

TEXAS STATUTORY SUPPORTED DECISION-MAKING AGREEMENT

NOTICE: This document is explained in the Supported Decision-Making Act, Subtitle I, Title 3, Estates Code. If you have any questions about this Supported Decision-making Agreement obtain competent legal advice. You may revoke this supported decision-making agreement later if you wish to do so.

I, _____ (your name), choose to make this agreement myself. I decided to make this agreement myself and no one told me to make this agreement.

I choose _____ (name) to be my Supporter.

Supporter Address: _____

Phone Number: _____

E-mail Address: _____

My supporter may help me with life decisions about:

Yes ___ No ___ what I eat, what I wear, and where I live

Yes ___ No ___ taking care of my health

Yes ___ No ___ making decisions about money

My supporter does not make decisions for me. My supporter may:

1. Help me get information for 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 tell people my decision.

Yes ___ No ___ My supporter may see my private health information. (A signed release under the Health Insurance Portability and Accountability Act of 1996 is attached).

Yes ___ No ___ My supporter may see my educational records. (A signed release under the Family Educational Rights and Privacy Act of 1974 is attached).

This supported decision-making agreement starts when signed and will continue until _____ (date) or until the supporter or I end the agreement or the agreement is ended by law.

Signed this _____ day of _____, _____
Day Month Year

(My Signature)

(My Printed Name)

Consent of Supporter

I, _____ (name), 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.