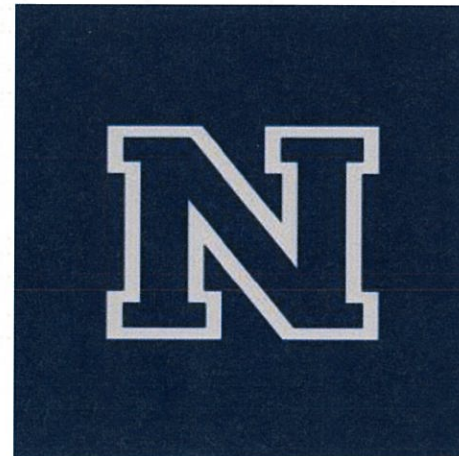



RETHINKING GUARDIANSHIP FOR PEOPLE WITH I/DD

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Guardianship is a situation,
recognized by law, under which
one person or entity exercises
power over and on behalf of
another person.

(“a ward”)



HOW ARE DECISION-MAKING ISSUES DIFFERENT BETWEEN SENIORS & PEOPLE WITH I/DD?

- Seniors are able to make decisions until a certain point in their lives and then have a need for support that will increase with time.
- People with I/DD may have a lifelong need for supported decision making, but their ability to make more of their own decisions may increase as they become more independent and/or knowledgeable.


PAST REASONS FOR SEEKING GUARDIANSHIP FOR A PERSON WITH I/DD

- Medical reasons
- Decisions about programs, records, etc.
- Financial decisions
- Placement decisions
- What will happen when parents are no longer around?
- Sex and related issues
- Administrative convenience



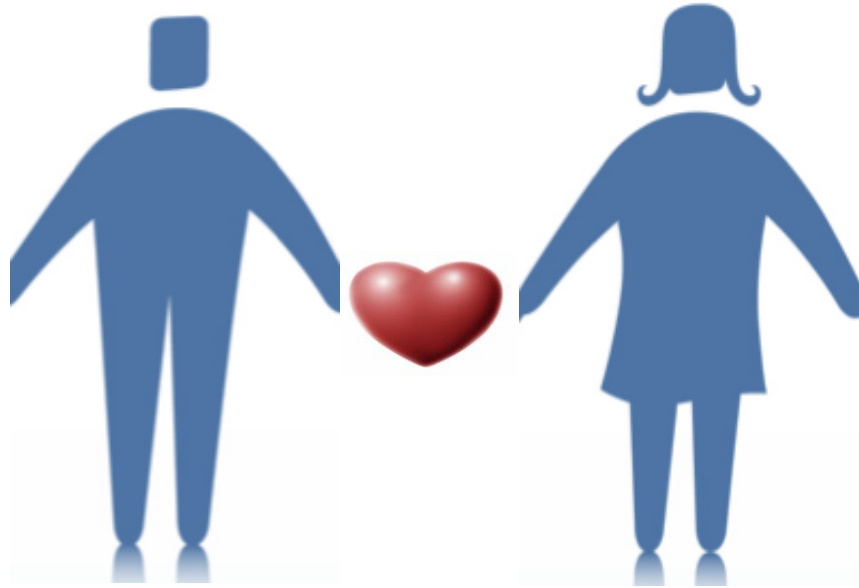
WHY AVOID GUARDIANSHIP?

- It is a public declaration of incompetency and does not promote independence, dignity, freedom of choice
- There is no due process: People being deemed “incompetent” do not have any representation
- It is not person-centered: People with I/DD are not free to make decisions about where they live or work
- Very difficult to modify or terminate
- Unintended Consequences



“The typical ward has fewer rights than the typical convicted felon – they no longer receive money or pay their bills. They cannot marry – or divorce... it is, in one short sentence, **the most punitive civil penalty that can be levied against an American citizen, with the exception of...the death penalty**”

-Claude Pepper, U.S. Representative



Intentions of Families when they become Guardians:

- Support their children
- Guide their children
- Protect their children



REALITY OF GUARDIANSHIP TO THE FAMILY

- The court system is much larger than the family and will be personally involved in the family's business
- The family will be accountable to the courts on a regular basis
- The courts can decide to remove the family from the relationship if it is not satisfied with the family's efforts.



Other Often Unintended Outcomes

- Parents or the next-in-line guardian sometimes are not vigilant (or there is a sudden death) in maintaining guardianship within the family network. The person with a disability ends up with a public guardian, which is not the intention of the family.
- A family member who does not act in the best interest of the loved one
- Unforeseen circumstances happen within a family



ALTERNATIVES THAT ENCOURAGE SUPPORTED DECISION MAKING

- Microboards, Circle of Friends, Advisors, Advocates
- Durable Power of Attorney for Health Care
- Durable Power of Attorney for Financial Matters



MICROBOARDS

- Organized circle of support for a person with I/DD
- Board of Directors, rotating terms for sustainability
- Can be an informal circle of advisors or can become a Medicaid provider that assists person with I/DD to hire/fire own support staff
- Not many in Nevada, although used successfully in other states – Inconsistency in getting approval as providers in Nevada



POWER OF ATTORNEY FOR HEALTH CARE

- Appoint an Agent to handle medical decisions or support person with I/DD in medical decisions
- Can be effective immediately
- Based on NRS 162A.700 to 162A.860
- Specific wording on form required, although authority can be as broad or narrow as desired
- Requires two witnesses or a Notary signature



CHALLENGES FOR PEOPLE WITH I/DD WITH NO GUARDIANSHIP AND NO MEDICAL POA

- Some physicians will not perform medical/surgical procedures on a person with I/DD who does not have a guardian or POA. They believe the medical/surgical consent forms are too complicated for a person with I/DD to fully understand and provide consent.

CHALLENGES WITH NEVADA'S DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS FOR PEOPLE WITH I/DD

- 6 pages long
- Some physicians will not accept this POA because it is too complicated for a person with I/DD to fully understand and provide consent

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

Warning to Persons Executing this Document

This is an important legal document. It creates a durable power of attorney for health care. Before executing this document, you should know these important facts:

1. This document gives the person you designate as your Agent the power to make health care decisions for you. This power is subject to any limitations of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.
2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests.
3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.
4. Unless you specify a shorter period in this document, the power will exist indefinitely from the date you execute this document and, if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.
5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.
6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.
7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other health care provider orally or in writing.
8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.
9. This document revokes any prior durable power of attorney for health care.
10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

MORE USEFUL TOOLS

- Durable Power of Attorney for Financial Matters
- 6 pages long
- Flexible - Can grant general authority or over specific areas
- May have same challenges as Medical POA

RECORDING REQUESTED BY:

SPACE ABOVE THIS LINE FOR RECORDER'S USE

NEVADA STATUTORY POWER OF ATTORNEY NRS 162A.620

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR FINANCIAL MATTERS. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

- THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT THE POWER TO MAKE DECISIONS CONCERNING YOUR PROPERTY FOR YOU. YOUR AGENT WILL BE ABLE TO MAKE DECISIONS AND ACT WITH RESPECT TO YOUR PROPERTY (INCLUDING YOUR MONEY) WHETHER OR NOT YOU ARE ABLE TO ACT FOR YOURSELF.
- THIS POWER OF ATTORNEY BECOMES EFFECTIVE IMMEDIATELY UNLESS YOU STATE OTHERWISE IN THE SPECIAL INSTRUCTIONS.
- THIS POWER OF ATTORNEY **DOES NOT** AUTHORIZE THE AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.
- THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.
- YOU SHOULD SELECT SOMEONE YOU TRUST TO SERVE AS YOUR AGENT. UNLESS YOU SPECIFY OTHERWISE, GENERALLY THE AGENT'S AUTHORITY WILL CONTINUE UNTIL YOU DIE OR REVOKE THE POWER OF ATTORNEY OR THE AGENT RESIGNS OR IS UNABLE TO ACT FOR YOU.
- YOUR AGENT IS ENTITLED TO REASONABLE COMPENSATION UNLESS YOU STATE OTHERWISE IN THE SPECIAL INSTRUCTIONS.
- THIS FORM PROVIDES FOR DESIGNATION OF ONE AGENT. IF YOU WISH TO NAME MORE THAN ONE AGENT YOU MAY NAME A CO-AGENT IN THE SPECIAL INSTRUCTIONS. CO-AGENTS ARE NOT REQUIRED TO ACT TOGETHER UNLESS YOU INCLUDE THAT REQUIREMENT IN THE SPECIAL INSTRUCTIONS.



POSSIBLE LEGISLATIVE/POLICY REMEDIES

- Appoint an attorney and a trained CASA (Court Appointed Special Advocates) to represent people with I/DD who are being considered for guardianship
- Mandate annual reviews of people with I/DD who have guardians to see if they want to & are able to have rights restored (Texas)



POSSIBLE LEGISLATIVE/POLICY REMEDIES

- Allow and encourage the use of microboards as service providers for supported decision making
- Add sections to NRS Guardianship & POA statutes that address people with I/DD
 - Include simpler Power of Attorney forms

POWER OF ATTORNEY FOR MEDICAL TREATMENT DECISIONS

I am _____. I live at _____. I want _____
to help me if I am sick and if I need to go to the doctor.

My mother/father read this paper to me before I signed it. I understand what he/she told me about this paper before I signed it.

If I am sick, my mother/father should take me to the doctor. If she/he is not at my house when I become sick, please call her/him to come to the doctor's office. I would like the doctor to talk to her/him and tell her/him what the matter is.

I would like to ask my mother/father what the doctor should do. I would like the doctor to do what my mother/father tells the doctor to do; she/he knows what is best for me.

Sometimes a doctor says that I need to have a shot or some other care. Sometimes a doctor says that I need to take pills or medicine. My mother/father will also decide what other care I should have, but she/he will talk to me about what care I need.

I would also like my mother/father to decide if I need to go to the dentist.

If I am very sick, I might need to go to a hospital. My mother/father can decide if I need to go to the hospital. I would like all of the people at the hospital to speak with my mother/father about what the people at the hospital should do for me. I would like my mother/father to decide about my care at the hospital even if I am unable to understand what my doctor says about me. This is very important since I want the people at the hospital to try very hard to care for me if I am sick. If I need to have an operation because I am very sick, I would like the people at the hospital talk to my mother/father. My mother/father will say "yes" or "no" and that is what the people at the hospital will do.

I understand that I want my mother/father to help decide what care I need, and I want people to listen to him or her about my care. If my mother/father is not happy with my doctor, then he or she is able to get another doctor to care for me.

(Signature or Mark)

(Date)

(Witness)

(Date)

(Witness)

(Date)

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)

QUESTIONS?

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Nevada Center for
Excellence in Disabilities