# Supported Decision-Making Plan

This supported decision-making plan ("Plan") is to support and accommodate an adult with a disability who is making their own life decisions. As used in this plan, "Principal" refers to the person with the disability identifying their chosen Supporter(s) and "Supporter" refers to the chosen individual(s) who have agreed to provide support to the Principal in accordance with the terms of this Plan.

**PROTECTION FOR THE ADULT WITH A DISABILITY**

If a person who receives a copy of this plan or is aware of the existence of this plan has cause to believe that the Principal is being abused, neglected, or exploited by a Supporter, report the alleged abuse, neglect, or exploitation to the MUI Department of the County Board of Developmental Disabilities for the county in which the Principal resides and/or local law enforcement as applicable.

I, _____, am the Principal creating this Plan. I appoint the people identified below to be my Supporter(s). I may choose to make decisions without involving my Supporter(s), I may seek additional support from other persons, and I may always add or remove individuals as a Supporter.

My Supporters do not make decisions for me. When I am making, communicating, or implementing my decisions, my Supporters may:

1. Help me get the information I need to make decisions. This includes medical, psychological, financial, educational, or other decisions.
2. Help me understand my choices and understand the benefits and negatives of each decision I need to make.
3. Help me communicate my decisions to the right people.
4. Help me monitor information about my life and services.
5. Help me advocate for my decisions to be implemented, understanding my personal values, beliefs, preferences, and heritage.

My supporter(s) are listed on the next page.

**Supporter #1:** Name: _____
Address: _____
Phone Number: _____
Email address: _____

I want this person to help me with: (check as many boxes as you want)
□ All of my decisions for which I ask for assistance
□ Making choices about my health
□ Making choices about how I spend my time
□ Making choices about food, clothing, where I live and where I work
□ Making choices about how I spend and save my money
□ I want limited assistance in the following areas only: _____
_____

I want this person to have access to information about me when it is relevant to a decision I am making with their support, including my personal information protected under:
(check as many boxes as you want)
□ Health Insurance Portability and Accountability Act of 1996
□ Family Educational Rights and Privacy Act of 1974
□ Financial Services Modernization Act of 1999

**Supporter #2:** Name: _____
Address: _____
Phone Number: _____
Email address: _____

I want this person to help me with: (check as many boxes as you want)
□ All of my decisions for which I ask for assistance
□ Making choices about my health
□ Making choices about how I spend my time
□ Making choices about food, clothing, where I live and where I work
□ Making choices about how I spend and save my money
□ I want limited assistance in the following areas only: _____
_____

I want this person to have access to information about me when it is relevant to a decision I am making with their support, including my personal information protected under:
(check as many boxes as you want)
□ Health Insurance Portability and Accountability Act of 1996
□ Family Educational Rights and Privacy Act of 1974
□ Financial Services Modernization Act of 1999

This plan starts when signed and will continue until my Supporters or I end the plan or the plan ends by law.

Signed this _____(day) of _____(month), _____(year).

_____ _____
Signature of Principal Printed Name of Principal

**IMPORTANT INFORMATION FOR SUPPORTERS:**

When you agree to provide support to an adult with a disability under this supported decision-making plan, you have a duty to:

1. Act in good faith at all times.
2. Act with loyalty to the Principal and fully disclose any and all conflicts of interest to the Principal and any other members of their support team (including a service and support administrator or a qualified intellectual disability professional). If you have a conflict of interest, you must refrain from advising or assisting the Principal with the decision.
3. Not make decisions on behalf of the individual but rather advocate for them and their choices.
4. If you are also an agent for the Principal in a General Durable Power of Attorney and/or a Health Care Advanced Directive, recognize that those documents should be secondary to this Plan and only used as a last resort.

**CONSENT OF SUPPORTER**

I, _____, consent to act as a Supporter under this agreement.

_____ _____
(Signature of Supporter) (Printed Name of Supporter)

**CONSENT OF SUPPORTER**

I, _____, consent to act as a Supporter under this agreement.

_____ _____
(Signature of Supporter) (Printed Name of Supporter)

**This Plan must be signed in front of two witnesses or a Notary Public.**

All witnesses must be adults over the age of 18 who are not parties to this Plan as the Principal or Supporter(s). By witnessing this plan, you are attesting that the plan was signed of the Principal's own free will and accord.

_____ _____

Witness #1 Printed Name of Witness #1

_____ _____

Witness #2 Printed Name of Witness #2

OR

STATE OF OHIO )
) ss.
COUNTY OF _____ )

This is an acknowledgment. No oath or affirmation was administered to the signers with regard to this notarial act. This foregoing instrument was acknowledged before me this ___ day of _____, 20__ by _____as the Principal and by _____ and _____ as Supporters.

[Seal]

_____

Notary Public
My commission expires:

Department of Developmental Disabilities