DEPLOYMENT KIT

Putting your Supported Decision-Making Agreement to work

An agreement only helps if the right people have it **before** the crisis. Use this kit in the first 24 hours after signing, and keep it current.

1. Who Gets What

Recipient	What to give them	When	Done
You (original)	Signed Agreement, all exhibits, HIPAA authorization, physician's letter. Keep in a fireproof place or in Legal Vault.	Day 1	☐
Each Supporter	Full copy, Supporter's Guide, Decision Log, contact sheet (Exhibit A).	Day 1	☐
Primary care doctor	Agreement, HIPAA authorization, Exhibit G cover page, Exhibit B, provider cover letter (Section 2). Ask that it be scanned into the chart and flagged.	Within 1 week	☐
Specialists and mental health provider	Same packet as for the primary care doctor, if the Agreement covers that area.	Within 2 weeks	☐
Local hospital(s)	Same packet, to the patient access or medical records office. Ask how to have it flagged in the system, and for confirmation.	Within 2 weeks	☐
Pharmacy	HIPAA authorization and Supporters' names.	Within 2 weeks	☐
Assisted living or home care agency (if any)	Same packet, with Exhibit B for the care plan, and a request for a care-plan meeting.	At admission or start	☐
Trustee, trust protector, and agents	Copy of the Agreement and Exhibits A, B and C. Ask each to acknowledge in writing that they have read it.	Within 1 week	☐
Your attorney	Signed copy for your file, so it can be coordinated with your trust and powers of attorney.	Day 1	☐
Bank or financial advisor (only if money is covered)	Agreement and the financial institution letter (Section 3). The bank may not honor it; the power of attorney does that.	Within 2 weeks	☐
Legal Vault or secure online storage	Scans of everything. Make sure Supporters know how to find it.	Day 1	☐
Your wallet and your refrigerator	Wallet card (Section 4) and a copy of the Home-First Discharge Card and Exhibit G, where first responders and visitors will see them.	Day 1	☐

2. Cover Letter to Doctors, Hospitals, and Facilities

[Date]

[Provider name and address]

Re: [Patient name], date of birth [_____] — Supported Decision-Making Agreement and Authorization

To the Medical Records Department and Care Team:

Enclosed are copies of my Supported Decision-Making Agreement for Aging in Place, my HIPAA authorization, and a one-page notice for my chart. I ask that you place them at the front of my chart, and note my Supporters' names and telephone numbers as the people to be contacted.

Please understand what this Agreement is and is not. **I make my own decisions.** My Supporters help me understand my choices, come to appointments when I ask, and help me communicate. They are not my guardian, and they cannot consent for me because of this Agreement. If I become unable to decide, the people named in my health care power of attorney and my other documents have authority, and they will give you copies when they act.

I ask that you:

- call my Supporters for care-plan meetings, discharge planning, and any change in my condition;
- speak with me directly, and use the accommodations I describe;
- call my Supporters and the physician named in my Agreement before deciding that I cannot go home; and
- tell my Supporters before any proposal for guardianship, or for my placement in a facility, other than an emergency.

Please confirm in writing, or by telephone to _____, that the enclosed documents have been placed in my chart. Thank you for your help in respecting my wishes.

Sincerely,

[Signature] [Printed name]

3. Letter to a Bank or Financial Institution (Only if Money Is Covered)

Re: [Customer name], account(s) [last four digits]

I have signed a Supported Decision-Making Agreement naming the persons listed below to help me understand and make decisions about my finances. **This is not a power of attorney.** I ask that you note my Supporters' names and telephone numbers, that you speak with me directly and with my Supporters when I ask them to be present, and that you tell my Supporters if you are concerned that I may be the victim of a scam or financial exploitation. Please do not release information or allow transactions on the basis of this letter alone. Any authority to act on my accounts must come from a separate power of attorney, joint ownership, or other documents that I have given you.

My Supporters: _____

4. Wallet Card

Cut along the line. Fold, and keep in your wallet or purse next to your insurance cards. Fill in the blanks.

FRONT	BACK
I MAKE MY OWN DECISIONS WITH HELP. I have a **Supported Decision-Making Agreement.** Please call my Supporters before any major decision or move: 1. _____ Tel _____ 2. _____ Tel _____ Name: _____ DOB _____	**I WANT TO LIVE AT HOME.** If I say I want to go home, please call my Supporters and my doctor first. **Also in my chart:** trust, power of attorney, health care power of attorney, HIPAA release, living will. Legal contact: _____ Tel _____ Documents at: _____

5. When to Take Action (Trigger Checklist)

If this happens	Do this
Hospital admission or emergency room visit	Give the packet. Ask inpatient vs. observation. Ask for the Supporter to be listed as a contact. Bring Exhibit B. Notify other Supporters and the trustee.
A fall, new diagnosis, or change in thinking or mood	Ask the doctor to look for treatable causes. Update Exhibit B. Tell Supporters. Consider a review of the Agreement.
A proposal to move to a facility or to start guardianship	Call the attorney, the other Supporters, the trustee, and the trust protector at once. Follow Part 8 of the Agreement. Ask for the named physician to see the person.
A Supporter dies, becomes ill, moves, or resigns	Use Exhibit F. Alternate steps in. Add a new Supporter and have the new Supporter sign the Consent. Notify everyone who has a copy.
A new doctor, hospital, or care agency	Give the packet within 1 week.
A change in the family (marriage, divorce, death, estrangement) **or in your estate plan**	Review the exclusions in Part 2.2 and the contact list in Exhibit A. Ask your attorney whether other documents need updating.
Concern about pressure, isolation, or money	Follow Part 6.4. Tell the other Supporters, the trustee, and the trust protector. Report to Adult Protective Services if serious.
One year since signing	Do the annual review (Section 6).

6. Annual Review and Re-Affirmation

Once a year, and after any hospital stay or major change, sit down with your Supporters and review.

- ☐ Do I still want these Supporters? Has anyone's situation changed?
- ☐ Are the areas of help in Part 3 still right? Do I want more help, or less?
- ☐ Is the contact sheet (Exhibit A) current, including doctors, pharmacy, trustee, agents, and trust protector?
- ☐ Is Exhibit B still accurate? What new things comfort me? What has changed?
- ☐ Does everyone who should have a copy have the current one?
- ☐ Are the HIPAA authorization and your mental health instructions still in force? (In Ohio, a declaration for mental health treatment lasts three years and can be renewed once, by signing it again. It cannot be changed. Check the date.)
- ☐ Have I seen my attorney recently to coordinate with my trust and other documents?

Re-affirmation

I have reviewed my Supported Decision-Making Agreement dated _____ with my Supporters. I confirm that it still states my wishes, **except for the changes written below.** (Attach a Notice of Change, Exhibit F, if needed.)

_____ Date: _____

Signature of person who made the Agreement

_____

Printed name

Year	Date reviewed	Initials: Person	Initials: Supporter 1	Initials: Supporter 2	Changes made?

7. If a Supporter Will Be Paid: Care Agreement Checklist

A Supporter who becomes a paid caregiver needs a written care agreement. This checklist is for discussion with your attorney **before** any payment. Payments to family can affect Medicaid and other benefits, and have tax consequences.

- ☐ The agreement is **in writing and signed before** services begin. Payments for services already done may be treated as gifts.
- ☐ It lists the **specific services** (for example, meals, bathing help, transportation, medication reminders, housekeeping) and the hours.
- ☐ The pay is **reasonable**, comparable to what an agency or independent caregiver would charge for the same service.
- ☐ A **log** records dates, hours, and what was done, and is signed by the caregiver. Keep it with the agreement.
- ☐ Payment is made **as services are provided** (or on a schedule in the agreement), not in a lump sum in advance, unless your attorney has advised otherwise.
- ☐ Your attorney has reviewed how the agreement, the payments, and the Medicaid look-back rules fit together.
- ☐ Your accountant or attorney has addressed **taxes**, including whether the caregiver is a household employee.
- ☐ The Supporter has **disclosed** the arrangement to you and to the other Supporters, as the Agreement requires.
- ☐ The agreement is **reviewed every year** and whenever care needs change.

A caution: a care agreement is for real services. It should **not** be used solely to manufacture a Medicaid spend-down, unless your attorney has specifically advised it **in writing**.

8. Your Hospital Bag

Keep a folder or bag ready, so that if you need to go to the hospital, nothing is forgotten:

- ☐ Supported Decision-Making Agreement, Exhibit B, Exhibit G, and the HIPAA authorization
- ☐ Health care power of attorney, living will, and mental health declaration
- ☐ Home-First Discharge Card
- ☐ Medicare, supplement, and other insurance cards, photo ID
- ☐ Current medicine list, allergies, and doctors' telephone numbers
- ☐ Glasses, hearing aids, dentures, and chargers
- ☐ A familiar object, photograph, or music from your Comfort and Calm Plan
- ☐ Contact sheet for your Supporters, trustee, and attorney