



Supported Decision-Making Agreement

Under the Supported Decision-Making Act:

A **Supporter** is an adult who has entered into an agreement with a Principal.

A **Principal** is an adult with ID/DD who seeks to enter or has entered into an agreement with a Supporter.

Important Information for the Supporter: Duties

If you agree to provide support to the Principal, you have a duty to:

- 1) act in good faith;
- 2) act within the authority granted in this agreement;
- 3) act loyally and without self-interest; and
- 4) avoid conflicts of interest.

Appointment of a Supporter

I, _____ (insert Principal's name), make this agreement of my own free will. I agree and designate that the following individual as my Supporter:

Name: _____

Address: _____

Phone Number: _____

Email Address: _____

My Supporter is to help me make decisions for myself and may help with making everyday life decisions relating to the following (items initialed by Principal). All other items should be marked as "NA" for "Not Applicable."

- _____ Obtaining food, clothing, and shelter.
- _____ Taking care of my physical and emotional health.
- _____ Managing my financial affairs.
- _____ Applying for public benefits.
- _____ Helping me find work.
- _____ Assisting with residential services.
- _____ Helping me with school.
- _____ Helping me advocate for myself.
- _____ Other, describe: _____

My Supporter is not allowed to make decisions for me. To help me with my decisions, my Supporter may:

- 1) help me access, collect, or obtain information that is relevant to a decision, including medical, psychological, financial, educational, housing and treatment records;
- 2) help me understand my options so that I can make an informed decision; and
- 3) help me communicate my decision to appropriate persons.

I want my Supporter to have (only items initialed by principal)

- _____ A release allowing my supporter to see protected health information under the Health Insurance Portability and Accountability Act of 1996, and/or confidential information under the Mental Health and Developmental Disabilities Confidentiality Act, and/or to see substance abuse records under Confidentiality of Alcohol and Drug Abuse Patient Records regulations is attached.

- _____ A release allowing my supporter to see educational records under the Family Educational Rights and Privacy Act of 1974 and the Illinois School Records Act is attached.

This supported decision-making agreement is effective immediately and will continue until _____(insert date) or until the agreement is terminated by my supporter or me or by operation of law.

Signed this _____ day of _____, 20____

(Signature of Principal)

(Printed Name of Principal)

Consent of Supporter

I, _____(name of supporter), consent to act as a supporter under this agreement.

(Signature of Supporter)

(Printed Name of Supporter)

(Witness 1 Signature)

(Printed Name of Witness 1)

(Witness 2 Signature)

(Printed Name of Witness 2)

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 ADULT PROTECTIVE SERVICES HOTLINE:

1-866-800-1409 OR 1-888-206-1327 (TTY)

This form is not intended to exclude other forms or agreements that identify the principal, supporter, and types of support.

GAC/07-21