

Mail all five completed forms and supplemental information to:

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

SDMC FORM 300

Declaration for Health Care Decisions Act



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

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

SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF APPROPRIATENESS
OF WITHDRAWAL OR WITHHOLDING OF
LIFE SUSTAINING TREATMENT ON BEHALF OF

DECLARATION FOR HEALTH CARE DECISIONS ACT

Declaration # (SDMC Use Only)

(Patient's Name)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

To the Surrogate Decision-Making Committee:

- I am the Declarant for the above named individual; my name, work address and telephone numbers are:
Name: _____ Title: _____
Agency/Organization Name: _____
Full Mailing Address: _____

List contact information where you can be reached Monday through Friday during regular business hours.

Work Phone (____) _____ EXT. _____ Work FAX (____) _____
Work Cell (____) _____ Beeper: (____) _____
Email _____

- Other than the agency you work for, list the primary contact person for all other OPWDD, OMH, or OASAS-funded or licensed/regulating 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. If physician checked YES to **HOSPICE** (ques. #6 on SDMC Form 320-A), include contact information for HOSPICE Coordinator below. **All persons listed below will receive notice of the hearing.**

Name: _____ Agency: _____ Address: _____ _____ Phone: (____) _____ Email: _____ Relationship: _____ Comments:	Name: _____ Agency: _____ Address: _____ _____ Phone: (____) _____ Email: _____ Relationship: _____ Comments:
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- Day Program Provider – List Agency: _____

4. Who explained the proposed withholding/withdrawal of life sustaining treatment(s) to the patient?
(Title Only) _____
5. Describe the efforts to determine the moral and religious beliefs of the patient, and the patient's reaction when the proposed withholding/withdrawal of life sustaining treatment(s) was/were explained.

- 6a. Are there any known Legally Authorized Surrogates specifically identified by Article 80 of the Mental Hygiene Law? Yes No If yes, check all that apply. Parent Spouse
 Adult Child Guardian/Conservator/Committee of the Person Health Care Proxy
- 6b. Indicate the status of the patient's mother. Living Deceased Whereabouts Unknown
 Indicate the status of the patient's father. Living Deceased Whereabouts Unknown
- 6c. Provide the following information for **anyone living listed above. Explain all of your answers.**

Name: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____	Name: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____
Name: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____	Name: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____

- 7a. Are there any known **ACTIVELY** involved adult siblings, or other family members, who do not wish to make the decision? Yes No If yes, list below.
- 7b. Are there any correspondents, community advocates or a FAMILY CARE PROVIDER? Yes No If yes, list below.
- 7c. If the patient has one or more actively involved siblings or other adult family members, explain why surrogate decision-making is needed (e.g.: family members are unavailable, family members do not wish to make the decision and/or they want SDMC to resolve a possible objection or difference of opinion). **Explain your answers.**

<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>
<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>

8. For persons listed in sections 6 and 7 who were not able to be contacted, please list what efforts were made to contact them to discuss this case.

9. As the Declarant, I have read SDMC Form 310 (Certification on Capacity) completed by

_____ and **signed on** _____
(Attending Physician) (Date)

and _____ and **signed on** _____
(Consulting Physician or NYS Licensed Psychologist) (Date)

indicating his/her professional opinions that the patient does not have the capacity to provide informed consent for the proposed withholding/withdrawal of life sustaining treatment(s).

10. The proposed withholding/withdrawal of life sustaining treatment(s) is/are as follows (per #5a on SDMC Forms 320-A and 320-B): _____

11. Is hospice admission anticipated? _____ Yes _____ No (Per #5f on SDMC 320-A and 320-B)

If the patient has been evaluated by Hospice, attach the evaluation.

12. As the Declarant, I have read **both** SDMC Forms 320-A and 320-B (Attending Physician Certification and Concurring Physician Certification) completed by

_____ **signed on** _____
(Name of Attending Physician) (Date)

_____ **signed on** _____
(Name of Concurring Physician) (Date)

describing the patient's medical condition, the risks, benefits and alternative(s) to this/these withholding/withdrawal of life sustaining treatment(s).

13. Based on your personal knowledge of this patient, describe in your own words why you think s/he lacks the capacity to consent or refuse the proposed withholding/withdrawing of life-sustaining treatment.

14. Based on your personal knowledge of this patient, explain in your own words why the proposed treatment decision(s) is/are in his/her best interest.

15. This declaration is made on behalf of:

a. Patient's Name: _____
Address: _____

Phone: (_____) _____
(Phone Number of Patient's Residence)

c. Type of Residence: ___ ICF ___ CR
___ DC ___ FC ___ IRA
___ PC ___ Hospital Psychiatric Ward
___ OMH funded or approved housing
___ Nursing Home ___ Adult Home
___ Assisted Living ___ Waiver Services
___ Other: _____

d. County of Residence: _____

b. Date of Birth: ____/____/____
(Month Day Year)

Age: _____

Sex: ___ Male ___ Female

Religion: _____

Does the patient speak/understand English?

___ Yes ___ No

Does the patient speak/understand a foreign language?

___ Yes ___ No

If Yes, which language: _____

Does the patient require an American Sign Language Interpreter? ___ Yes ___ No

Does the patient use a communication board or other assistive device? ___ Yes ___ No

Please ensure that the person who best communicates with the patient attends the SDMC hearing.

16. This request is based on the patient's qualifying medical condition other than mental retardation or developmental disability, with recognition that a person with mental retardation or developmental disability is entitled to full and equal rights, equal protection, respect, medical care and dignity afforded to persons without mental retardation or developmental disabilities and without any financial considerations that affect the health care provider or any other party. To the best of my knowledge, the above information and statements are truthful and complete.

Print Declarant's Name Clearly

Declarant's Signature

Date

NOTE: THIS FORM MUST BE DATED THE SAME/LATER THAN THE OTHER SDMC FORMS IN THE CASE.

17. Name of Second Contact: _____ Title: _____
(NAME OF PERSON WHO WILL BE CONTACTED IF YOU ARE NOT AVAILABLE.)

Second Contact's Full Mailing Address (Organization Name): _____

Street

City

State

Zip

Work Phone (_____) _____ EXT. _____

FAX Phone (_____) _____ Work Cell (_____) _____

Email _____