SUPPORTED DECISION-MAKING AGREEMENT

FOR AGING IN PLACE

A private agreement in which I choose the people who help me make my own decisions, and tell everyone else what I want if my abilities change

Ohio Edition

NOTICE OF RIGHTS (to be read aloud, or communicated in a way that suits me, before anyone signs)

- This is a form I can use to choose people I trust to help me make my own decisions. They are called **Supporters**.
- I have the right to make my own decisions and the right to decide who helps me. **I do not have to sign this Agreement.** No doctor, hospital, nursing home, bank, family member or other person may require me to sign it as a condition of care, a place to live, or anything else.
- If I sign, **I still make the final decision.** My Supporters cannot make a decision for me, sign for me, or consent to or refuse treatment for me. This Agreement is not a power of attorney and it does not appoint a guardian.
- I can change or cancel this Agreement at any time, in writing or simply by telling a Supporter, a doctor, or someone else.
- I can add, remove or replace Supporters at any time.
- **This Agreement is a request and a statement of my wishes. It is not a court order.** It cannot force a hospital, bank, nursing home, or anyone else to accept my Supporters' involvement. It works by showing clearly what I want, and by working together with my trust, my powers of attorney, and my other advance directives. Part 10 explains how.

PART 1. ABOUT ME

My full name: _____

Date of birth: _____

Home address: _____

County and state: _____

Telephone: _____

Email: _____

Today's date: _____

1.1 In my own words

These pages guide everyone who helps me. They matter most if I can no longer say these things for myself.

What matters most to me in my life now:

_____

Where and how I want to live as I age:

_____

What worries or frightens me most:

_____

The people, places, pets, activities and beliefs I never want to lose touch with:

_____

1.2 How I decide and communicate best (check all that apply)

☐ I decide best when I have time. Please do not rush me or ask me to decide on the spot.

☐ I decide best in the morning / afternoon / evening (circle one).

☐ I need information in writing, in large print, or in short pieces.

☐ I need a quiet place and one person talking at a time.

☐ I need my glasses, hearing aids, dentures, or other device before any important conversation.

☐ I understand best when someone explains it plainly and then asks me to say it back in my own words.

☐ I sometimes say "yes" or "no" when I really mean "I am not sure." Please ask again another way.

☐ When I am upset, tired, in pain, or confused, it helps to:
_____

☐ Other:
_____
____

PART 2. MY SUPPORTERS

I choose the following people to be my Supporters. I understand that each must read and sign the Supporter's Consent in the Signatures section (D), and that a person who cannot truthfully make the statements in it cannot be my Supporter.

Supporter 1

Name: _____

Relationship to me: _____

Address: _____

Telephone (home / cell): _____

Email: _____

Supporter 2 (leave blank if none)

Name: _____

Relationship to me: _____

Address: _____

Telephone (home / cell): _____

Email: _____

Supporter 3 (leave blank if none)

Name: _____

Relationship to me: _____

Address: _____

Telephone (home / cell): _____

Email: _____

Alternate Supporter

If a Supporter dies, resigns, becomes unable to serve, or becomes ineligible, I want this person to take that Supporter's place:

Name: _____

Relationship to me: _____

Telephone / email: _____

2.1 How my Supporters work together (check one)

☐ **Independently:** each Supporter helps me only with the decisions I assign in Part 3.

☐ **Together:** my Supporters consult one another and work as a team to help me.

☐ **In order:** Supporter 2 helps me when Supporter 1 is unavailable, and Supporter 3 when both are unavailable.

2.2 People I do NOT want involved in my decisions

I do not want the following people to serve as my Supporters, or to be consulted about my decisions unless I say so in writing:

_____

2.3 One independent voice

I understand that it is wise for at least one of my Supporters to be someone who is **not my spouse or partner** and who has **no financial interest** in my choices, because a spouse may also be

affected by changes in health and may have needs that differ from mine. If I have only my spouse or partner as a Supporter, I accept that choice knowingly.

PART 3. DECISIONS I WANT HELP WITH

For each area, check the box under the Supporter(s) who may help me. Check **"I decide alone"** for any area where I do not want help from anyone. If a row is blank, my Supporters may not help me in that area unless I tell them.

#	Area of my life	Supp. 1	Supp. 2	Supp. 3	I decide alone
1	**Everyday medical care:** doctors, tests, treatments, medicines, surgery, therapies	☐	☐	☐	☐
2	**Mental health and emotional well-being:** counseling, medication, memory care, hospital or facility admission	☐	☐	☐	☐
3	**Where I live and care settings:** staying home, rehabilitation, assisted living, nursing home, discharge plans	☐	☐	☐	☐
4	**Help at home:** caregivers, home health, meals, cleaning, repairs, safety technology, adapting my home	☐	☐	☐	☐
5	**Everyday money:** bills, banking, budgeting, mail, spotting scams	☐	☐	☐	☐
6	**Big money decisions:** investments, loans, large gifts or purchases, selling or transferring property	☐	☐	☐	☐
7	**Insurance and benefits:** Medicare, supplements, Advantage plans, long-term care insurance, Medicaid, VA, Social Security	☐	☐	☐	☐
8	**Legal matters:** my estate plan, hiring and working with a lawyer, court papers and notices	☐	☐	☐	☐
9	**Relationships and social life:** visitors, family, friends, faith community, clubs, dating or marriage	☐	☐	☐	☐
10	**Driving, transportation and safety:** driving, keys, firearms, wandering, personal alarms	☐	☐	☐	☐
11	**Phone, mail, computer and online accounts**	☐	☐	☐	☐
12	**End-of-life wishes:** comfort care, hospice, funeral and burial wishes	☐	☐	☐	☐
13	**Other:** _____	☐	☐	☐	☐

3.1 Special instructions or limits

Anything I want to add, limit, or explain about Part 3 (for example, "Supporter 2 may help with my medical decisions but may never see my financial records"):

PART 4. HOW MY SUPPORTERS MAY HELP ME

In the areas I have checked, my Supporters may do the following **at my direction**. I have crossed out anything I do not want.

1. Get Information: Help me find and gather information, including medical, psychological, financial, insurance, legal and care records, using the releases I sign.

2. Explain It Plainly: Explain my choices in words I understand, and as many times as I need.

3. **Talk It Through**: Discuss with me the benefits, the risks, the alternatives, and what is likely to happen if I do nothing, so that I can decide for myself.
4. **Be With Me**: Be present, in person or by phone or video, at appointments, care-plan meetings, discharge planning meetings and other conversations when I ask.
5. **Help Me Remember**: Take notes, keep a calendar, and ask me to say the plan back to them so we both know what I decided.
6. **Speak What I Decide**: Help me tell doctors, family, banks, insurers, and others what I have decided, in my words.
7. **Help Me Carry It Out**: Make calls, schedule, fill out paperwork I have decided on, pick up prescriptions, and arrange services as I direct.
8. **Receive Notices**: Be copied on notices from providers, facilities, insurers, banks and courts about the areas I have checked.
9. **Stay With Me in a Hospital or Facility**: Visit me, attend care meetings, and ask staff questions on my behalf.

I also decide the following (check one for each):

☐ My Supporters **may** talk with my doctors and other providers when I am not present or cannot communicate at the moment.

☐ My Supporters **may talk with providers only when I am present** or I have said it is all right.

☐ My Supporters **may** see notes from counseling or psychotherapy, and information about mental health or substance-use treatment.

☐ My Supporters **may not** see notes from counseling or psychotherapy, or information about mental health or substance-use treatment, unless I say so at the time.

PART 5. WHAT MY SUPPORTERS MAY NOT DO

This Agreement gives my Supporters **no authority to decide for me.** In particular, my Supporters may not, because of this Agreement:

- **Decide or Sign For Me**: make a decision for me, sign my name, consent to or refuse treatment for me, or sign admission papers or become a "responsible party" for me.
- **Pressure or Hide**: pressure me, trick me, rush me, speak over me, withhold information I need, or put their wishes ahead of mine.
- **Isolate Me**: keep me from the people on my list in Part 6, or limit my visitors, mail, phone, or internet.
- **Profit From Me**: take, borrow, or accept money, property, gifts, or payment from me or for helping me, except as written in a separate agreement I have signed, or as my trust provides.
- **Move Me**: move me from my home or arrange for me to live somewhere else without discussing it with me first and following Part 8.
- **End My Marriage or Change My Plan**: ask a court, or anyone, to end or annul my marriage, or to change my estate plan, trust, beneficiaries, or other advance directives for me.
- **Seek Control Over Me**: ask a court for guardianship or conservatorship over me, except by following Part 8.

Other things I do not want my Supporters to do:

PART 6. KEEPING ME CONNECTED AND SAFE

6.1 People I always want to be able to see and talk with

I do not want anyone, including a Supporter, a family member, an agent, or a facility, to isolate me. I want to keep my contact, in person, by phone, by mail and online, with these people (and the pets, faith leaders and groups I have listed in Part 1):

I ask that my Supporters, agents, and any facility where I live protect that contact, and that it be limited only to protect me from immediate danger, and only for as long as that danger lasts.

6.2 Money and property

This Agreement does not give any Supporter access to my accounts, my property, or my trust. Anyone who needs that authority must have it under a separate legal document.

6.3 Conflicts of interest and payment

Each Supporter must tell me, and the other Supporters, if he or she expects to receive anything from my estate, trust, or care, or if he or she is also my paid caregiver, agent, or trustee. A Supporter who provides paid services to me must have a written care agreement, signed in advance, that pays a reasonable rate for actual services. Because payments to family members can affect eligibility for benefits such as Medicaid, I will have a lawyer review any care agreement before it begins. Being my Supporter is otherwise an unpaid role, except for reimbursement of reasonable expenses.

6.4 Speaking up

If a Supporter sees signs that another Supporter, a family member, or anyone else is pressuring, isolating, neglecting or taking advantage of me, I ask that Supporter to (1) tell my other Supporters, my trustee, and my trust protector, and (2) report to Adult Protective Services or the police when the concern is serious. I understand that a Supporter who sees abuse, neglect, or exploitation is free to report it, and I want that.

Adult Protective Services

Ohio: call 1-855-OHIO-APS (1-855-644-6277), or the county department of job and family services.

6.5 Phone, computer, and online accounts

My Supporters may help me use my phone, computer, email, and online accounts, set up alerts for scams, and keep track of my accounts, in the areas I have checked in Part 3. **I will not write passwords or account numbers in this Agreement.** My list of devices, accounts, and where to find them is kept separately, in my Digital Assets Inventory Worksheet, stored with my other important papers. A Supporter may enter my accounts or devices only as I allow, and never to move, spend, or take my money or property. Legal authority over my digital property comes only from my trust, my powers of attorney, and the account settings I have chosen.

PART 7. IF MY ABILITIES CHANGE

I know that my health, memory, or thinking may change. I want my Supporters, my doctors, and everyone else to follow these instructions.

7.1 Support first

If I have trouble making a decision, I ask everyone to **increase support, not take away my decision.** That means more time, simpler words, written notes, a quieter place, a better time of day, a trusted person beside me, and a second conversation another day.

7.2 One decision at a time, and good days and bad days

My ability to decide may be different for different decisions, and different from one day to the next. I ask that my capacity be considered for **each decision**, and that important decisions wait for a better time when that is safe.

7.3 Look for fixable causes first

Before anyone decides that a change in my thinking or behavior is permanent, I ask that my doctors and Supporters look for causes that can be treated, including infection (such as a urinary tract infection), pain, dehydration, constipation, poor sleep, hospitalization or surgery, new or changed medicines, hearing or vision loss, depression, and grief. If the cause is treated, I want to be assessed again.

7.4 Who may decide that I have lost capacity

This Agreement does not authorize anyone to declare me incapacitated or incompetent. The question is governed by the Competency Clause in my trust and the other documents I have signed. As of the date I sign, the physicians I have named for that purpose are:

Primary physician: _____

Telephone: _____

Alternate physician: _____

Telephone: _____

7.5 What continues if I lose capacity

If I can no longer make decisions, I intend this Agreement to **continue** as the clearest statement I can make of my wishes, to the fullest extent the law allows. My Supporters will not become my agents or decision-makers because of it, but I ask that:

- my Supporters continue to be **told** about my care, admissions, discharges, and important changes;
- my Supporters be allowed to **be present** and **be heard** when decisions about me are made;
- my agents, my trustee, and my doctors **consult my Supporters** and give weight to what they say about what I would want; and
- decisions made for me be based on **what I have said and what I would choose**, as shown in this Agreement and in Exhibit B, and not on what is easiest or least costly for others.

These are my requests and my statements of what I want. They do not give my Supporters legal authority, and a court, hospital, bank, or other person may not be required to follow them.

7.6 If I get better

If I recover, I want my own authority to be restored as quickly as my trust and the law allow, and I want my Supporters to help me ask for that.

7.7 If a Supporter is also my agent or trustee

A Supporter may also be my agent under a power of attorney, my trustee, or my health care agent. Those roles have their own rules. I ask that the person keep them separate:

- **As Supporter**: help me decide, and follow the choice I make, whenever I can make it with support.
- **As Agent or Trustee**: act only when that document gives authority, and then decide as I would have decided, using what I wrote in this Agreement and Exhibit B. If my current wish and my earlier wishes seem to conflict, I want my current wish followed unless doing so would put me in serious danger, and then I want the person to consult my other Supporters and the physician I named in Section 7.4 first.
- **Say Which Hat**: tell the people you are dealing with which role you are acting in.

PART 8. NOTICE AND CONSULTATION BEFORE GUARDIANSHIP, FACILITY PLACEMENT, OR MAJOR CHANGES

8.1 What I ask

Before anyone (a family member, a hospital, a nursing home, an agency, a bank, or anyone else) files a petition for a guardian or conservator for me, or places me in a nursing home, assisted living facility, psychiatric facility, or other care setting for more than a short, planned stay, I ask that the person:

1. **Tell My Supporters**: notify each of my Supporters, my trustee, and my trust protector, in writing, as soon as possible, and give them time to talk with me and with the physician I have named in Section 7.4;
2. **Consider Alternatives**: consider, and show that they have tried, less restrictive options: this Agreement, my trust and its private guardian provisions, my powers of attorney, home services, respite, adult day services, and the other choices in Exhibit B;
3. **Hear Me**: meet with me and listen to me, with a Supporter beside me if I wish, and write down what I say I want; and
4. **Give Notice of Any Hearing**: give my Supporters written notice of any court hearing about me, and let them be heard.

8.2 Emergencies

In a true emergency, I want people to protect my life and safety first, and to notify my Supporters as soon as they can.

8.3 If a court still must appoint a guardian

I have set up my affairs so that a court-appointed guardian should not be needed. If, despite that, a court decides that a guardian is necessary, I ask that the court:

- appoint **only a guardian of my person**, never a guardian of my assets, which are managed under my trust and powers of attorney;
- make the guardianship **limited** to the specific decisions and **as short as possible**, with regular review and with a plan to end it; and
- appoint the person I name here, or, if that person cannot serve, the agent I named in my health care power of attorney:

My nominee for guardian of my person: _____

Relationship / telephone: _____

I ask that this Agreement, and the notice and consultation I request in this Part, be considered as evidence of my wishes and of the alternatives available to me.

8.4 Ohio law

I understand that Ohio has no law that specifically recognizes a supported decision-making agreement for an adult in my position. I ask the probate court to consider this Agreement, my trust, and my powers of attorney as less restrictive ways to meet my needs, before it appoints a guardian, and to hear from my Supporters. I ask that I be represented by a lawyer of my choice at any hearing.

PART 9. A REQUEST TO PROVIDERS AND FACILITIES

To every hospital, doctor, nurse, social worker, discharge planner, nursing home, assisted living facility, home health agency, bank and agency that receives a copy of this Agreement: I ask for your help. I understand that this Agreement is not a court order and that you may not be required to follow it. Here is what I am asking:

- **Call My Supporters**: please list my Supporters as the people to be called for care-plan meetings, discharge planning, changes in my condition, falls, medication changes, and any proposal to move me.
- **Keep Me at Home When You Can**: I want to live in my own home for as long as I safely can. If I say that I want to go home, please do not treat that as a symptom. Call my Supporters and the physician I named, and look at every home-based option, including paid caregivers, home health, equipment, and family help, before deciding that I cannot go.
- **Ask Me**: please speak to me directly, explain things plainly, and ask for my own choice, even if I am hospitalized or ill.
- **Use It in Good Faith**: I ask that you rely on this Agreement as a statement of my wishes unless you have received notice that I have cancelled it or want to cancel it. It does not authorize my Supporters to consent for me.
- **Protect Me**: if anyone has reason to believe I am being abused, neglected, or exploited, including by a Supporter, they may report it to Adult Protective Services, and I want them to.

PART 10. HOW THIS AGREEMENT FITS WITH MY OTHER DOCUMENTS

I have other documents that give particular people legal authority. This Agreement does not replace or cancel any of them. **If anything here conflicts with a document that gives someone legal authority to act for me, that document controls as to who has authority. I ask every agent and trustee to follow this Agreement's statements of my wishes and to consult my Supporters.**

Document	Who decides	When	How my Supporters fit
This Agreement	**I do**	Now, with help	Supporters help me understand, decide, and communicate. They do not decide.
Revocable living trust, including its Competency Clause	I do, then my trustee	Trustee acts only if the physician(s) I named certify that I cannot manage my affairs	Supporters are consulted and informed. The trust's aging in place and private-guardian provisions guide the trustee.
General durable power of attorney (money and property)	My agent	As my document says	Supporters help me while I can act; agent consults them if I cannot.
Health care power of	My agent, then only	When my doctor finds I	Supporters stay informed, are

Document	Who decides	When	How my Supporters fit
attorney and living will	if I cannot decide	cannot decide	present, and speak to my wishes.
Declaration for mental health treatment (Ohio), a separate document	My mental health proxy, within what I wrote	When the declaration becomes operative under Ohio law: communicated to my provider and two providers find I lack capacity	Supporters are told, and help carry out my written wishes.
HIPAA authorization (Exhibit D)	Not applicable	Now	Lets providers share information with my Supporters.
Competency Clause Addendum	The physician(s) I named	When capacity is in question	Supporters may ask for an evaluation or a re-evaluation.

PART 11. START DATE, CHANGES, AND ENDING THE AGREEMENT

- **Start**: This Agreement starts when it is signed and witnessed or notarized as described below, and it continues until I end it, or until the date I fill in here (optional): _____.
- **Changing It**: I may change or cancel this Agreement, or any Supporter's role, at any time, in writing or by telling a Supporter, a doctor, or another person. A form for this is Exhibit F.
- **A Supporter Leaving**: A Supporter may resign at any time by telling me and the other Supporters. A Supporter's role ends automatically if the Supporter dies, becomes unable to serve, or can no longer truthfully make the statements in the Supporter's Consent.
- **If I Cancel Under Pressure**: If I cancel this Agreement after contact from someone who benefits from my doing so, I ask my other Supporters, my trustee, or my trust protector to ask the physician I named to speak with me privately to confirm that the decision is my own.
- **Yearly Review**: I will review this Agreement with my Supporters at least once a year, and after any hospital stay, new diagnosis, move, or death or illness of a Supporter.
- **Copies**: A copy or scan of this Agreement is as good as the original.
- **Law**: This Agreement is governed by the laws of the state where I live. If any part is not enforceable, the rest remains in effect.

SIGNATURES

A. My statement and signature

I am an adult. I have read this Agreement, or it has been read or explained to me in a way I understand. I am signing of my own free will. I know that I do not have to sign it, that I can change or cancel it at any time, and that no one required me to sign it as a condition of care or housing. I understand that my Supporters cannot make decisions for me.

_____ Date: _____

Signature of the person making this Agreement

_____

Printed name

Date signed: _____

B. Witnesses (two adults)

We witnessed the person named above sign this Agreement, and we believe that he or she appears to understand it, to be of sound mind, and to be acting freely, and not under duress, fraud, or undue influence. Each of us confirms that we are at least 18 years old and that we are **not** (1) related to the person by blood, marriage, or adoption; (2) a Supporter, or a Supporter's spouse, relative, or employee; (3) the person's doctor, therapist, or other health care provider, or the owner, operator, or an employee of any facility where the person lives or receives care; or (4) a person with a financial interest in the person's estate or trust.

_____ Date: _____

Witness 1: signature

_____

Printed name

_____ Date: _____

Witness 2: signature

_____

Printed name

C. Read-aloud certification

This Agreement was read aloud, or otherwise communicated, to the person named above, in the presence of the witnesses or notary, in a form appropriate to that person's needs and preferences:

☐ Read aloud in full by: _____

☐ Communicated another way (describe): _____

D. Supporter's consent and statement

Each Supporter signs a separate copy of this page. I consent to serve as a Supporter for _____ (name of person), and I understand and agree that:

1. **My Job**: My job is to help this person understand, make, and communicate his or her own decisions, and to honor his or her wishes, even when I would choose differently.
2. **No Authority to Decide**: I have no authority to decide for this person or to sign for this person because of this Agreement.
3. **Honesty and Good Faith**: I will act honestly and in good faith, keep this person's information private, and not pressure or isolate this person.
4. **Conflicts**: I have told this person about any conflict of interest, and I will keep doing so. My conflicts, if any, are: _____.
5. **Speaking Up**: I will speak up and, when needed, report if I believe this person is being abused, neglected, or exploited.

I state that, to the best of my knowledge, each of the following is true:

☐ No government agency has found that I abused, neglected, or exploited this person, or any child, older adult, or person with a disability.

☐ In the last seven years I have not been convicted of any sexual offense or aggravated assault where the victim was a child, an older adult, or a person with a disability, and I have not been convicted of fraud, theft, forgery, or extortion.

☐ I am not this person's doctor or other health care provider, or the owner, operator, or an employee of any place where this person lives or receives care, unless I am this person's relative.

☐ I do not work for a government agency that is financially responsible for this person's care, unless I am this person's relative.

_____ Date: _____

Signature of Supporter

_____

Printed name

Relationship to me: _____

Address / telephone: _____

E. Notary acknowledgment

State of _____ County of _____

This document was acknowledged before me on _____ (date) by _____ (name of person making this Agreement) and by _____ (name of each Supporter).

Each person named above was personally known to me or proved his or her identity to me. Based on my observation and conversation, the person making this Agreement appeared to be of sound mind and not acting under duress, fraud, or undue influence.

_____
Notary Public

_____
Printed name

My commission expires: _____

Both witnesses and a notary are recommended. Together they make it much harder for anyone to challenge the Agreement later.

EXHIBIT A. MY PEOPLE AND MY CONTACT SHEET

Keep this page current. Give a copy to each Supporter and keep one with this Agreement.

Role	Name	Telephone / email
Supporter 1		
Supporter 2		
Supporter 3		
Alternate Supporter		
Spouse or partner		
Trustee / successor trustee		
Trust protector		
Agent: power of attorney for money		
Agent: health care power of attorney		
Mental health proxy (if any)		
Physician named to determine competency		
Primary care doctor		
Other doctors / specialists		
Pharmacy		
Mental health provider (if any)		
Attorney		
Financial advisor / banker		
Insurance (Medicare, supplement, LTC)		
Faith leader / friend to be told		
Neighbor with a key		

Where my original documents are kept: _____

Legal Vault / online storage: _____

EXHIBIT B. MY AGING IN PLACE AND COMFORT AND CALM PLAN

This exhibit helps people care for me the way I want to be cared for, especially when I can no longer explain it. I fill it out with my Supporters and update it every year.

B-1 My preference for where I receive care (number in the order I prefer)

_____ My own home, with paid or family help
_____ My own home, with adult day services or respite stays
_____ The home of a family member or friend
_____ A small residential setting or a senior apartment with services
_____ Assisted living
_____ A nursing home, only for a short, goal-directed stay, with a written plan to return home
_____ Other: _____

I want my care to take place in the **least institutional setting possible, regardless of cost,** as my trust provides. I want each move to a more restrictive setting to be a last resort and to be reviewed often.

B-2 What helps me feel safe, calm, and like myself

List the things that comfort me. Ordinary things matter. Familiar things reach me when words do not.

Music, songs, or programs I love:

Smells, foods, drinks, and tastes I enjoy:

Photographs, objects, clothing, or places that are important to me:

My daily routines (waking, meals, bath, bedtime, prayer, television, walks):

People, pets, and activities that settle me:

Spiritual, religious, or cultural practices I want kept:

B-3 What upsets me, and what to try first

Things that frighten or upset me (noise, crowds, being rushed, being touched, strangers, the dark):

When I seem agitated, restless, or afraid, please try these first:

☐ **Look for the reason first.** Check for pain, hunger, thirst, a full bladder or bowel, tiredness, boredom, loneliness, noise, being too hot or cold, and fear. Watch how I behave and what I do just before I become upset.

☐ I ask that **non-drug approaches** be tried and recorded before any medicine is used to manage my behavior, unless there is immediate danger.

☐ I ask that my Supporters be called when I am upset, because their voices or presence may help.

This page is not a declaration for mental health treatment and does not authorize anyone to consent to or refuse treatment. My written instructions about specific psychiatric medicines, electroconvulsive treatment, and admission to a psychiatric facility belong in a separate legal document (an Ohio declaration for mental health treatment, or my health care power of attorney), and they control over this page.

B-4 My wishes about visitors, privacy and personal care

Who I want or do not want to help with bathing and personal care; privacy preferences; who may visit; anything else:

EXHIBIT C. COUPLES: RIDER FOR MARRIED OR PARTNERED HOUSEHOLDS

Each spouse or partner completes his or her own Agreement and this Rider. Spouses may name each other as Supporters, but each should also name someone else. This Rider is part of the Agreement of:

Name: _____

My spouse / partner: _____

C-1 My spouse or partner

☐ My spouse/partner **may** be my Supporter, in the areas I checked in Part 3.

☐ My spouse/partner **may not** be my Supporter. I want my spouse/partner to be informed and visited, but not to help me decide.

☐ My spouse/partner **may** be my Supporter, but another Supporter must be told before any decision about moving me, or about my money.

C-2 If our needs are different

I know that one of us may need more care, or a different setting, than the other, and that keeping us both at home may become difficult. I want the following to guide my Supporters, my agents, and my trustee:

1. **Support Both of Us at Home First**: Try added in-home help, respite, equipment, adult day services, home modifications, and family help for **both** of us before any move.
2. **Protect the Spouse Most Able to Live Independently**: If both cannot stay at home, give primary consideration to the independence, safety and health of the spouse who is most capable of living independently, and look for less institutional choices for the other.
3. **Stay Together as Much as Possible**: If we must live apart, choose places close to each other, and arrange frequent visits, shared meals, and holidays together.
4. **Never Move Me for Cost or Convenience Alone**: My spouse's needs are not, by themselves, a reason to move me, and my needs are not, by themselves, a reason to move my spouse.
5. **Keep Our Marriage**: No one may ask a court to end or annul our marriage on behalf of either of us.
6. **Resolve Disagreements Fairly**: If my Supporters and my spouse's Supporters disagree, they should meet together, with the physician or geriatric care manager each of us named, and write down a plan we would both want.

Other wishes for our household:

_____

_____ Date: _____

Signature of person making this Rider

_____

Printed name

EXHIBIT D. AUTHORIZATION TO SHARE HEALTH INFORMATION (HIPAA)

This Authorization is intended to meet the requirements of the federal privacy rule, 45 C.F.R. 164.508. It is separate from any other release.

Name of person giving this authorization: _____

Date of birth: _____

1. Who may share my information

I authorize every doctor, nurse, therapist, hospital, nursing home, assisted living facility, home health or hospice agency, pharmacy, laboratory, insurance company, Medicare, Medicaid, and any other health care provider or plan ("my providers") that has information about me to share it as stated here.

2. Who may receive my information

My Supporters named in Part 2 of my Supported Decision-Making Agreement, and any alternate or successor Supporter I later name in writing, including:

_____

3. What information may be shared

☐ All of my health information, including records, test results, diagnoses, treatment and discharge plans, medication lists, and billing and insurance information.

☐ Only the following:

_____

☐ I **also** authorize release of mental health information, alcohol or drug treatment information, HIV/AIDS information, genetic information, and reproductive health information. ____ initial

☐ I **do not** authorize release of psychotherapy notes. ____ initial

4. Why

To help me understand my health, make my own decisions, coordinate my care, and plan for care at home. This is at my request.

5. How long

☐ This Authorization ends on: _____

☐ This Authorization continues until I revoke it in writing, or until I die. It continues even if I later lose capacity.

6. My rights

- I can **revoke** this Authorization at any time by writing to my provider. A revocation does not apply to information already shared in reliance on it.
- I do **not** have to sign this Authorization to get treatment, payment, enrollment, or benefits.
- Information shared under this Authorization may be shared again by the person who receives it and may no longer be protected by federal privacy law.
- I am entitled to a copy of this signed form.

_____ Date: _____

Signature of person giving this authorization

_____

Printed name

Copies of this signed Authorization are as good as the original.

EXHIBIT E. PHYSICIAN'S LETTER ABOUT UNDERSTANDING AT SIGNING (RECOMMENDED)

Optional. It is not required for the Agreement to be valid, but a letter from the person's physician dated close to the signing is strong evidence that the person understood what he or she signed. Ask the physician to examine the person within 30 days before or after signing.

To whom it may concern:

I am a licensed physician. I have examined _____ (the person) on _____ (date). I have reviewed with the person the nature and effect of the Supported Decision-Making Agreement dated _____, including that the person chooses Supporters to help him or her make decisions, that the Supporters cannot decide for the person, and that the person may cancel it at any time.

In my professional opinion, at the time of my examination the person:

☐ understood the nature and effect of the Agreement;

☐ could say, in his or her own words, who the Supporters are and what they will help with;

☐ could communicate a choice, and appeared to be acting freely and voluntarily; and

☐ appeared free from duress or undue influence at the time I saw the person, as far as I could tell.

Support or accommodations used during the evaluation (for example, more time, hearing or vision aids): _____.

This letter concerns the person's understanding on the date stated. It is not a general opinion about the person's capacity for other decisions.

_____ Date: _____

Physician signature

_____

Printed name

Printed name and license number: _____

Practice / telephone: _____

EXHIBIT F. NOTICE OF CHANGE, RESIGNATION, OR CANCELLATION

Use this form to tell people about a change. Send a copy to everyone who received the Agreement (see Exhibit A and the Deployment Kit list).

Name of person with the Agreement: _____ Date: _____

Agreement dated: _____

☐ I **cancel** the entire Agreement.

☐ I **remove** this Supporter: _____

☐ I **add** this Supporter: _____ (new Supporter's Consent is attached)

☐ I **resign** as Supporter. (Supporter signs below)

☐ I **change** the following in Part 3, 4, 5, 6, or 8 (describe):

_____

_____ Date: _____

Signature of the person who made the Agreement (or Supporter, if resigning)

_____

Printed name

Please tell my doctors, facilities, and others who have a copy. Anyone who has received this notice should stop relying on the cancelled parts of the Agreement.

EXHIBIT G. NOTICE TO HOSPITALS, NURSING HOMES, AND OTHER PROVIDERS

Please place at the front of my chart

Patient: _____ **Date of birth:** _____

This patient has signed a **Supported Decision-Making Agreement** and has named the Supporters listed on Exhibit A. The patient **makes his or her own decisions**. The Supporters help the patient understand, decide, and communicate. They are **not** guardians or agents by virtue of this Agreement.

- **Please Call**: the Supporters for care-plan meetings, discharge planning, changes in condition, medication changes, falls, and any proposal for the patient to be moved.
- **Please Ask the Patient**: speak with the patient directly, explain in plain language, and record the patient's own choice. Please use the accommodations in Part 1 of the Agreement.
- **Please Note**: the patient wishes to age in place and to receive care in the least institutional setting possible. If the patient says he or she wants to go home, please call the Supporters and the physician named in Section 7.4 before concluding that the patient cannot.
- **Please Look for Fixable Causes**: before attributing confusion or agitation to dementia, check for infection, pain, dehydration, medication effects, and other treatable causes.
- **Other Documents**: the patient also has a trust, powers of attorney, a health care power of attorney, a living will, and a HIPAA authorization, which are available through the contacts on Exhibit A.
- **Guardianship**: the patient asks that no guardianship proceeding be started without notice to the Supporters, the trustee, and the physician named in the Agreement.

Supporter contact: _____ **Telephone:** _____