcare ☐ Education ☐ Relationships

☐ Employment ☐ Legal Matters ☐ Daily Living ☐ Services/Supports

☐ Yes ☐ No My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996. This lets my Supporters see my medical records. *(*If yes, I will provide a signed release form for *HIPAA Authorization)*

☐ 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). This lets my Supporters see my school information. (If yes, I will provide a signed release form for *Authorization to Disclose Educational Information)*

APPOINTMENT OF SUPPORTER(S)

SUPPORTER #2

Name: _____

Address: _____

Phone Number: _____

Email address: _____

Relationship: _____

I want this person to help me with making choices about: *(check as many boxes as you want)*

- ☐ **Buying or obtaining food and clothing**
- ☐ **Where I live and who I live with**
- ☐ **My personal relationships, including friendships, dating. sex, and marriage**
- ☐ **How I spend my time, hobbies, and activities**
- ☐ **My education or trainings, including what classes I will take and what accommodations I will have**
- ☐ **If I work and/or where I work, and what accommodations I will have**
- ☐ **Choosing the level of services and supports and managing the people who work with me**
- ☐ **Hiring a lawyer if I need one and working with the lawyer**
- ☐ **My physical health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My mental health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My financial affairs, like banking and budgeting (if ☑ the Finance Addendum must be completed)**
- ☐ **Other:** _____

I express myself and show what I want in the following ways:

Telling people my likes and dislikes.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Telling people what I do and do not want to do.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Areas I specifically do not want Supporter #1 to assist me with:

☐ Finances ☐ Healthcare ☐ Education ☐ Relationships

☐ Employment ☐ Legal Matters ☐ Daily Living ☐ Services/Supports

☐ Yes ☐ No My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996. This lets my Supporters see my medical records. *(*If yes, I will provide a signed release form for *HIPAA Authorization)*

☐ 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). This lets my Supporters see my school information. (If yes, I will provide a signed release form for *Authorization to Disclose Educational Information)*

APPOINTMENT OF SUPPORTER(S)

SUPPORTER #3

Name: _____

Address: _____

Phone Number: _____

Email address: _____

Relationship: _____

I want this person to help me with making choices about: *(check as many boxes as you want)*

- ☐ **Buying or obtaining food and clothing**
- ☐ **Where I live and who I live with**
- ☐ **My personal relationships, including friendships, dating. sex, and marriage**
- ☐ **How I spend my time, hobbies, and activities**
- ☐ **My education or trainings, including what classes I will take and what accommodations I will have**
- ☐ **If I work and/or where I work, and what accommodations I will have**
- ☐ **Choosing the level of services and supports and managing the people who work with me**
- ☐ **Hiring a lawyer if I need one and working with the lawyer**
- ☐ **My physical health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My mental health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My financial affairs, like banking and budgeting (if ☑ the Finance Addendum must be completed)**
- ☐ **Other:** _____

I express myself and show what I want in the following ways:

Telling people my likes and dislikes.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Telling people what I do and do not want to do.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Areas I specifically do not want Supporter #1 to assist me with:

☐ Finances ☐ Healthcare ☐ Education ☐ Relationships

☐ Employment ☐ Legal Matters ☐ Daily Living ☐ Services/Supports

☐ Yes ☐ No My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996. This lets my Supporters see my medical records. *(*If yes, I will provide a signed release form for *HIPAA Authorization)*

☐ 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). This lets my Supporters see my school information. (If yes, I will provide a signed release form for *Authorization to Disclose Educational Information)*

APPOINTMENT OF SUPPORTER(S)

SUPPORTER #4

Name: _____

Address: _____

Phone Number: _____

Email address: _____

Relationship: _____

I want this person to help me with making choices about: *(check as many boxes as you want)*

- ☐ **Buying or obtaining food and clothing**
- ☐ **Where I live and who I live with**
- ☐ **My personal relationships, including friendships, dating. sex, and marriage**
- ☐ **How I spend my time, hobbies, and activities**
- ☐ **My education or trainings, including what classes I will take and what accommodations I will have**
- ☐ **If I work and/or where I work, and what accommodations I will have**
- ☐ **Choosing the level of services and supports and managing the people who work with me**
- ☐ **Hiring a lawyer if I need one and working with the lawyer**
- ☐ **My physical health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My mental health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My financial affairs, like banking and budgeting (if ☑ the Finance Addendum must be completed)**
- ☐ **Other:** _____

I express myself and show what I want in the following ways:

Telling people my likes and dislikes.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Telling people what I do and do not want to do.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Areas I specifically do not want Supporter #1 to assist me with:

☐ Finances ☐ Healthcare ☐ Education ☐ Relationships

☐ Employment ☐ Legal Matters ☐ Daily Living ☐ Services/Supports

☐ Yes ☐ No My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996. This lets my Supporters see my medical records. *(*If yes, I will provide a signed release form for *HIPAA Authorization)*

☐ 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). This lets my Supporters see my school information. (If yes, I will provide a signed release form for *Authorization to Disclose Educational Information)*

APPOINTMENT OF SUPPORTER(S):

SUPPORTER #5

Name: _____

Address: _____

Phone Number: _____

Email address: _____

Relationship: _____

I want this person to help me with making choices about: *(check as many boxes as you want)*

- ☐ **Buying or obtaining food and clothing**
- ☐ **Where I live and who I live with**
- ☐ **My personal relationships, including friendships, dating. sex, and marriage**
- ☐ **How I spend my time, hobbies, and activities**
- ☐ **My education or trainings, including what classes I will take and what accommodations I will have**
- ☐ **If I work and/or where I work, and what accommodations I will have**
- ☐ **Choosing the level of services and supports and managing the people who work with me**
- ☐ **Hiring a lawyer if I need one and working with the lawyer**
- ☐ **My physical health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My mental health (if ☑ the Healthcare Addendum must be completed)**
- ☐ **My financial affairs, like banking and budgeting (if ☑ the Finance Addendum must be completed)**
- ☐ **Other:** _____

I express myself and show what I want in the following ways:

Telling people my likes and dislikes.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Telling people what I do and do not want to do.

☐ Verbally ☐ In Writing ☐ Using Assistive Technology ☐ Demonstrate ☐ Other _____

Areas I specifically do not want Supporter #1 to assist me with:

☐ Finances ☐ Healthcare ☐ Education ☐ Relationships

☐ Employment ☐ Legal Matters ☐ Daily Living ☐ Services/Supports

☐ Yes ☐ No My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996. This lets my Supporters see my medical records. *(*If yes, I will provide a signed release form for *HIPAA Authorization)*

☐ 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). This lets my Supporters see my school information. (If yes, I will provide a signed release form for *Authorization to Disclose Educational Information)*

CONSENT OF SUPPORTER #1

I, _____ consent to act as _____'s Supporter under this agreement. I understand that my job as a supporter is to honor and express his/her expressed wishes. My support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; and helping this person communicate his/her choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith. In the event I cannot perform my job under this agreement, I will contact the Decision-Maker and/or other team member(s).

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

_____ _____

Printed Name of Supporter Printed Name of Witness

State of West Virginia County of _____

This record was acknowledged before me on _____ (date)

By _____ (Name of Supporter) and

SEAL

_____

Signature of Notary

_____

My Commission Expires: _____ Title of Office

CONSENT OF SUPPORTER #2

I, _____ consent to act as _____'s Supporter under this agreement. I understand that my job as a supporter is to honor and express his/her expressed wishes. My support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; and helping this person communicate his/her choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith. In the event I cannot perform my job under this agreement, I will contact the Decision-Maker and/or other team member(s).

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

_____ _____

Printed Name of Supporter Printed Name of Witness

State of West Virginia County of _____

This record was acknowledged before me on _____ (date)

By _____ (Name of Supporter) and

SEAL

_____

Signature of Notary

_____

My Commission Expires: _____ Title of Office

CONSENT OF SUPPORTER #3

I, _____ consent to act as _____'s Supporter under this agreement. I understand that my job as a supporter is to honor and express his/her expressed wishes. My support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; and helping this person communicate his/her choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith. In the event I cannot perform my job under this agreement, I will contact the Decision-Maker and/or other team member(s).

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

_____ _____

Printed Name of Supporter Printed Name of Witness

State of West Virginia County of _____

This record was acknowledged before me on _____ (date)

By _____ (Name of Supporter) and

SEAL

_____

Signature of Notary

_____

My Commission Expires: _____ Title of Office

CONSENT OF SUPPORTER #4

I, _____ consent to act as _____'s Supporter under this agreement. I understand that my job as a supporter is to honor and express his/her expressed wishes. My support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; and helping this person communicate his/her choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith. In the event I cannot perform my job under this agreement, I will contact the Decision-Maker and/or other team member(s).

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

_____ _____

Printed Name of Supporter Printed Name of Witness

State of West Virginia County of _____

This record was acknowledged before me on _____ (date)

By _____ (Name of Supporter) and

SEAL

_____

Signature of Notary

_____

My Commission Expires: _____ Title of Office

CONSENT OF SUPPORTER #5

I, _____ consent to act as _____'s Supporter under this agreement. I understand that my job as a supporter is to honor and express his/her expressed wishes. My support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; and helping this person communicate his/her choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith. In the event I cannot perform my job under this agreement, I will contact the Decision-Maker and/or other team member(s).

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

_____ _____

Printed Name of Supporter Printed Name of Witness

State of West Virginia County of _____

This record was acknowledged before me on _____ (date)

By _____ (Name of Supporter) and

SEAL

_____

Signature of Notary

_____

My Commission Expires: _____ Title of Office

SUPPORTED DECISION-MAKING AGREEMENT – HEALTH CARE ADDENDUM

You have the right to make your own health care decisions and the right to decide who helps you make those decisions. If you do not want a person named in this form to help you make health care decisions, you do not have to give them permission to help you with your physical or mental health choices.

If you sign this agreement, you still have the right to make the final decision about your health care. Your healthcare supporter cannot force you to accept health care that you do not want, or take away health care that you do want.

This agreement does not give my Supporter the authority to make decisions about my health care for me, or to influence me to make decisions that do not reflect my expressed wishes and preferences. My Supporter's consent to providing or withholding treatment is not a substitute for my consent.

☐ **MY PHYSICAL HEALTH**

☐ Yes ☐ No Help me make appointments with doctors, dentists, therapists, case managers, or other health care providers

☐ Yes ☐ No Help me keep track of information about my physical healthcare, including my medical records, and whether I have had recommended medical check-ups, tests and vaccines

☐ Yes ☐ No Help me with my physical healthcare plan, including, but not limited to, taking medications, monitoring blood sugar, administering insulin, and refilling prescriptions

☐ Yes ☐ No Permission for my supporter to talk to doctors when I am not present or when I am temporarily unable to communicate.

☐ **MY MENTAL HEALTH**

☐ Yes ☐ No Help me make appointments with doctors, therapists, case managers, or other health care providers

☐ Yes ☐ No Help me keep track of information about my healthcare, including my medical records, and whether I have had recommended medical check-ups and tests

☐ Yes ☐ No Help me with my mental health care plan, including, but not limited to, taking medications, and refilling prescriptions

☐ Yes ☐ No Permission for my supporter to talk to doctors when I am not present or when I am temporarily unable to communicate.

☐ Yes ☐ No Permission for my supporter to access psychotherapy notes or other information conversations I have had during mental health counseling, substance use counseling, or group or family therapy.

_____ _____

Supporter's Signature Date

_____ _____

Decision-Maker's Signature Date

SUPPORTED DECISION-MAKING AGREEMENT – HEALTH CARE ADDENDUM

You have the right to make your own health care decisions and the right to decide who helps you make those decisions. If you do not want a person named in this form to help you make health care decisions, you do not have to give them permission to help you with your physical or mental health choices.

If you sign this agreement, you still have the right to make the final decision about your health care. Your healthcare supporter cannot force you to accept health care that you do not want, or take away health care that you do want.

This agreement does not give my Supporter the authority to make decisions about my health care for me, or to influence me to make decisions that do not reflect my expressed wishes and preferences. My Supporter's consent to providing or withholding treatment is not a substitute for my consent.

☐ **MY PHYSICAL HEALTH**

☐ Yes ☐ No Help me make appointments with doctors, dentists, therapists, case managers, or other health care providers

☐ Yes ☐ No Help me keep track of information about my physical healthcare, including my medical records, and whether I have had recommended medical check-ups, tests and vaccines

☐ Yes ☐ No Help me with my physical healthcare plan, including, but not limited to, taking medications, monitoring blood sugar, administering insulin, and refilling prescriptions

☐ Yes ☐ No Permission for my supporter to talk to doctors when I am not present or when I am temporarily unable to communicate.

☐ **MY MENTAL HEALTH**

☐ Yes ☐ No Help me make appointments with doctors, therapists, case managers, or other health care providers

☐ Yes ☐ No Help me keep track of information about my healthcare, including my medical records, and whether I have had recommended medical check-ups and tests

☐ Yes ☐ No Help me with my mental health care plan, including, but not limited to, taking medications, and refilling prescriptions

☐ Yes ☐ No Permission for my supporter to talk to doctors when I am not present or when I am temporarily unable to communicate.

☐ Yes ☐ No Permission for my supporter to access psychotherapy notes or other information conversations I have had during mental health counseling, substance use counseling, or group or family therapy.

_____ _____

Supporter's Signature Date

_____ _____

Decision-Maker's Signature Date

SUPPORTED DECISION-MAKING AGREEMENT – FINANCE ADDENDUM

You have the right to make your own finance decisions and the right to decide who helps you make those decisions. If you do not want a person named in this form to help you make finance decisions, you do not have to give them permission to help you with your financial choices.

If you sign this agreement, you still have the right to make the final decision about your finances. Your Supporter cannot force you to spend or save your money in a way that you do not want, or manage it in a way that you do not want.

This agreement does not give my Supporter the authority to make decisions about my health care for me, or to influence me to make decisions that do not reflect my expressed wishes and preferences. My Supporter's consent to providing or withholding treatment is not a substitute for my consent

I want to have supporters help me make decisions about how I spend my money and how I save my money.

Consent of Supporters - Financial

I, _____ consent to act as _____'s supporter for financial decisions under this agreement. I agree to provide financial records to the supported decision-making monitor (listed below) monthly / quarterly / annually (circle one). I understand that my job as a supporter is to honor and present the wishes of the person with a disability. I understand that my support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; communicating the person's choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith.

_____ _____

Supporter's Signature Date

Consent of Monitor - **A monitor must be appointed to oversee financial supporters.**

I, _____ consent to act as a Monitor for financial decisions under this agreement. I agree to review the financial records of the person with a disability when provided by the supporters every month. I agree to make reasonable efforts to ensure that the supporters under this agreement are acting honestly, in good faith, and in accordance with the choices of the person with a disability. If I suspect financial abuse, misuse of funds, bad faith, or failure to comply with the decisions of the person with a disability, I will require the supporters to explain their actions. If the supporter fails to provide this information or if I continue to have reason to believe that the supporter is abusing or failing to comply with the wishes of the person with a disability, I will promptly inform Adult Protective Services.

_____ _____

Monitor's Signature Date

SUPPORTED DECISION-MAKING AGREEMENT – FINANCE ADDENDUM

You have the right to make your own finance decisions and the right to decide who helps you make those decisions. If you do not want a person named in this form to help you make finance decisions, you do not have to give them permission to help you with your financial choices.

If you sign this agreement, you still have the right to make the final decision about your finances. Your Supporter cannot force you to spend or save your money in a way that you do not want, or manage it in a way that you do not want.

This agreement does not give my Supporter the authority to make decisions about my health care for me, or to influence me to make decisions that do not reflect my expressed wishes and preferences. My Supporter's consent to providing or withholding treatment is not a substitute for my consent

I want to have supporters help me make decisions about how I spend my money and how I save my money.

Consent of Supporters - Financial

I, _____ consent to act as _____'s supporter for financial decisions under this agreement. I agree to provide financial records to the supported decision-making monitor (listed below) monthly / quarterly / annually (circle one). I understand that my job as a supporter is to honor and present the wishes of the person with a disability. I understand that my support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; communicating the person's choice. I know that I may *not* make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith.

_____ _____

Supporter's Signature Date

Consent of Monitor - **A monitor must be appointed to oversee financial supporters.**

I, _____ consent to act as a Monitor for financial decisions under this agreement. I agree to review the financial records of the person with a disability when provided by the supporters every month. I agree to make reasonable efforts to ensure that the supporters under this agreement are acting honestly, in good faith, and in accordance with the choices of the person with a disability. If I suspect financial abuse, misuse of funds, bad faith, or failure to comply with the decisions of the person with a disability, I will require the supporters to explain their actions. If the supporter fails to provide this information or if I continue to have reason to believe that the supporter is abusing or failing to comply with the wishes of the person with a disability, I will promptly inform Adult Protective Services.

_____ _____

Monitor's Signature Date

MEETING AND TIMELINE CONSIDERATIONS

My support people are very important to me and I want to be respectful of their time. I know that I can call them to ask questions about my goals in this agreement at any time, but I would like to talk with my whole Supported Decision Making team:
Check one:

- ☐ Every week
- ☐ One time a month
- ☐ Two times a month
- ☐ Every Six Months
- ☐ One time a year
- ☐ Before an important meeting (IEP/Doctor/Dentist)
- ☐ I do not want my support team to meet on a regular basis

There will be times that I need to discuss certain topics in more detail and it won't be necessary to call the entire team together. Here is what I would like to do for specific Supporters:

TOPIC	HOW OFTEN* (SEE EXAMPLES BELOW)	IN PERSON Y OR N	BY PHONE Y OR N	BY VIDEO Y OR N
Finances				
Healthcare				
Education				
Relationships				
Employment				
Legal Matters				
Daily Living				
Services/Supports				
Other				

***Write down how often you will meet with this supporter(s) in the HOW OFTEN boxes above. Examples:**

"every week", "every month", "every time I am making a certain kind of choice",
"every time I have to go to the doctor", "every time I get a check",
"only when I have a question or want advice"

ADDITIONAL DOCUMENTATION OR ATTACHMENTS

I understand that certain documents may give my Supporters more authority in my life or access to my personal information. I am including those documents as part of this agreement:

- ☐ Authorization for Release of Records
  - ☐ Health Insurance Portability and Accountability Act (HIPAA) Release
  - ☐ Family Educational Rights and Privacy Act (FERPA) Release
  - ☐ Other Release
- ☐ Letters of Guardianship [☐ Temporary / ☐ Permanent]
  - ☐ Guardianship of the Person and Estate
  - ☐ Guardianship of the Person
  - ☐ Guardianship of the Estate
- ☐ Power of Attorney
  - ☐ General
  - ☐ Financial
  - ☐ Medical
- ☐ Durable Power of Attorney
  - ☐ General
  - ☐ Financial
  - ☐ Medical
- ☐ Protective Order
- ☐ Educational Surrogate Authorization
- ☐ Trust Documents
- ☐ Health Care Representative Authorization
- ☐ Psychiatric Advanced Directive
- ☐ Representative Payee Authorization
- ☐ WVABLE Documentation
- ☐ Living Will
- ☐ Other_____

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 WV Bureau for Children and Families by calling the Centralized Intake for Abuse and Neglect Hotline at **1-800-352-6513** or online at https://dhhr.wv.gov/bcf/Services/Pages/Centralized-Intake-for-Abuse-and-Neglect.

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.

REMINDER

This agreement should be reviewed by all parties to the agreement, and t*his agreement must be read out loud or otherwise communicated to all parties to the agreement in the presence of a notary. The form of communication shall be appropriate to the needs and preferences of each party,* **including each individual's language and sensory processing wants or needs.** Each Supporter will acknowledge by signature his/her/their role as determined by the Decision-Maker.

SIGNATURE OF ADULT WITH A DISABILITY

This Supported Decision-Making agreement starts immediately upon signing and will continue until the agreement is stopped by me or my supporters, or the agreement ends by law.

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

I have reviewed, agree with, and understand all the information contained in this Supported Decision- Making Agreement.

I understand that this agreement may be revoked by me or by my supporter(s) at any time.

_____ _____

Printed Name of Decision-Maker Printed Name of Witness

State of West Virginia County of _____

This record was acknowledged before me on _____ (date)

By _____ (Name of Decision-Maker) and

By _____ (Name of Witness)

SEAL

_____

Signature of Notary

_____

Title of Office

My Commission Expires: _____

The text of this agreement was communicated to the person with a disability in my presence by:

- Reading the full agreement aloud
- Otherwise communicating the agreement to the person with a disability (*describe communication* used):

NOTES

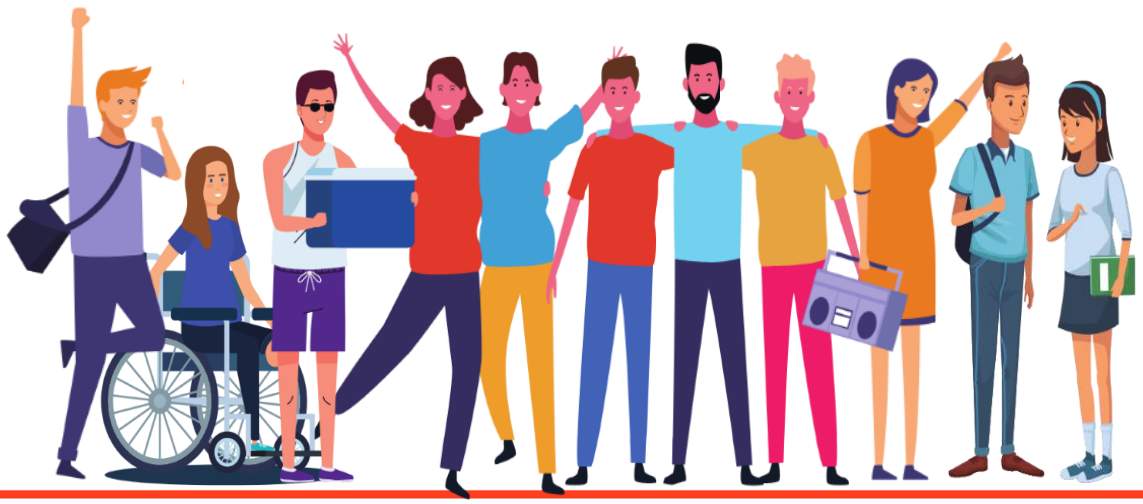
"…where people use trusted friends, family members, and professionals to help them understand the situations and choices they face, so they may make their own decisions – is a means for increasing self-determination by encouraging and empowering people to make their own decisions about their lives to the maximum extent possible."

National Resource Center for Support Decision Making, 2016

SUPPORTED DECISION-MAKING

WEST VIRGINIA

EMPOWERED & ABLE!



For More Information Contact Astrive Advocacy, Inc.
www.astrive.org
www.facebook.com/astriveadvocacy
christina.smith@astrive.org