***The following is an adaptation of the "Statement of Principles" by the Coalition on Alternatives to Guardianship".***

## STATEMENT OF PRINCIPLES

## SUMMARY STATEMENT

Every person can make choices and has a right to make decisions. People who have a cognitive or intellectual disability may express those choices/decisions in non-traditional ways. Any legal system or proceeding which deprives an individual of her/his right to be accommodated and supported in choosing and making decisions and which appoints a substitute decision-maker based on tests of competence, makes that person vulnerable and deprives him/her not only of his/her right to self-determination but also of other rights which should be inalienable.

PRINCIPLES

1. Each individual can choose and make decisions about his/her life.
2. Each individual has the right to make decisions (self-determination).
3. Individuals may want help from other persons of their choosing with whom they have trusting relationships, including family members or friends, to make decisions or have them interpreted, and to communicate them to others. This is called supported decision making.
4. Individuals who have an intellectual disability may communicate choices, wishes, likes and dislikes in non-traditional ways which can include actions rather than language. Friends, family members, or others who are trusted by the individual, can help to interpret these decisions.
5. This natural interdependence of people must be recognized and supported decisions that are made within such trusted, supportive relationships must be given status and validation.
6. All adults have the right to make decisions with support or to name a substitute (e.g. by power of attorney) to make decisions for them.
7. Laws and/or policies that do not recognize supported decision making or that protect other interests at the expense of the individual's right to self-determination discriminate against persons who have an intellectual disability and make them more vulnerable
8. Individuals should never be assessed to determine competency; decisions should be reviewable if there is concern that the will of the individual is not being respected or that the individual is being exploited.
9. Any legal system or proceeding which sets up a test of competency to be used to appoint a substitute decision-maker puts the individual at risk of also losing other rights.
10. A decision that could not have been made by the individual without support, e.g. consent for non-therapeutic sterilization, experimentation or other non-therapeutic procedures which could offend human dignity, should not be made within supported decision making relationships.

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# PERSON CENTERED PLANNING

A person centered plan assists individuals to create a personalized image of a desirable future. The development of a plan suggests a process that can organize and guide community change in alliance with people with disabilities, thus building the bridge from both sides.

Essential to all person centered plans are the following characteristics:

**Person Directed** – The plan for the person is that the person's vision of what he or she would like to be and do. The plan is not static, but rather it changes as new opportunities and obstacles arise.

**Capacity Building** – Planning focuses on the person's gifts, talents and skills rather than deficits. It builds upon the individuals to engage in activities that promote a sense of belonging in the community.

**Person Centered** – The focus is continually on the person for whom the pan is being developed, and not on plugging the person into available slots in a program. The individual's choices and preference must be honored.

**Network Building** – The process brings together people who care about the person, and are committed to helping the person articulate their vision of a desirable future. They learn together and invent new courses of action to make the vision an reality.

**Outcome based** – The plan focuses on increasing any or all of the following experiences which are valued by the individual:

- Growing in relationships or having friends.
- Contributing or performing functional/meaningful activities.
- Sharing ordinary places or being part of their own community.
- Gaining respect or having a valued role which expresses their gifts and talents.
- Making choices that are meaningful and express individual identity.

**Community Accountability** – The plan will assure adequate supports when there are issues of health and safety, while respecting and according their full dignity as a fully participating member of the community.

Adopted by the Howell Group of Michigan, October 1994

# ***SAMPLE ONLY***

**DESIGNATION FOR DURABLE POWER OF ATTORNEY FOR MEDICAL TREATMENT, RESIDENTIAL PLACEMENT, AND PROGRAM DECISIONS**

**I am _____ and I live at _____. I want my mother, _____to help me if I am sick and need to see a doctor. I want her to make decisions about my medical care, including medication and surgery.**

**I also want my mother, _____ to make decisions about where I will live. She can sign any papers needed to arrange for a place for me to live.**

**I also want her to make decisions about work and other programs that I participate in.**

**If my mother, _____ is not available, I would like my _____, _____ to make these decisions instead.**

**If neither of the above are available, I would like my _____, _____ to make these decisions.**

**I would like these powers to last even if I become unable to understand this form in the future. I understand that if I want to change my mind about who makes these decisions, I can destroy this paper or let people know I want to change my mind.**

_____ _____

**(Date) (Signed)**

**STATEMENT OF WITNESSES**

**We sign below as witnesses. This was signed in our presence. The signer appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.**

**Signed by witness: _____**

**_____**

**(Print full name)**

**Signed by witness: _____**

**_____**

**(Print full name)**

# ***SAMPLE ONLY***

## *CONSENT TO AUTHORIZE ADVOCACY AND RELEASE OF INFORMATION*

I, _____ hereby authorize Community Mental Health, in accordance with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to release/ exchange information with my parents, _____ _____, which pertains to my services, programs and living situation, and any other protected health and mental health information, including any psychotherapy notes. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR Part 2).

I also wish that my parents be invited to any and all meetings about me, and I do not want any decisions made without their input. If CMH has any documents I need to sign, my parents must sign first to acknowledge their receipt of these documents and their concurrence with them, before I will sign. This authorization, unless otherwise revoked by me, is intended to remain in effect for the duration of time I receive mental health services, etc. or until I revoke this authorization, whichever comes first.

_____

(name)

_____

(date)

# ***SAMPLE ONLY***

## *CONSENT TO AUTHORIZE ADVOCACY AND RELEASE OF INFORMATION*

I, _____, hereby authorize _____ Schools, in accordance with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to release / exchange information with my parents, _____ _____, which pertains to my school program and placement. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR Part 2).

I also wish that my parents be invited to any and all meetings about me, and I do not want any decisions made without their input. If the schools have any documents I need to sign, my parents must sign first, before I will sign. This authorization, unless otherwise revoked by me, is intended to remain in effect for the duration of time I receive special education services or until my twenty-seventh birthday, whichever comes first.

_____
(name)

_____
(date)