

<p>Mail all <u>five completed</u> forms and <u>supplemental information</u> to:</p> <p>NYS Justice Center for the Protection of People with Special Needs SDMC 401 State Street Schenectady, NY 12305</p>	<p>INSTRUCTIONS FOR SDMC FORM 300</p> <p>Declaration for Health Care Decisions Act</p>	
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**If this is your first time preparing a case or you have questions, call 518-549-0328
Do not double side case information, including forms. Do not staple pages together.**

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 provide all requested information completely and accurately. Phone numbers must be where you are available during regular business hours. You must be available to answer any case-related questions, obtain additional information and assist in scheduling the hearing.

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

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. If physician checked YES to **HOSPICE** (ques. #6 on SDMC Form 320-A), include contact information for HOSPICE Coordinator. **All persons listed will receive notice of the hearing.**
3. List the agency that provides day programming, if any.
4. Write the title (not the name) of the treatment team member who explained the proposed withholding/withdrawal of life sustaining treatment(s) to the patient. **This must be someone familiar to the patient.** The treatment decision must be explained to the patient.
5. Write a description of how the patient responded to the information/description of the proposed withholding/withdrawal of life sustaining treatment(s). Include any information you have about the patient's moral or religious preferences or opinions; or preferences/opinions about the proposed decision, either previously stated or stated during the interview made by the patient.
- 6a. Answer the question and check all legally authorized surrogates from the list that apply to this patient. Remember, if any of these individuals exist and are authorized, willing and available to give consent, they may provide consent on behalf of the person and the case would not need to be submitted to SDMC. If they exist but are not authorized, available or willing to give consent, provide documentation of this in response to question 5c of SDMC Form 300. This list only includes those who are identified as surrogates per MHL Article 80.
- 6b. If the parent(s) is/are not available, indicate whether they are living, deceased or their whereabouts are unknown. Explain in the boxes below.

- 6c. Fill in all of the information in the boxes for anyone living outlined in 5a and 5b, explaining your answers in the comments section in each box as applicable.

Per Article 17-A, Section 1750-b of the Surrogate's Court Procedure Act and OMRDD Regulations 633.11, actively involved adult siblings and actively involved other adult family members can also make the major medical treatment decision. If the patient has any of these family members, these individuals must be contacted to determine if they wish to make the decision. If any are 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 in the boxes on page 3 of SDMC Form 300.

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

- 7a. Check yes or no and list in the boxes below only **actively** involved adult sibling(s) or other family who are unavailable to make the decision, who do not wish to make the decision or are unauthorized to make the decision.
- 7b. Check yes or no and list any advocates, correspondents and/or Family Care Providers in the boxes below.
- 7c. If the patient has one or more actively involved sibling or other family member, explain why surrogate decision-making is needed. Provide an explanation for your answers in the comments section.
8. If anyone listed in #6 or #7 could not be contacted, explain the efforts made to contact them.
9. As the Declarant you must read the SDMC Form 310, then fill in both the Attending Physician's name and the Consulting Physician's or Licensed Psychologist's name and the date it was signed.
10. Write out the exact medical decision concerning the withdrawal or withholding of life sustaining treatment(s) being requested as specified in the SDMC Form 320-A and SDMC Form 320-B, question #5a.
11. Check yes or no based on the answer to #6 on SDMC Form 320-A and SDMC Form 320-B. If the patient has been evaluated by hospice, attach the evaluation.
12. As the Declarant you must read **both** the SDMC Form 320-A completed by the Attending Physician and the SDMC Form 320-B completed by the Concurring Physician, then fill in their names and the dates the forms were signed.
13. Based on your personal knowledge of and interactions with the patient, describe in your own words why you think the patient lacks capacity to make the decision(s). Can the patient understand the risks, benefits and alternative(s) to consenting to or refusing the proposed withholding/withdrawing of life sustaining treatment(s)?
14. Based on your personal knowledge of and interactions with the patient, explain in your own words how the proposed decision(s) is/are going to serve the best interests of the patient.

15. Complete the following information for the patient:
- a. Write the patient's name, complete mailing address, and phone number.
 - b. 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.
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Please ensure that the person who best communicates with the patient attends the SDMC hearing.
 - c. Check the type of the patient's residence.
 - d. List COUNTY of residence.
16. As the Declarant you must read the affirmation concerning the patient's qualifying medical condition and equal protection under the law as defined by Article 17-A, Section 1750-B of the Surrogate's Court Procedure Act. Clearly print your (the Declarant's) name as listed on page one. You must sign the form and date it. This date must be the same as or later than the dates on the following forms:
- SDMC Form 310, SDMC Form 320-A, SDMC Form 320-B and SDMC Form 330**
17. Accurately complete all of the requested information for a second person to be contacted about the case in the event you (the Declarant) cannot be reached or are not available when we need to contact you.