WEST virginia legislature

2024 regular session

Introduced

House Bill 5136

By Delegate Criss

[Introduced; Referred

to the Committee on ]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §44A-6-1, §44A-6-2, §44A-6-3, §44A-6-4, and §44A-6-5, all relating to creating the Supported Decision-Making Act; providing for a legislative purpose; providing for definitions; laying out the requirements for the petition; and providing for transitional planning.

Be it enacted by the Legislature of West Virginia:

ARTICLE 6. supported decision- making act.

§44A-6-1. Legislative purpose.

The purpose of this bill is to establish the Supported Decision-Making Act, which authorizes an adult with a disability to enter into a supported decision-making agreement in which he or she designates one or more supporters to provide assistance when making decisions or engaging in certain other activities. An adult who enters into the agreement voluntarily and understands the nature and effect of the agreement.

§44A-6-2. Definitions.

For the purpose of this article:

(a) "Adult" means an individual 18 years of age or older.

(b) "Coercion" means use of force or threats to persuade someone to do something.

(c) "Decision-maker" means an adult who seeks to execute or has executed, a supported-decision making agreement with one or more supporters under this chapter.

(d) "Disability" means, with respect to an individual, a physical or mental impairment that substantially limit one or more major life activities.

(e) "Supported decision-making" means the process of supporting, without impeding the self-determination of the decision-maker, and accommodating the decision-maker in making life decisions, including decisions related to where the decision-maker wants to live; the services, supports, financial decisions, and medical care the decision-maker wants to receive; whom the decision-maker wants to live with; and where the decision-maker wants to work.

(f) "Supported decision-making agreement" is an agreement a decision-maker enters into with one or more supporters under this section to use supported decision-making.

(g) "Supporter" means an adult who has entered into a supported decision-making agreement with a decision-maker.

§44A-6-3. Applicability.

(a) A decision-maker may voluntarily, without undue influence or coercion, enter into a supported decision-making agreement with a supporter or supporters. The decision-maker may amend or terminate a supported decision-making agreement at any time.

(b) Except as limited by a supported decision-making agreement, a supporter may provide to the decision-maker the following decision-making assistance with the decision-maker's affairs with the consent of the decision-maker:

(1) Assisting with making decisions, communicating decisions, and understanding information about options for the responsibilities of, and the consequences of decisions.

(2) Accessing, obtaining, and understanding information that is relevant to decisions necessary for the decision-maker to manage his or her affairs, including medical, psychological, financial, and educational information, and medical and other records. The information is kept privileged and confidential, as applicable, and is subject to neither unauthorized access, nor use, nor disclosure.

(3) Ascertaining the wishes and decisions of the decision-maker; assisting in communicating those wishes and decisions to other persons; and advocating to ensure their implementation; and

(4) Accompanying the decision-maker and participating in discussions with other persons when the decision-maker is making decisions or attempting to obtain information for decisions.

(c) A supporter may exercise only the authority granted to the supporter in the supported decision­making agreement.

(d) Except as provided in paragraph (b), the supported decision-making agreement extends until terminated by the decision-maker, all supporters, the terms of the agreement, or court order, following notice and an opportunity to be heard, and if the decision-maker is indigent and does not have counsel, the appointment of counsel.

(e) If the supported decision-making agreement includes more than one supporter, the agreement shall survive for supporters who have not terminated unless it is terminated by the decision-maker or by all supporters.

(f) The supported decision-making agreement is suspended when Adult Protective Services, any mandatory reporter or representative from an authorized agency, or a court of competent jurisdiction finds that the adult with a disability has been abused, neglected, or exploited by a supporter or supporters. The agreement may survive if one or more of the supporters who were not found to have abused, neglected, or exploited the adult with a disability continues to be willing to serve as a supporter and the decision-maker agrees.

(g)(1) A supporter is only authorized to assist in the decision-maker accessing, collecting, or obtaining information that is relevant to a decision authorized under the supported decision-making agreement and to which the decision-maker agrees to that the supporter should have access.

(2) If a supporter assists the decision-maker in accessing, collecting, or obtaining personal information, including protected health information under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) or educational records under the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. section 1232g), the supporter shall ensure the information is kept privileged and confidential, as applicable, and is subject to neither unauthorized access, nor use, nor disclosure.

(3) The existence of a supported decision-making agreement does not preclude a decision­maker from seeking personal information without the assistance of the supporter.

(4) A supported decision-making agreement must be signed voluntarily, without coercion or undue influence, by the decision-maker and the supporter or supporters in the presence of two or more subscribing witnesses who are 18 years of age, and unrelated to the person with the disability, or a notary public.

(h) A supported decision-making agreement is valid only if it is in the form of the agreement in the subsection above. The agreement is intended to be personalized by the decision-maker to reflect his or her personal circumstances. The decision-maker should describe in the agreement the type of decision-making assistance he or she would like from his or her supporters.

(i) Agreement:

**SUPPORTED DECISION-MAKING AGREEMENT.**

My name is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My address is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My phone number is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My email address is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I want to have people I trust help me make decisions. The people who will help me are called Supporters. I can say what kind of help my Supporters will give me. I am entering into this agreement voluntarily and I understand that:

□ I can talk to an attorney before I sign this agreement.

□ I do not have to sign this agreement.

□ This agreement is because I want supporters to help me make decisions.

□ My supporter cannot make decisions for me.

□ I can end this agreement when I want it to.

□ I can change this agreement when I want to.

□ If I end this agreement or change this agreement, I must let my supporters know about the change. Anyone with a copy of the agreement needs to get a copy of the change in writing.

□ I can change my list of supporters when I want to.

□ My supporter(s) can quit if they want to.

□ If I have more than one Supporter in any area, those Supporters will work jointly (together) unless I note otherwise.

□ My Supporter(s) is not liable for any consequences or decisions I make unless my Supporter's actions or omissions amount to fraud, misrepresentation, recklessness, or willful or wanton misconduct.

My Supporter(s) are not allowed to make choices for me. To help me with my choices, my supporters may:

Help me find out more about my options and what choices I have by giving me information in a way I can understand.

Help me understand what the choices are so I can make a good decision for me by discussing both the good things and bad things (pros and cons) that could happen if I make one decision or another.

Help me communicate or tell other people about my decision so the right people know what I want.

This supported decision-making agreement starts right now and will continue until the agreement is stopped by me or my supporters, or the agreement ends by law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Decision-Maker Date (Month/Day/Year).

APPOINTMENT OF SUPPORTER(S) - SEPARATE FORM FOR EACH SUPPORTER

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I want this person to help me with making choices about: (check as many boxes as you want)

□ Buying or obtaining food and clothing

□ Where I live and whom I live with

□ My personal relationships, including friendships, dating, sex, and marriage

□ How I spend my time, hobbies, and activities

□ My education or training, including what classes I will take and what accommodations I will have

□ If I work and/or where I work, and what accommodations I will have

□ Choosing the level of services and supports and managing the people who work with me

□ Hiring a lawyer if I need one and working with the lawyer

□ My physical health (if yes, the Healthcare Addendum must be completed)

□ My mental health (if yes, the Healthcare Addendum must be completed)

□ My financial affairs, like banking and budgeting (if yes, the Finance Addendum must be completed)

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I express myself and show what I want in the following ways:

Telling people my likes and dislikes.

□ Verbally □In Writing □Using Assistive Technology □ Demonstrate □ Other

Telling people what I do and do not want to do.

□ Verbally □ In Writing □ Using Assistive Technology □ Demonstrate □ Other

Areas I specifically do not want Supporter(s) to assist me with:

□ Finances □ Healthcare □ Education □ Relationships

□ Employment □ Legal Matters □ Daily Living □ Services/Supports

□ Yes □ No My Supporter may see my private health information under the Health Insurance Portability and Accountability Act of 1996. This lets my Supporters see my medical records. (If yes, I will provide a signed release form for HIPAA Authorization).

□ 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). This lets my Supporters see my school information. (If yes, I will provide a signed release form for Authorization to Disclose Educational Information)

**CONSENT OF SUPPORTER(S) - SEPARATE FORM FOR EACH SUPPORTER**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_, consent to act as \_\_\_\_\_\_\_\_\_\_\_'s Supporter under this agreement. I understand that my job as a Supporter is to honor and express his/her expressed wishes. My support might include giving this person information in a way he/she can understand; discussing the pros and cons of decisions; and helping this person communicate his/her choice. I know that I may not make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith. In the event I cannot perform my job under this agreement, I will contact the Decision-Maker and/or other team member(s).

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Supporter Printed Name of Witness

State of West Virginia County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This record was acknowledged before me on \_\_\_\_\_\_\_\_\_\_\_\_ (date).

(Name of Supporter) and

Signature of Notary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of Office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUPPORTED DECISION-MAKING AGREEMENT - HEALTH CARE ADDENDUM**

You have the right to make your own health care decisions and the right to decide who helps you make those decisions. If you do not want a person named in this form to help you make health care decisions, you do not have to give them permission to help you with your physical or mental health choices. If you sign this agreement, you still have the right to make the final decision about your health care. Your health care supporter cannot force you to accept health care that you do not want or take away health care that you do want. This agreement does not give my Supporter the authority to make decisions about my health care for me, or to influence me to make decisions that do not reflect my expressed wishes and preferences. My Supporter's consent to providing or withholding treatment is not a substitute for my consent.

MY PHYSICAL HEALTH

□ Yes □ No Help me make appointments with doctors, dentists, therapists, case managers, or other health care providers

□ Yes □ No Help me keep track of information about my physical health care, including my medical records, and whether I have had recommended medical check-ups, tests, and vaccines

□ Yes □ No Help me with my physical health care plan, including, but not limited to, taking medications, monitoring blood sugar, administering insulin, and refilling prescriptions

□ Yes □ No Permission for my supporter to talk to doctors when I am not present or when I am temporarily unable to communicate.

MY MENTAL HEALTH

□ Yes □ No Help me make appointments with doctors, therapists, case managers, or

other health care providers

□ Yes □ No Help me keep track of information about my health care, including my

medical records, and whether I have had recommended medical check-ups and tests

□ Yes □ No Help me with my mental health care plan, including, but not limited to, taking medications, and refilling prescriptions

□ Yes □ No Permission for my supporter to talk to doctors when I am not present or when I am temporarily unable to communicate.

□ Yes □ No Permission for my supporter to access psychotherapy notes or other

information conversations I have had during mental health counseling, substance use counseling, or group or family therapy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supporter's Signature Date

Decision-Maker's Signature Date

**SUPPORTED DECISION-MAKING AGREEMENT - FINANCE ADDENDUM**

You have the right to make your own finance decisions and the right to decide who helps you make those decisions. If you do not want a person named in this form to help you make finance decisions, you do not have to give them permission to help you with your financial choices. If you sign this agreement, you still have the right to make the final decision about your finances. Your Supporter cannot force you to spend or save your money in a way that you do not want, or manage it in a way that you do not want.

This agreement does not give my Supporter the authority to make decisions about my healthcare for me, or to influence me to make decisions that do not reflect my expressed wishes and preferences. My Supporter's consent to providing or withholding treatment is not a substitute for my consent.

I want to have supporters help me make decisions about how I spend my money and how I save my money.

Consent of Supporters - Financial

I, \_\_\_\_\_\_\_\_\_, consent to act as \_\_\_\_\_\_\_\_\_'s supporter for financial decisions under this agreement. I agree to provide financial records to the supported decision-making monitor (listed below) monthly/ quarterly/ annually (circle one). I understand that my job as a supporter is to honor and present the wishes of the person with a disability. I understand that my support might include giving this person information in a way he/she can understand; discussing pros and cons of decisions; communicating the person's choice. I know that I may not make decisions for this person. I agree to support this person's decisions to the best of my ability, honestly, and in good faith.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supporter's Signature Date

Consent of Monitor - A monitor must be appointed to oversee financial supporters.

I, \_\_\_\_\_\_\_\_\_\_\_\_, consent to act as a Monitor for financial decisions under this agreement. I agree to review the financial records of the person with a disability when provided by the supporters every month. I agree to make reasonable efforts to ensure that the supporters under this agreement are acting honestly, in good faith, and in accordance with the choices of the person with a disability. If I suspect financial abuse, misuse of funds, bad faith, or failure to comply with the decisions of the person with a disability, I will require the supporters to explain their actions. If the supporter fails to provide this information or if I continue to have reason to believe that the supporter is abusing or failing to comply with the wishes of the person with a disability, I

will promptly inform Adult Protective Services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Monitor's Signature Date

MEETING AND TIMELINE CONSIDERATIONS

My support people are very important to me and I want to be respectful of their time. I know that I can call them to ask questions about my goals in this agreement at any time, but I would like to talk with my whole Supported Decision Making team:

Check one:

□ Every week

□One time a month

□ Two times a month

□ Every Six Months

□ One time a year

□ Before an important meeting (IEP/Doctor/Dentist)

□ I do not want my support team to meet on a regular basis

There will be times that I need to discuss certain topics in more detail and it won't be necessary to call the entire team together. Here is what I would like to do for specific Supporters:

MEETING TOPIC:

Finances How Often? In Person? By Phone? By Video?

Health care How Often? In Person? By Phone? By Video?

Education How Often? In Person? By Phone? By Video?

Relationships How Often? In Person? By Phone? By Video?

Legal Matters How Often? In Person? By Phone? By Video?

Daily Living How Often? In Person? By Phone? By Video?

Services/Supports How Often? In Person? By Phone? By Video?

Other How Often? In Person? By Phone? By Video?

ADDITIONAL DOCUMENTATION OR ATTACHMENTS

I understand that certain documents may give my Supporters more authority in my life or access to my personal information. I am including those documents as part of this agreement:

□ Authorization for Release of Records

□ Health Insurance Portability and Accountability Act (HIPAA) Release

□ Family Educational Rights and Privacy Act (FERPA) Release

□ Other Release

□ Letters of Guardianship [□Temporary/ □ Permanent]

□ Guardianship of the Person and Estate

□ Guardianship of the Person

□ Guardianship of the Estate

□ Power of Attorney

□ General

□ Financial

□ Medical

□ Durable Power of Attorney

□ General

□ Financial

□ Medical

□ Protective Order

□ Educational Surrogate Authorization

□ Trust Documents

□ Health Care Representative Authorization

□ Psychiatric Advanced Directive

□ Representative Payee Authorization

□ WVABLE Documentation

□ Living Will

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 the WV Bureau for Children and Families by calling the Centralized Intake for Abuse and Neglect Hotline at 1-800-352-6513 or online at https://dhhr.wv.gov/bcf/Services/Pages/Centralized-lntake-for­Abuse-and-Neglect.

DUTY OF CERTAIN PERSONS WITH RESPECT TO AGREEMENT

A person who receives the original or a copy of a Supported Decision-Making agreement shall rely on the agreement. A person is not subject to criminal or civil liability and has not engaged in professional misconduct for an act or omission of the act or omission is done in good faith and in reliance on a Supported Decision-Making agreement.

REMINDER

This agreement should be reviewed by all parties to the agreement, and this agreement must be read out loud or otherwise communicated to all parties to the agreement in the presence of a notary. The form of communication shall be appropriate to the needs and preferences of each party, including each individual's language and sensory processing wants or needs. Each Supporter will acknowledge by signature his/her/their role as determined by the Decision-Maker.

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

I have reviewed, agree with, and understand all the information contained in this Supported Decision- Making Agreement.

I understand that this agreement may be revoked by me or by my supporter(s) at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Decision-Maker Printed Name of Witness

State of West Virginia County of \_\_\_\_\_\_\_\_\_\_\_\_\_

This record was acknowledged before me on \_\_\_\_\_\_\_\_\_\_\_ (date)

By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Decision-Maker) and

By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Witness)

[SEAL}

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Notary

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The text of this agreement was communicated to the person with a disability in my presence by:

□ Reading the full agreement aloud

□ Otherwise communicating the agreement to the person with a disability (describe

communication used):

(j) A supported decision-making agreement may be in any form not inconsistent with the first subsection of this article and the other requirements of this chapter.

(k)(1) A person who receives the original or copy of a supported decision-making agreement shall rely on the agreement and recognize a decision or request made or communicated with the decision-making assistance of a supporter under this chapter as the decision or request of the decision-maker.

(2) A person who, in good faith, acts in reliance on an authorization in a supported decision-making agreement is not subject to civil or criminal liability or to discipline for unprofessional conduct for relying on a decision made in accordance with a supported decision-making agreement.

(3) Execution of a supported decision-making agreement may not be a condition of participation in any activity, service, or program.

(l) If a person who receives a copy of a supported decision-making agreement or is aware of the existence of a supported decision-making agreement or is aware of the existence of a supported decision-making agreement has cause to believe that the decision-maker is being abused, neglected, or exploited by the supporter, the person shall report the alleged abuse, neglect, or exploitation to the WV Department of Health and Human Resources Adult Protective Services.

§44A-6-4. Requirements of petition.

The petition for guardianship must state:

(a) Whether alternatives to guardianship and available supports and services to avoid guardianship, including a supported decision-making agreement, were considered; and

(b) Whether any alternatives to guardianship and supports and services are feasible and would avoid the need for guardianship.

§44A-6-5. Transitional planning.

State agencies shall inform individuals and families who are in a transition planning process, of the availability of supported decision-making as an alternative to guardianship in such cases where adult guardianship is being contemplated.

NOTE: The purpose of this bill is to create the Supported Decision-Making Act. The bill provides for a legislative purpose. The bill provides for definitions. The bill lays out the requirements for the petition. Finally, the bill provides for transitional planning.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.