

Mail all four completed forms and supplemental information to:

NYS Justice Center for the Protection  
of People with Special Needs  
SDMC  
401 State Street  
Schenectady, NY 12305

## INSTRUCTIONS FOR SDMC FORM 200

### Declaration for Surrogate Decision-Making



**If this is your first time preparing a case or if you have questions, call SDMC at 518-549-0328.**

**Do not double side case information, including forms. Do not staple pages together.**

**The scheduled date of hearing may be delayed until requested information has been received.**

1. This is an acknowledgement that you are accepting the role of Declarant and prepared to act in that capacity in order to secure informed consent on behalf of the patient for the needed medical treatment. As such all requested information must be complete and accurate. Phone numbers and email addresses must be where you can be reached during regular business hours. You must be available to answer any case-related questions, obtain additional information and assist in scheduling the hearing.
2. Other than the agency you work for, list the primary contact person for all other OPWDD, OMH, or OASAS-funded or licensed/regulated organizations/agencies providing services to the patient (MSC, Nurse, Residential, etc.). If the patient is hospitalized, but the declarant is not a member of hospital staff, list the hospital contact information also. All persons listed will receive notice of the hearing.
3. List the agency name that provides day programming for the patient.
4. Write the title (not the name) of the treatment team member who explained the proposed major medical treatment(s) to the patient. **This must be someone familiar to the patient.** The procedure must be explained to the patient. Write a description of how the patient responded to the information/description of the proposed major medical treatment(s), i.e., “patient walked away”, “patient responded yes, but was unable to explain procedure’s risks when questioned”, etc.
- 5a. Answer the question and check all legally authorized surrogates from the list that apply to this patient. Remember, if any of these individuals are authorized, willing and available to give consent, they may provide consent on behalf of the person and the case would not be submitted to SDMC. If they are not authorized, available or willing to give consent, provide documentation of this in response to question 5c of SDMC Form 200. This list only includes those who are specifically recognized as legally authorized surrogates per MHL Article 80.
- 5b. Indicate the status of the patient’s mother. Indicate the status of the patient’s father. Indicate if their whereabouts are unknown. Explain in the boxes below.
- 5c. Fill in all of the information in the boxes for anyone living outlined in #5a and #5b, explaining why they are not available to participate in the decision making process in the comments section in each box as applicable.

**For current or former Office for Persons with Developmental Disabilities (OPWDD) patients ONLY:**

Per OPWDD Regulations 633.11, actively involved adult siblings, or other adult family members and the Consumer Advisory Board (CAB) can also give or withhold consent. If the patient has any of these family members or is represented by CAB, these individuals must be contacted to determine if they wish to make the decision. If any are authorized, willing and available, the case would not need to be submitted to SDMC. If they do not wish to make the decision, they are listed on page 3, #6 of SDMC Form 200.

**For Patients Residing in Facilities Licensed, Operated or Funded by the Office of Mental Health (OMH):**

Siblings and other family members are considered correspondents only. They are not authorized by regulations to make the decision.

**If you are unsure who is a surrogate or correspondent, please call SDMC at 518 549-0328.**

- 6a. Check yes or no and list only **actively** involved adult sibling(s) or other family who are unavailable, do not wish to make the decision or are unauthorized to make the decision in the boxes below.
- 6b. Check yes or no and list any advocates, correspondents and/or Family Care Providers in the boxes below.
- 6c. **For current or former OPWDD patients ONLY:**

If the patient has one or more actively involved siblings or other family members, explain why the case is being submitted to the Surrogate Decision-Making Committee in the comments section.
7. If there is anyone listed in #5 or #6 who could not be contacted; explain the efforts made to contact them.
8. As the Declarant you must then read SDMC Form 210, fill in the NYS licensed psychiatrist or psychologist's name and the date the SDMC Form 210 was signed.
9. Write out the complete name of the proposed major medical treatment(s) being requested as written by the doctor, dentist or podiatrist on the SDMC Form 220-A, #4a and 4b.
10. Check yes or no based on the doctor's/dentist's/podiatrist's answer to #7 on SDMC Form 220-A. If you are unsure what type of anesthesia is being requested, please check with the MD prior to completing or submitting your case.
11. Check yes or no based on the answer to #5 on SDMC Form 220-A.
12. The Declarant must read SDMC Form 220-A and then fill in the doctor, dentist or podiatrist's name and the date the SDMC Form 220-A was signed.
13. Based on your personal knowledge and interactions with the patient, **describe in your own words** why you think the patient lacks capacity to give or withhold informed consent. Can the patient understand the risks and benefits of having and not having the proposed major medical treatment(s)?

14. Based on your personal knowledge and interactions with the patient, **explain in your own words** why you believe the proposed treatment(s) is/are in the best interest of the patient.
- 15a. Write the patient's name, complete mailing address, and phone number.
- 15b. Write the patient's date of birth, age, sex, religion. The panel will be asking the patient questions at the hearing. Please indicate if the patient speaks or **UNDERSTANDS** English or a foreign language. If the patient speaks or understands another language, specify which one. Does this patient use American Sign Language to communicate? Indicate Yes or No. Does this patient have a communication board or other assistive device? Indicate Yes or No. If yes, this assistive device must be brought to the hearing. **Please ensure that the person who best communicates with the patient attends the SDMC hearing.**
- 15c. Check the type of the patient's residence.
- 15d. List county of New York State residence.
16. Clearly print your (the Declarant's) name as you listed it on page one. You must sign the form and date it. **This date must be the same as or later than the dates listed on the following forms: SDMC Form 210, SDMC Form 220-A, SDMC Form 220-B.**
17. Accurately complete all of the requested information for a second person, who is familiar with the patient, to be contacted regarding the case if you, the Declarant, cannot be reached or are not available.