



Is 18 the Magic Number?

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Learning Objectives

1.	Identify key decision-making support options, including supported-decision making for individuals who are approaching 18 years old
2.	Be equipped with knowledge and strategies to assess decision-making skills and educate families of ALL decision-making support options so they can make informed decisions on the least-restrictive option(s) to pursue
3.	Understand clinician involvement in implementing and documenting decision-making support options – saving clinical time and improving clinician-patient communication down the road

Disclosures: Nothing to disclose.

Think about your life for a moment...

- What decisions do you make independently everyday?
- Are there decisions in your life you need help with? Who helps you make them?



Turning 18 Defined

- **Age of Majority (or Legal Adult)** – “The age at which a person is granted by law the rights and responsibilities of an adult” (Merriam-Webster, n.d.).
- **Transfer of Rights** – “The transfer of rights under the IDEA refers to the process by which the rights granted to parents under the IDEA will transfer to the student upon reaching the age of majority” (Massachusetts Department of Elementary and Secondary Education, n.d.)

TRANSFER OF RIGHTS TO STUDENT

The student and parent(s) must be notified at least 1 year before the student's 18th birthday that decision-making rights will transfer from parent(s) to the student when the student turns 18. Is the student 17 or will they turn 17 during the timeframe of this IEP?

☐ Yes ☐ No

On what date was the student provided with the notice of transfer of rights and a copy of procedural safeguards concerning special education rights?

On what date was the parent(s) provided with notice of transfer of rights and a copy of procedural safeguards concerning special education rights?

* The dotted line indicates that this page of this IEP is dedicated to secondary transition planning.

(Massachusetts Department of Elementary and Secondary Education, n.d., p. 8).

Turning 18 does not lead to an overnight increase in decision-making capacity, but overnight you become legally responsible for all your decisions.

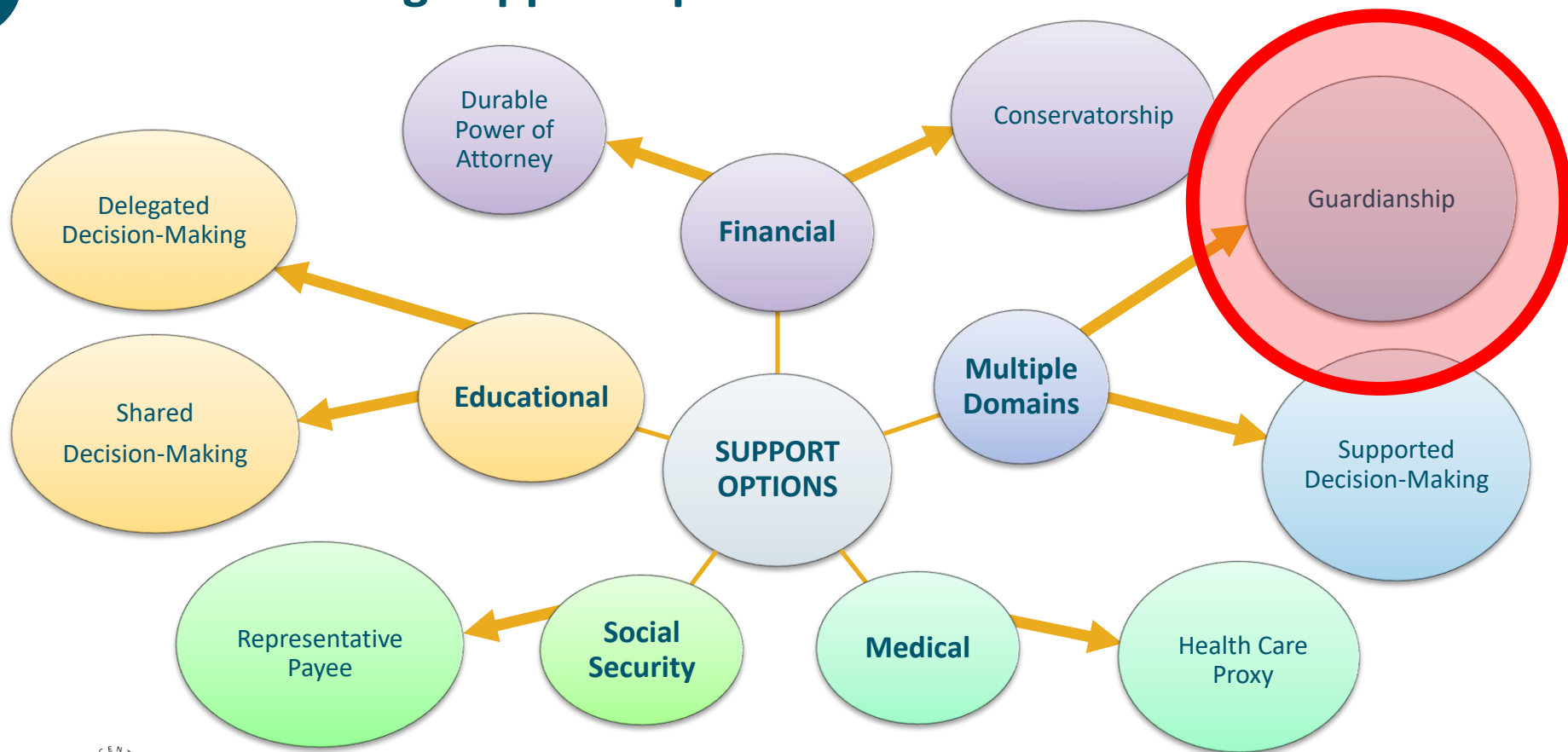


Vulnerable Time for Youth with Neurodevelopmental Conditions

- Many parents/caregivers are **highly involved in care/support** throughout childhood
- When an individual turns age 18, parents/caregivers often **lose access to information** and are **removed from the line of communication**
- This happens simultaneous to childhood **services abruptly ending** and **complex application processes** for adult services beginning
- **Societal expectations of becoming an adult may not match individual readiness** to do so. An individual may need support completing applications, communicating their needs, and making decisions
- An individual may **continue to need decision-making supports** throughout adulthood
- There can be a **sense of urgency to put decision-making supports in place**, without considering ALL options, including the least-restrictive decision-making support option



Decision-Making Support Options



Decision-Making Continuum

Continuum ranging from fully autonomous to fully substituted decision-making

Least restrictive decision-making environment

Balance autonomy with safety and support

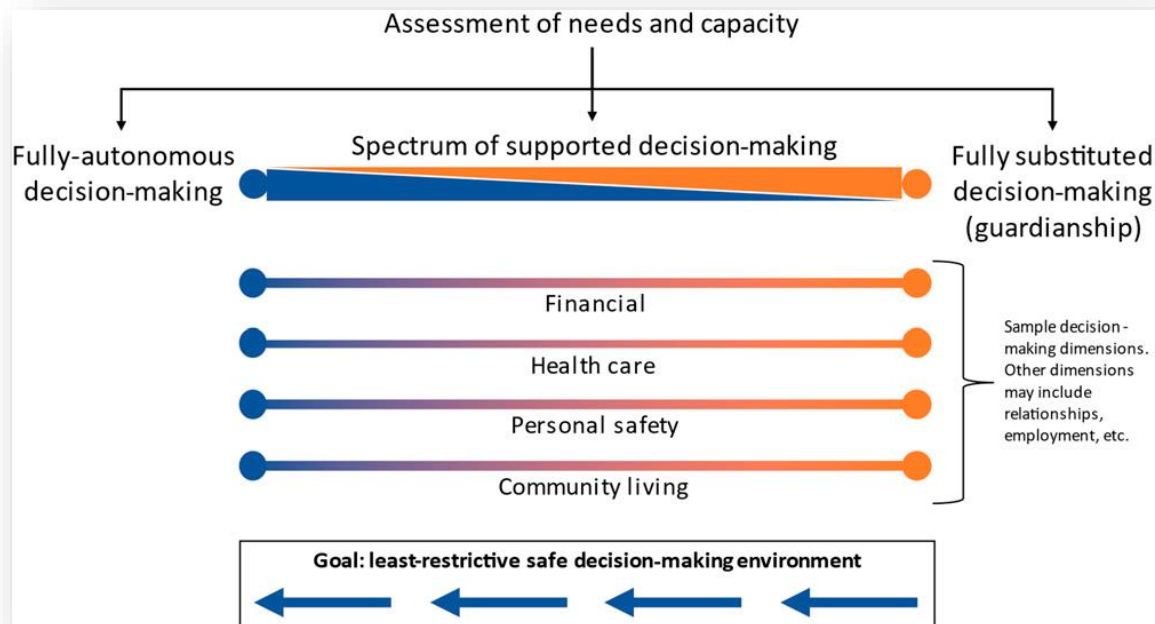


Figure 1. Continuum of decision-making for youth with IDD to guide alternative decision-making options (Turchi et al., 2024, p. 5).

Importance of Self-Determination

APA Dictionary of Psychology (n.d.) defines self-determination as “the process or result of engaging in behaviors without interference or undue influence from other people or external demands. Self-determination refers particularly to behaviors that improve one’s circumstances, including decision making, problem solving, self-management, self-instruction, and self-advocacy.”

*“Research has found **reduced self-determination can lead to diminished quality of life outcomes and reduced community integration and participation**” (National Council on Disability et al., 2019, p. 33).*

Self-determination grows when someone:

Is given meaningful choices

Practices problem-solving

Learns from real-life experiences

Expresses their preferences

Receives feedback and guidance

When someone can make decisions, they are actively practicing self-determination

What Do We Know About Decision-Making Skills?

1. Decision-making capacity is not “all-or-nothing”

2. Decision-making skills develop over time

3. Supports can enhance decision making skills



What is Decision-Making Capacity?

Capacity – *The ability to make a specific decision at a specific time. It is commonly used in a clinical setting.*

Appelbaum & Grisso (1988) Four Abilities Model:

1. Choice

2. Understanding

3. Appreciation

4. Reasoning

Capacity is decision specific

e.g., you can have the capacity to make some medical decisions but not others

Capacity is time specific

i.e., it can improve or decline over time

NOTE: Capacity is not based on an individual diagnosis

Tools for Assessing Decision-Making Skills

- What decisions can the individual make independently?
- What decisions can an individual make with some support?
- What decisions, if any, can they not safely make at this time?



It is best practice to offer support before determining incapacity.

Examples of supports can include visuals, Augmentative and Alternative Communication (AAC) devices, trusted supporters, and extra time.

A person who can make decisions with support, has capacity to make the decision.

Tools for Assessing Decision-Making Skills

AUTONOMY CHECKLIST

Skill	Haven't Tried	Needs Practice	Can Do with Help	Can Do by Myself	Notes
☐ I can cook at least 5 healthy meals by operating kitchen appliances and following recipes.					
☐ I can set the table before meals and wash the dishes after meals.					
☐ I can dress appropriately for the weather and occasion.					
☐ I can put my dirty clothes in the hamper, wash them using the washer and dryer, fold them when they are clean, and put them back where they belong.					
☐ I shower regularly and brush my teeth every day.					
☐ I can do simple first aid and take care of my own minor injuries or illnesses (small cuts, headaches, colds).					
☐ I can clean my room, make my bed, and change the bedding.					
☐ I can manage a calendar and keep track of important appointments and tasks.					
☐ I know what to do in the case of an emergency.					
☐ I can manage my money and follow a budget.					
☐ I know how to search for things I need in my community (groceries, post office, bank, pharmacy).					



The Autism Program
AT BOSTON MEDICAL CENTER

The Autism Program Transition Clinic
Transition Navigator: Simone Dufresne, MA, CAS
BMC.org/Autism • autismprogram@bmc.org

(Boston Medical Center's Autism Program, n.d.-b)

Age of Majority

Identifying Skills & Support Needs

Adapted from the Exceptional Lives Guardianship Guide: What can your family member do, and what do they need help with?

Before You Begin

It is always important to involve your adolescent and/or those closest to them in important life decisions like making a plan for support. Think about what your adolescent can do and where they need help, for either the short or long term. Examples of these skills are provided here.



Medical Care

- ☐ Seek medical care when they are sick or injured
- ☐ Weigh the risks and benefits of medical procedures
- ☐ Understand the need for routine medical care
- ☐ Understand that they may still need a medical procedure, even if it is painful or unpleasant
- ☐ Assess whether taking a certain medicine is important, even though it may have unpleasant side effects
- ☐ Provide accurate information about their medical condition
- ☐ Follow medical advice and treatment plans



Legal/Decision-Making

- ☐ Understand what it means to sign documents
- ☐ Make sound decisions in important life areas like housing, school, and work

Education

- ☐ Understand their learning issues and the services they need at school
- ☐ Advocate to get the services they need



Self-care and Safety

- ☐ Use basic safety skills: staying away from dangerous areas, locking doors, not talking to strangers, being careful around fires, stoves, candles, etc.
- ☐ Get help during emergencies like fires or accidents



Finances

- ☐ Apply for a credit card/open a bank account and manage these accounts
- ☐ Apply for and manage SSI benefits
- ☐ Keep money safe so it's not lost or stolen
- ☐ Keep a monthly spending budget
- ☐ Pay for expenses



Communication

- ☐ Communicate effectively (verbally or by other means)
- ☐ Understand that they have choices
- ☐ Express their preferences

Living Arrangements

- ☐ Take care of themselves, physically
- ☐ Buy food, clothing, and shelter
- ☐ Live in a group setting and respect others' needs for quiet, privacy, and cleanliness

Vocational/Adult Services

- ☐ Apply for services from government agencies (DDS, MRC, DMH)
- ☐ Access the services they need, like job training, job support, or day programs
- ☐ Advocate for themselves to get the best possible services

Discussing Decision-Making Supports with Families

1. Start discussing transition to adulthood well before age 18

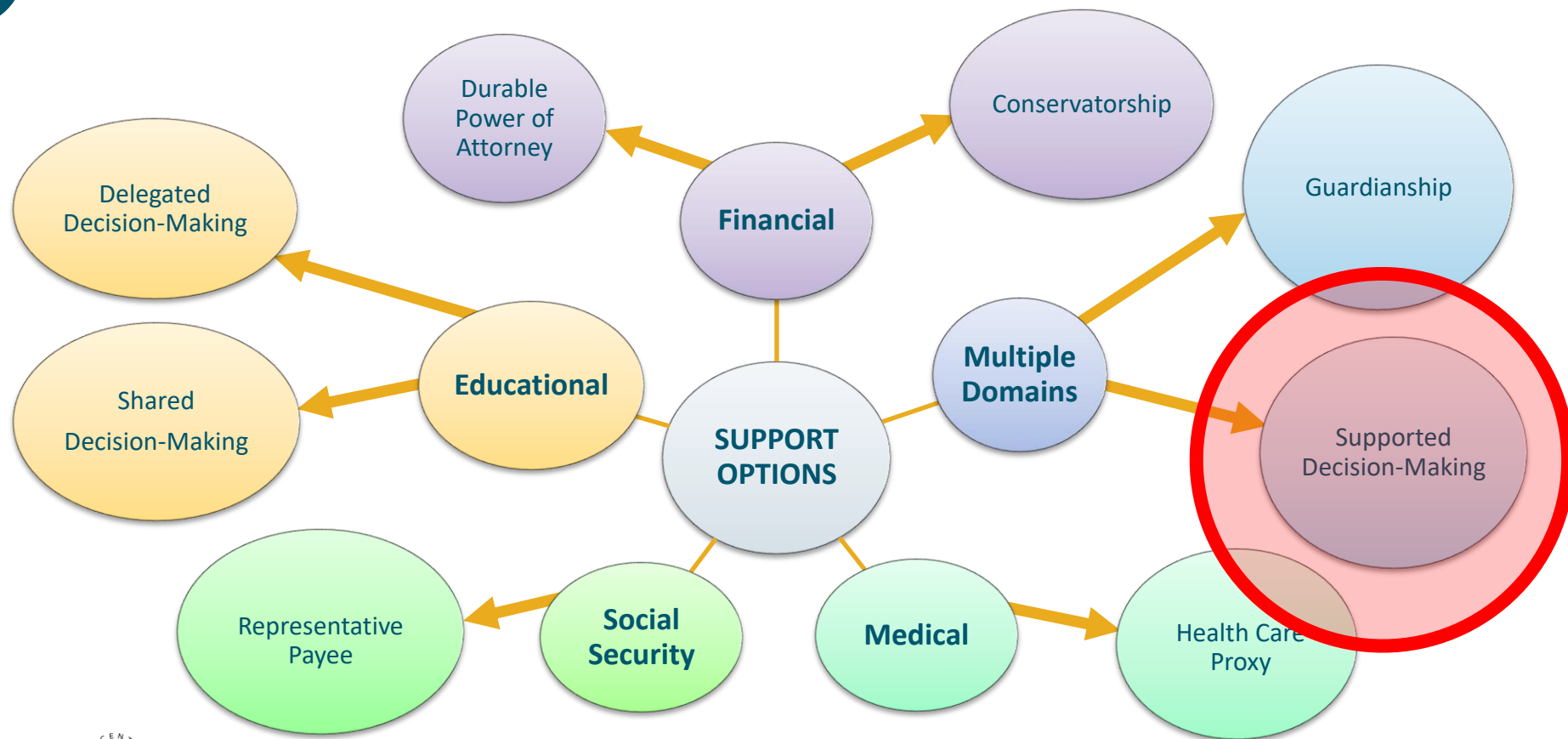
2. Include adolescents in the conversations

3. Start with goals and values, then lead with strengths

4. Present ALL options and emphasize the least restrictive option

5. Encourage ongoing decision-making skill development

Decision-Making Support Options



Case Studies: *Introduction*

Patient 1: *Jeremy*

- 22 yo autistic male with ID
- Lives with mom and older brother
- Interests: basketball, listening to music, walking dog, and **cleaning**
- Minimally verbal and communicates with an augmentative and alternative communication (AAC) device. Challenges with multi-part tasks, safety awareness, and unfamiliar routines
- **Strengths: Friendly and joyful to be around, good at following directions, takes great care of his dog**
- **Attends a Community-Based Day Supports (CBDS) day program. Mom and brother became his guardians, with limited guardianship**
- **Needs help with some activities of daily living (ADLs), navigating the community safely, and independent living skills at home**



Patient 2: *Sabrina*

- 18 yo Hispanic female with ASD & ADHD
- Lives with parents and 3x younger siblings
- Interests: Painting, helping others and **dancing**
- Challenges with executive functioning skills, maintaining friendships and receptive communication
- **Strengths: Motivated to build independence, kind and helpful, creative and hard working**
- **Graduated high school and started community college**
- **Needs help with understanding medical information and making appointments, managing her bank account and budget, navigating friendships and finding a job**





Supported Decision-Making

Supported Decision-Making

- Supported decision-making (SDM) involves an individual **identifying a support network** of people to assist them in making life decisions
- The individual receives support and is **empowered to make their own decisions**
- The individual **keeps their decision-making rights**



This is different to **Shared Decision-Making**, which is a collaborative process, where patients and healthcare professionals work together to make informed decisions about the patient's medical care by combining medical expertise with patient values and preferences

Supported Decision-Making: *In the USA*

“At least 23 States and the District of Columbia have passed comprehensive legislation related to SDM Agreements. These statutes create a legal framework for formal recognition of SDM and include various safeguards and protections” (Center for Public Representation, 2025).

Massachusetts SDM Bills:

- H.4852 (Prior draft: H.261)
- S.155



**Center for Public Representation
partnered with 5 MA organizations
to implement a SDM pilot**

Advocates

MA Families Organizing for Change

Multicultural Community Services

Nonotuck Resource Associates, Inc

Northeast Arc

(Center for Public Representation, 2025)

Supported Decision-Making: *Implementation*

WHO

WHAT

WHEN

HOW

Supported Decision-Making Agreement developed by Center for Public Representation

This is the Supported Decision-Making Agreement of

Name : _____ Date of birth: _____

Address: _____

Telephone: _____ Email: _____

A. I need supporter(s) to help me make decisions about:

- ☐ Taking care of my financial affairs, like banking
- ☐ Hiring a lawyer if I need one and working with the lawyer
- ☐ My health care, including large and small health care decisions
- ☐ Personal care (like where I live, the support services I need, managing the people who work with me, my diet, exercise, education, safety and activities)
- ☐ Other matters: _____

B. I expect my supporter(s) to help me in the following ways:

- ☐ Giving me information in a way I can understand
- ☐ Discussing the good things and bad things (pros and cons) that could happen if I make one decision or another
- ☐ Telling other people my wishes
- ☐ _____

1

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

- ☐ Telling people my likes and dislikes.
- ☐ Telling people what I do and do not want to do.
- ☐ _____
- ☐ _____

D. I designate the following individual(s) to be part of my Supported Decision-Making Network to assist me in making decisions.

Network Supporter #1

Name: _____ Date of birth: _____

Address: _____

Telephone: _____ Email: _____

Relationship: _____

Areas of Assistance for Supporter #1: *Check all that apply:*

- ☐ Finances ☐ Healthcare ☐ Living Arrangements
- ☐ Relationships/Social ☐ Employment ☐ Legal Matters
- ☐ Other (please specify): _____

Areas I don't want Supporter #1 to assist me with:

Network Supporter #2

Name: _____ Date of birth: _____

Address: _____

2

Supported Decision-Making: Case Study - Sabrina

Supported Decision-Making Agreement developed by Center for Public Representation

This is the Supported Decision-Making Agreement of

Name : _____ Date of birth: _____

Address: _____

Telephone: _____ Email: _____

A. I need supporter(s) to help me make decisions about:

- ☐ Taking care of my financial affairs, like banking
- ☐ Hiring a lawyer if I need one and working with the lawyer
- ☐ My health care, including large and small health care decisions
- ☐ Personal care (like where I live, the support services I need, managing the people who work with me, my diet, exercise, education, safety and activities)
- ☐ Other matters: _____

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- ☐ Giving me information in a way I can understand
- ☐ Discussing the good things and bad things (pros and cons) that could happen if I make one decision or another
- ☐ Telling other people my wishes
- ☐ _____

1

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Areas of Assistance for Supporter #1: *Check all that apply.*

- ☐ Finances ☐ Healthcare ☐ Living Arrangements
- ☐ Relationships/Social ☐ Employment ☐ Legal Matters
- ☐ Other (please specify): _____

Areas I don't want Supporter #1 to assist me with:

Network Supporter #2

Name: _____ Date of birth: _____

Address: _____

2



Decision Making Supports in Healthcare

Health Care Proxy

A Health Care Proxy (HCP) is a legal document that allows an individual to name **another individual they know and trust to make health care decisions for them** if they become **unable to make or communicate health care decisions**.

The Massachusetts Medical Society lists **9 discussion questions** for individuals who are signing an HCP to discuss with their health care agent (HCA) about their healthcare. For example:

1. “What, if any, religious or personal beliefs do you have about sickness, health care decision-making, or dying?”
2. “Is there anyone you specifically would NOT want involved in helping to make health care decisions on your behalf?”
(Massachusetts Medical Society, n.d.-a).



Health Care Proxy

KEY INFORMATION

A health care proxy (HCP) can't be used to communicate with the patient's health care agent (HCA) about the patient's medical information unless the HCP is invoked

The HCP is invoked when a **clinician determines the individual can no longer communicate/make medical decisions** and this is documented in the medical chart

The patient can revoke the HCP at any time

MASSACHUSETTS HEALTH CARE PROXY YOUR BIRTH DATE
____/____/____

1. I, _____, (Principal -- PRINT your name) _____, residing at _____
(Street) (City or Town) (State)
appoint as my Health Care Agent: _____
(Name of person you choose as Agent)
of _____
(Street) (City/town) (State) (Phone)
(OPTIONAL: If my Agent is unwilling or unable to serve, then I appoint as my Alternate Agent:
_____, of _____
(Name of person you choose as Alternate Agent)
_____.
(Street) (City/town) (State) (Phone)

2. My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, if any, you wish to place on your Agent's authority): _____

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

3. Signed: _____

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

(Name) (Street)

(City/town) (State)

4. **WITNESS STATEMENT:** We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document.
In our presence, on this _____ day of _____, 20 ____

Witness #1 _____ Witness #1 _____
(Signature) (Signature)

Name (print) _____ Name (print) _____
Address: _____ Address: _____

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Release of Information

- A medical release of information (ROI) allows another person to **see information in an individual's medical records** and **communicate with clinicians about their health care**
- A medical ROI **does not allow the person who** information is released to, **to make any medical decisions**



Massachusetts Department of Public Health Authorization for Release of Information Permission to Share Information

If you want the _____ to share information about you with another person or organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, _____, give my permission for _____ (print your name) _____ (Fill in name of person or organization) to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information

Please describe the information you want the _____ to share about you. (Fill in name of person or organization)

Please include any dates and details you want to share.

B. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

_____ I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

_____ I specifically give permission, as required by M.G.L. c. 111, § 70G, to share information in my record about my genetic information.

_____ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request," if you are initiating the request.

SECTION IV – Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section II:

Name _____
Organization _____
Address _____
EMail _____

Guardianship: Case Study - Jeremy

- Guardianship is a **legal process** in which a guardian is granted permission to take care of and make decisions for another adult
- If an adult is appointed a guardian, the individual's **decision-making rights legally transfer** from the individual to the guardian

TYPES OF GUARDIANSHIP

Full Guardianship

Limited Guardianship

Temporary Guardianship

Rogers Guardianship



LIMITATIONS TO GUARDIANSHIP			
In the Interests of: _____ Incapacitated Person First Name Middle Name Last Name			Docket No. _____
The Incapacitated Person shall retain the following rights or responsibilities:			
Self Care			
☒ To be responsible for bathing, dressing, toileting, and dental care (with assistance, as needed).			
☒ To choose and determine daily meals.			
Medical Decision Making and Management			
☐ To make and communicate routine health care decisions.			
☐ To choose a health or longterm care facility.			
☐ To choose and direct home health care providers.			
☐ To manage medications (with assistance, as needed).			
Home and Community Life			
☐ To choose to reside/live at home with appropriate accommodations, as needed.			
☒ To be responsible for maintaining and cleaning the home (with assistance, as needed).			
☒ To be left alone (with time limit).			
☐ To drive with a valid driver's license.			
☐ To use public transportation independently.			
☐ To make choices about roommates.			
☐ To select and plan daily and leisure activities.			
☐ To vote, and to register for the same.			
☐ To smoke at times and places of the Incapacitated Person's choosing, within the law.			
☐ To seek and obtain employment.			
☐ To travel.			
☐ To determine with whom to have friendships and visitation.			
☐ To determine participation in religious activities.			
☐ To use the telephone, computer or e-mail privately without supervision.			
☐ _____			
Date _____			JUDGE OF THE PROBATE AND FAMILY COURT

MPC 720 (8/30/19)

page 4 of 4

Guardianship: Application Process

CLINICAL TEAM REPORT

INSTRUCTIONS FOR COMPLETION

This document will be used by the Probate and Family Court in the process of determining whether to appoint a guardian and/or conservator to assume responsibility for an individual with an intellectual disability. A licensed psychologist, registered physician, and licensed social worker, each of whom is experienced in the evaluation of persons with an intellectual disability, must complete this form.

To the licensed psychologist, registered physician, and licensed social worker completing this document: You must complete this document. If there is any information about which you do not have direct knowledge, you are encouraged to make inquiry of such persons as may be necessary to complete the entire form. These might include other healthcare professionals and/or others acquainted with the individual (e.g. family members or social service professionals). Identify sources of written or oral information under Section 1.

If you are completing this form on the computer and additional space is required for any narrative section, the section will expand to permit additional information. **Do not use medical terminology and/or abbreviations without explaining them in terms that a lay person can understand.**

ALL PAGES AND SECTIONS CONTAINED HEREIN MUST BE COMPLETED

To the Honorable Justices of the Probate and Family Court:

The clinicians listed below in section 1 hereby certify under the penalties of perjury that they:

1. are licensed by the Commonwealth of Massachusetts and are experienced in evaluation of persons with an intellectual disability;

2. personally examined _____ (First Name) _____ (Middle Name) _____ (Last Name) _____ (Age) _____ (City/Town) _____ (State) _____ (Zip) _____ (Apt. Unit, No. etc.) _____ who resides at _____ (Address) _____

Dates of Examination(s): _____ (Month) _____ (Day) _____ (Year) on _____ (Month) _____ (Day) _____ (Year)

Licensed psychologist on: _____ (First Name) _____ (Middle Name) _____ (Last Name) _____ (Age) _____ (City/Town) _____ (State) _____ (Zip) _____ (Apt. Unit, No. etc.) _____

Registered physician specializing in: _____ (First Name) _____ (Middle Name) _____ (Last Name) _____ (Age) _____ (City/Town) _____ (State) _____ (Zip) _____ (Apt. Unit, No. etc.) _____

Licensed social worker on: _____ (First Name) _____ (Middle Name) _____ (Last Name) _____ (Age) _____ (City/Town) _____ (State) _____ (Zip) _____ (Apt. Unit, No. etc.) _____

The information provided in this report is for the use of the Court and is not to be confidential.

Clinical Team Report (CTR)

3 Signatures:

- Registered physician
- Licensed social worker
- Licensed psychologist

180 DAYS

MEDICAL CERTIFICATE GUARDIANSHIP OR CONSERVATORSHIP

INSTRUCTIONS FOR COMPLETION

This document will be used by the Probate and Family Court in the process of determining whether to appoint a guardian and/or conservator to assume responsibility for an individual in some or all areas of decision making and functioning. If however, a guardianship or conservatorship is being sought for an intellectually disabled person, do not use this document. A separate Clinical Team Report is required.

To the registered physician, licensed psychologist, certified psychiatric nurse clinical specialist, or other person authorized by law to prescribe antipsychotic medication in Massachusetts: I am employed by _____ (Name of Facility) _____ (Address) _____ (City/Town) _____ (State) _____ (Zip/Post) _____

You must complete this document. If there is any information about which you do not have direct knowledge, you are encouraged to make inquiry of such persons as may be necessary to complete the entire form. These persons might include other healthcare professionals and/or others acquainted with the individual (e.g. family members or social service professionals). If you receive information from others, the names of these individuals must be listed in the Certification Section and attribution identified.

If you are completing this form on the computer and additional space is required for any narrative section, the section will expand to permit additional information. **Do not use medical terminology and/or abbreviations without explaining them in terms that a lay person can understand.**

ALL OF THE ATTACHED PAGES AND SECTIONS CONTAINED THEREIN MUST BE COMPLETED.

To the Honorable Justices of the Probate and Family Court:

The undersigned hereby certifies under the penalties of perjury that I am:

☐ a registered physician specializing in the area of: _____

☐ a licensed psychologist.

☐ a certified psychiatric nurse clinical specialist.

☐ a nurse practitioner with experience in the area of: _____

I am prepared to present a statement of my qualification to the Court by written affidavit or personal appearance if directed to do so.

I personally examined: _____ (First Name) _____ (Middle Name) _____ (Last Name) _____ (Age) _____ (City/Town) _____ (State) _____ (Zip) _____ (Apt. Unit, No. etc.) _____ who resides at _____ (Address) _____

on _____ (Month) _____ (Day) _____ (Year) at _____ (City/Town) _____ (State) _____ (Zip) _____ (Apt. Unit, No. etc.) _____

Prior to examination, I informed the patient that communications would not be confidential.

☐ Yes.

☐ No. Explain: _____

Medical Certificate (MC)

1 signature:

- Registered physician **OR**
- Licensed psychologist **OR**
- Certified psychiatric nurse clinical specialist

30 DAYS

CLINICIAN'S AFFIDAVIT AS TO COMPETENCY AND TREATMENT

Docket No. _____ Commonwealth of Massachusetts The Trial Court Probate and Family Court

In Re: Guardianship of: _____ Division _____

First Name _____ Middle Name _____ Last Name _____

Proposed Incapacitated Person/Respondent _____

I, _____ (First Name) _____ (M.I.) _____ (Last Name) _____, do hereby state to my best knowledge and belief:

1. I am a licensed physician, certified psychiatric nurse clinical specialist, or other person so authorized by law to prescribe antipsychotic medication in Massachusetts. I am employed by _____ (Name of Facility) _____ (Address) _____ (City/Town) _____ (State) _____ (Zip/Post) _____ (Apt. Unit, No. etc.) _____

2. I supervise the psychiatric treatment of Respondent who is a ☐ resident ☐ patient at _____ (Name of Facility) _____ (Address) _____ (City/Town) _____ (State) _____ (Zip/Post) _____ (Apt. Unit, No. etc.) _____

The Respondent is a _____ year old ☐ male ☐ female who was admitted on _____ (Month) _____ (Day) _____ (Year).

3. I first consulted on the treatment of the Respondent on _____ (Month) _____ (Day) _____ (Year). On that date, and since that time, I observed the Respondent and reviewed the Respondent's medical records. I am familiar with the Respondent's case history.

4. I have conferred with the following clinical staff in rendering the opinions expressed in this affidavit:

Name	Title/Relationship
_____	_____
_____	_____
_____	_____
_____	_____

5. Respondent's clinically diagnosed condition is: _____ (click to add) (click to remove)

6. The Respondent was admitted or most recently was seen on _____ (Month) _____ (Day) _____ (Year).

7. Respondent has been in the past the _____ (Month) _____ (Day) _____ (Year).

MPC 800 (6/17/10)

Clinician's Affidavit as to Competency and Treatment

1 signature:

- Registered physician **OR**
- Psychiatrist **OR**
- Certified psychiatric nurse clinical specialist

Guardianship: Application Process

Save as PDF Reset Form

PETITION FOR APPOINTMENT OF GUARDIAN FOR AN INCAPACITATED PERSON

Docket No. Commonwealth of Massachusetts The Trial Court Probate and Family Court

In the Interests of: First Name Middle Name Last Name Division

Alleged Incapacitated Person/Respondent

The Court shall encourage the development of maximum self-reliance and independence of the Incapacitated Person and make appointive and other orders only to the extent necessitated by the Incapacitated Person's limitations or other conditions warranting the procedure.

1. Information about the Respondent:

Name: First Name M.I. Last Name

Primary Language: ☐ English ☐ Other: Primary Phone #:

Date of Birth: Age: Gender:

Principal Residence: (Address) (Apt. Unit, No. etc.) (City/Town) (State) (Zip)

Date Residence was established:

Current Address: ☐ Same as Above or ☐ the following address: (Address) (Apt. Unit, No. etc.) (City/Town) (State) (Zip)

If this appointment is made, Respondent will reside at ☐ Principal Residence ☐ Current Address ☐ the following address: (Address) (Apt. Unit, No. etc.) (City/Town) (State) (Zip)

Respondent ☐ is ☐ is not alleged intellectually disabled.

2. Information about the Petitioner:

Name: First Name M.I. Last Name (Address) (Apt. Unit, No. etc.) (City/Town) (State) (Zip)

Primary Phone #: Relationship to Respondent:

E-mail:

State your interest in the appointment:

☐ An attachment to this petition provides information on co-petitioner(s). click to add click to remove

3. The Petitioner is requesting: ☐ to be appointed ☐ that some suitable person be appointed ☐ that the person named below be appointed:

MPC 120 (10/8/19) page 1 of 6

Save as PDF Reset Form

BOND

Docket No. Commonwealth of Massachusetts The Trial Court Probate and Family Court

☐ Without sureties
☐ With personal sureties
☐ With corporate surety Bond #:

In the Interests of: First Name Middle Name Last Name Division

Incapacitated Person/Protected Person/Ward/Decedent/Trust

The condition of this bond is the faithful discharge by the fiduciary of all duties according to law (for Public Administrators see G. L. c. 194, § 2). By executing this bond, a Personal Representative or Trustee submits personally to the jurisdiction of any court of the Commonwealth in any proceeding pertaining to the estate that may be instituted by any interested person. By executing this Bond, any other fiduciary submits personally to the jurisdiction of the Court which issued the Letters of Appointment. This bond is not void after the first recovery but may be proceeded against from time to time until the whole penalty is exhausted.

Estimated Value of Real Estate Estimated Value of Personal Estate

Penal Sum of Bond (if applicable)

1. Fiduciary Name: First Name M.I. Last Name (Address) (Apt. Unit, No. etc.) (City/Town) (State) (Zip) Primary Phone #:

2. Fiduciary Name: First Name M.I. Last Name (Address) (Apt. Unit, No. etc.) (City/Town) (State) (Zip) Primary Phone #:

click to add click to remove

The undersigned fiduciary accepts appointment as and stand(s) personally bound to the First Justice of said Court and his or her successors as obligee for the benefit of the persons interested in the estate and declare(s) the above estimates to be true and accurate to the best of his/her knowledge and belief.

Date Signature of Fiduciary 1.

Date Signature of Fiduciary 2.

MPC 801 (4/15/16) page 1 of 2

Guardianship: *Application Process*





Decision Making Supports Beyond Healthcare

Educational Decision-Making Supports

DECISION-MAKING OPTIONS FOR STUDENT*

Complete for student who has turned 18. Please indicate the decision-making option that the student or court-appointed legal guardian has selected:

- ☐ The student will make their own educational decisions.
- ☐ The student will share decision-making with their parent, caregiver, or other adult.
Individual with whom the student will share decision-making: _____
- ☐ The student has delegated decision-making to their parent, caregiver, or other adult.
Individual to whom the student has delegated decision-making: _____
- ☐ A court has appointed a legal guardian for the student who will make educational decisions.
Name of court-appointed legal guardian: _____

Date of determination: _____



IMPORTANT:

If a student disagrees with the adult appointed to support with educational decision-making on an educational decision, the student's decision will stand

Financial Decision-Making Supports

Durable Power of Attorney

Representative Payee

Joint Bank Account

Special Needs Trust

ABLE Account



Additional Decision-Making Support Areas: *Case Study - Jeremy*



Takeaways



Action Steps

1

Provide families information on ALL decision-making support options and encourage exploration of the least restrictive options such as supported decision-making

2

Routinely discuss decision-making skills with families (*e.g., offer autonomy questionnaires*) to encourage and measure decision-making skill development

3

Ensure collection and documentation of guardianship, supported decision-making, health care proxy and release of information paperwork

18 isn't the magic number—it's just the opening act...

Contact Information

- **Presenter Email:**
Katie.Campbell@bmc.org
- **NUY Clinic Email:**
NUYinfo@bmc.org



Neurodivergent Urban Youth (NUY) Clinic Website



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