SUPPORTED DECISION-MAKING AGREEMENT

2017 WISCONSIN ACT 345 – Wisconsin Chapter 52

APPOINTMENT OF SUPPORTER

I, _____ (insert name), make this agreement voluntarily and of my own free will. I agree and designate that:

_____

(print) Name of supporter

Address of supporter City State zip

_____

E-mail address of supporter

Phone number(s) of supporter Cell Phone

is my supporter.

For the following everyday life decisions, if I have checked "Yes," my supporter may help me with that type of decision, but if I have checked "No," my supporter may not help me with that type of decision:

Obtaining food, clothing, and shelter — Yes.... No....

Taking care of my physical health — Yes.... No....

Managing my financial affairs — Yes.... No....

Taking care of my mental health — Yes.... No....

Applying for public benefits — Yes.... No....

Assistance with seeking vocational rehabilitation services and other vocational supports — Yes.... No....

The following are other decisions I have specifically identified that I would like assistance with ....

_____

_____

_____

If I have not checked either “Yes" or “No" or specifically identified and listed a decision immediately above, my supporter may not help me with that type of decision.

My supporter is not allowed to make decisions for me.

To help me with my decisions, my supporter may do any of the following, if I have checked “Yes”:

1. Help me access, collect, or obtain information, including records, relevant to a decision. If I have checked “Yes,” my supporter may help me access, collect, or obtain the type of information specified, including relevant records, but if I have checked “No,” or I have not checked either “Yes” or “No,” my supporter may not help me access, collect, or obtain that type of information:

   Medical — Yes.... No....

   Psychological — Yes.... No....

   Financial — Yes.... No....

   Education — Yes.... No....

   Treatment — Yes.... No....

   Other — Yes.... No.... (If “Yes,” specify the other type(s) of information with which the supporter may assist ....)

2. Help me understand my options so I can make an informed decision. Yes.... No....

3. Help me communicate my decision to appropriate persons. Yes.... No....

4. Help me access appropriate personal records, including protected health information under the Health Insurance Portability and Accountability Act, the Family Educational Rights and Privacy Act, and other records that may or may not require a release for specific decisions I want to make. Yes.... No....

EFFECTIVE DATE OF SUPPORTED DECISION-MAKING AGREEMENT

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.

_____

(print) Name of person designating a supporter

_____

Signature Date

CONSENT OF SUPPORTER

I know _____ (name of person) personally or I have received proof of his or her identity and I believe him or her to be at least 18 years of age and entering this agreement knowingly and voluntarily. I am at least 18 years of age.

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

Supporter:

_____

(print) Name of supporter

_____

Address of supporter City State zip

_____

E-mail address of supporter

_____

Phone number(s) of supporter Cell Phone

_____

Signature Date

STATEMENT AND SIGNATURE OF WITNESSES OR SIGNATURE OF NOTARY

(This agreement must be signed either by 2 witnesses who are at least 18 years of age or by a notary public.)

OPTION I: WITNESSES

I know .... (name of person) personally or I have received proof of his or her identity and I believe him or her to be at least 18 years of age and entering this agreement knowingly and voluntarily. I am at least 18 years of age.

Witness No. 1:

_____

(print) Name

Address City State zip

Phone number(s) Cell Phone

Signature Date

Witness No. 2:

_____

(print) Name

Address City State zip

Phone number(s) Cell Phone

Signature Date

OPTION II: NOTARY PUBLIC

State of .... _____

County of .... _____

This document was acknowledged before me on .... _____ (date), by _____ (name of adult with a functional impairment) and _____ (name of supporter).

_____Signature of notary ....(Seal, if any, of notary)

Printed name .... _____

My commission expires: .... _____