

You Can Do It *Without* a Conservatorship!

Some people think a person with a disability needs a conservatorship when they turn 18. But there are ways to address common concerns that are easier, cheaper, and less restrictive than conservatorships.

This packet includes information and sample forms to help people with disabilities get support from family or other trusted supporters in medical, educational, and financial decisions without losing their rights.

*How can supporters help with **medical decisions**?*

- A person with a disability can sign a HIPAA Release permitting supporters to access her records.
 - “Sharing My Medical Information” is a plain-language release you can use.
- A person can invite anyone they trust to attend any medical appointments.
- A person with a disability can sign a Durable Power of Attorney for Health Care, which identifies supporters authorized to make decisions if she becomes incapacitated.
 - “If I Need Help Making Medical Choices” is a plain-language power of attorney.

*How can supporters stay involved in **education**?*

- A person with a disability can sign an authorization permitting supporters to attend IEP meetings and access her educational records.
 - “Sharing School Information” is a plain-language authorization.
- A student can invite anyone to an IEP meeting even without signing any paperwork.

*How can supporters help with **money management**?*

- Supporters can become the representative payee for government checks. SSI and other benefits will go directly to the representative payee.
- Supporters can monitor a person’s spending through various tools, including joint bank accounts, automatic bill pay, or debit cards from companies, like TrueLink, that offer prepaid debit cards that can be customized to protect against scams and fraud.

*To learn more, please contact the ACLU Disability Rights Program at:
www.aclu.org/disability • zbrennan-krohn@aclu.org*

Sharing My Medical Information

(Plain Language HIPAA Authorization for Disclosure of Health Information)

My name is _____.

My doctor's office or hospital is called: _____.

It is in this city: _____.

My doctors and nurses write notes about me. They also write about the tests they do. These notes are called **records**.

I want to share my medical records.

The person who can see my records is:

Name: _____

Address: _____

Phone number: _____

Email address: _____

This person can see:

Check one box.

- All of my medical records.
- Only some records. The records this person **can see** are:

Write what records you want the person to see.

Sharing My Medical Information

Sample HIPAA Authorization for Disclosure of Health Information

This person can see my records until:

Check one box.

This date: _____.

When I sign a form to say that this person can no longer see my records.

I have decided to share my medical records with _____.

I know that I do not have to share these records.

I know that I can stop this agreement at any time.

My doctors and nurses have to be very careful with my medical records. They cannot usually show my records to other people. The person who I am sharing my records with cannot share them with other people unless I agree.

I trust the person I am sharing my records with.

My signature:

The date today is: _____.

If I Need Help Making Medical Choices

(Plain Language Durable Power of Attorney for Health Care, adapted from CA Probate Code § 4701)

My name is _____.

My address is _____.

My birthday is _____.

My agents

If I cannot make health choices for myself, I want someone to make choices for me.

The person who will make these choices for me is called my **agent**.
My agents cannot be my doctor or someone who works in the hospital or a group home where I live.

My agent will only make choices for me if I cannot say what I want.

My agent's name is: _____.

My agent's address is: _____.

My agent's phone number is: _____.

If I need help and my agent is away or cannot help me, another person can help me. This person is a **back-up agent**.

My back-up agent's name is: _____.

Their address is: _____.

Their phone number is: _____.

When my agent can help me

My agent can make choices for me if my doctor says that I cannot make my own choices.

If the doctor thinks I cannot make my own choices, he or she must explain why in writing.

What my agent can do:

My agent can make choices for me if I cannot make my own choices.

My agent can choose what medicine I will get.

My agent can see the notes doctors and nurses write about me.

My agent can choose when I should stay in the hospital.

I agree that my agent can do all of these things.

Your signature: _____

When my agent is making choices for me, my agent must do what I want.

I will talk to my agent about what is important to me.

If my agent does not know what I want, he or she must make choices that will help me the most.

If my agent does not know what I want, he or she can talk to other people who love me and care about me.

I know that I have to sign this form with two people who are **witnesses**.

My witnesses will sign on the next page.

My signature: _____.

Today's date is: _____.

THIS DOCUMENT MUST SIGNED BY TWO WITNESSES.

WITNESSES: Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA

- (1) That the individual who signed or acknowledged this Power of Attorney for Healthcare is personally known to me, or that the individual's identity was proven to me by convincing evidence.
- (2) That the individual signed or acknowledged this Power of Attorney for Healthcare in my presence,
- (3) That the individual appears to be of sound mind and under no duress, fraud, or undue influence,
- (4) That I am **not** a person appointed as agent by this Power of Attorney for Healthcare, and
- (5) That I am **not** the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness

Name _____ Signature _____

Date: _____ Address _____

Second Witness

Name _____ Signature _____

Date: _____ Address _____

ONE OF THE PRECEDING WITNESSES ALSO MUST SIGN THE FOLLOWING DECLARATION:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operations of law.

Date: _____

Signature: _____

Only if the person making this power of attorney is unable to write, both witnesses must complete this section:

_____, being unable to write, made his/her mark in our presence and requested the first of the undersigned to write his/her name, which he/she did, and we now subscribe our names as witnesses thereto.

Signature of Witness #1

Signature of Witness #2

Only if the person making this power of attorney lives in a nursing home, this section must be completed by the patient advocate or ombudsman:

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code:

Name _____ Signature: _____

Date: _____ Address: _____

City: _____ State: _____

Sharing School Information

(Plain Language Authorization to Disclose Educational Information)

My name is _____.

My address is _____.

I go to school at _____.

My school is in this city: _____.

I have an IEP.

I want someone to help me make choices about school.

The person I want to help me is:

_____.

This person's phone number is: _____.

I want this person to come to my IEP meetings.

I want this person to get all the information that I get from my school.

It is okay for this person to see information that my school has about me.

This agreement to share school information will continue until I say it should stop.

My signature: _____

Today's date is: _____