

Supported Decision Making Agreement

***DISCLAIMER: Under the Louisiana law, the individual can use the form below or any form that that the individual chooses to use. This form is just a sample that includes the minimum requirements required by law.

This agreement is governed by the Dustin Gary Act, also known as Supported Decision-Making, R.S. 13:4261.101 through 4 4261.302 of Louisiana Statute. This supported decision-making agreement is to support and accommodate an individual with a disability to make life decisions, including decisions related to where and with whom the individual wants to live, the services, supports, and medical care the individual wants to receive, and where the individual wants to work, without impeding the self-determination of the individual with a disability.

This agreement may be revoked by the individual with a disability or his or her supporter at any time. If either the individual with a disability or his or her supporter has any questions about the agreement, he or she should speak with a lawyer before signing this supported decision-making agreement.

I (Name of Adult with Disability), _____ am entering into this agreement voluntarily.

I choose (Name of Supporter) _____ to be my Supporter.

Supporter's Address: _____

Phone Number: _____

E-mail Address: _____

My Supporter may help me with life decisions about:

- obtaining food, clothing and a place to live: Yes ___ No___
- my physical health: Yes ___ No___
- my mental health: Yes ___ No___
- managing my money or property: Yes ___ No___
- getting an education or other training: Yes ___ No___
- choosing and maintaining my services and supports: Yes ___ No___
- finding a job: Yes ___ No___
- Other: _____

My Supporter does not make decisions for me. To help me make decisions, my Supporter may:

1. Help me get the information I need to make medical, psychological, financial, or educational decisions.
2. Help me understand my choices so I can make the best decision for me.
3. Help me communicate my decision to the right people.

Yes____ No____ My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996. I will provide a signed release.

Yes____ No____ My Supporter may see my educational records under the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. Section 1232g). I will provide a signed release.

This agreement starts when signed and will continue until _____ (date) or until my Supporter or I end the agreement or the agreement ends by law.

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

(Signature of Adult with Disability)

(Printed Name of Adult with Disability)

Consent of Supporter

I (Name of Supporter), _____ consent to act as a Supporter under this agreement.

(Signature of Supporter)

(Printed Name of Supporter)

This agreement must be signed in front of two witnesses a Notary Public.

(Witness 1 Signature)

(Printed Name of Witness 1)

(Witness 2 Signature)

(Printed Name of Witness 2)

Notary Public State of _____ Parish of _____

This document was acknowledged before me on _____ (date)

By _____ (Name of Adult with a Disability)

and _____ (Name of Supporter)

(Signature of Notary)

(Printed Name of Notary)

(Seal, if any, of notary) My commission expires: _____

---- 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 Adult Protective Services (APS) is responsible for investigating reports and arranging for services to protect vulnerable adults ages 18-59 and emancipated minors who are at risk of abuse, neglect, exploitation or extortion. Reports of adult abuse may be made 24 hours a day, seven days a week, to **1.800.898.4910**(toll-free)