AN ACT

RELATING TO PROBATE PRACTICE AND PROCEDURE -- SUPPORTED DECISION-MAKING ACT

Introduced By: Representatives Craven, Knight, and McEntee

Date Introduced: March 23, 2018

Referred To: House Judiciary

It is enacted by the General Assembly as follows:

SECTION 1. Title 33 of the General Laws entitled "PROBATE PRACTICE AND PROCEDURE" is hereby amended by adding thereto the following chapter:

CHAPTER 15.3

SUPPORTED DECISION-MAKING ACT

33-15.3-1. Short title.

This chapter shall be known and may be cited as the "Supported Decision-Making Act."

33-15.3-2. Purpose.

(a) The purpose of this chapter is to achieve all of the following:

(1) Provide assistance in gathering and assessing information, making informed decisions, and communicating decisions for adults who would benefit from decision-making assistance;

(2) Give supporters legal status to be with the adult and participate in discussions with others when the adult is making decisions or attempting to obtain information;

(3) Enable supporters to assist in making and communicating decisions for the adult but not substitute as the decision maker for that adult; and

(4) Establish the use of supported decision-making as an alternative to guardianship.

(b) This chapter is to be administered and interpreted in accordance with all of the following principles:
(1) All adults should be able to choose to live in the manner they wish and to accept or refuse support, assistance, or protection;

(2) All adults should be able to be informed about and participate in the management of their affairs; and

(3) The values, beliefs, wishes, cultural norms, and traditions that adults hold, should be respected in supporting adults to manage their affairs.

33-15.3-3. Definitions.

For the purposes of this chapter:

(1) "Adult" means an individual who is eighteen (18) years of age or older.

(2) "Affairs" means personal, health care, and financial matters arising in the course of activities of daily living and includes all of the following:

(i) Those health care and personal affairs in which adults make their own health care decisions, including monitoring their own health; obtaining, scheduling, and coordinating health and support services; understanding health care information and options; and making personal decisions, including those to provide for their own care and comfort; and

(ii) Those financial affairs in which adults manage their income and assets and its use for clothing, support, care, comfort, education, shelter, and payment of other liabilities of the individual.

(3) "Good faith" means honesty in fact and the observance of reasonable standards of fair dealing.

(4) "Immediate family member" means a spouse, child, sibling, parent, grandparent, grandchild, stepparent, stepchild, or stepsibling.

(5) "Person" means an adult; health care institution; health care provider; corporation; partnership; limited liability company; association; joint venture; government; governmental subdivision, agency, or instrumentality; public corporation; or any other legal or commercial entity.

(6) "Principal" means an adult who seeks to enter, or has entered, into a supported decision-making agreement with a supporter under this chapter.

(7) "Supported decision-making" means a process of supporting and accommodating an adult to enable the adult to make life decisions, including decisions related to where the adult wants to live, the services, supports, and medical care the adult wants to receive, whom the adult wants to live with, where the adult wants to work, and how the adult wants to manage finances, without impeding the self-determination of the adult.

(8) "Supported decision-making agreement" or "the agreement" means an agreement
between a principal and a supporter entered into under this chapter.

(9) "Supporter" means a person who is named in a supported decision-making agreement and is not prohibited from acting pursuant to § 33-15.3-6(b).

(10) "Support services" means a coordinated system of social and other services supplied by private, state, institutional, or community providers designed to help maintain the independence of an adult, including any of the following:

(i) Homemaker-type services, including house repair, home cleaning, laundry, shopping, and meal-provision;

(ii) Companion-type services, including transportation, escort, and facilitation of written, oral, and electronic communication;

(iii) Visiting nurse and attendant care;

(iv) Health care provision;

(v) Physical and psychosocial assessments;

(vi) Financial assessments and advisement on banking, taxes, loans, investments, and management of real property;

(vii) Legal assessments and advisement;

(viii) Education and educational assessment and advisement;

(ix) Hands-on treatment or care, including assistance with activities of daily living such as bathing, dressing, eating, range of motion, toileting, transferring, and ambulation;

(x) Care planning; and

(xi) Other services needed to maintain the independence of an adult.

33-15.3-4. Presumption of capacity.

(a) All adults are presumed to be capable of managing their affairs and to have legal capacity.

(b) The manner in which an adult communicates with others is not grounds for deciding that the adult is incapable of managing the adult’s affairs.

(c) Execution of a supported decision-making agreement may not be used as evidence of incapacity and does not preclude the ability of the adult who has entered into such an agreement to act independently of the agreement.

33-15.3-5. Supported decision-making agreements.

(a) A supported decision-making agreement must include all of the following:

(1) Designation of at least one supporter;

(2) The types of decisions for which the supporter is authorized to assist; and

(3) The types of decisions, if any, for which the supporter may not assist.
(b) A supported decision-making agreement may include any of the following:

(i) Designation of more than one supporter;

(ii) Provision for an alternate to act in the place of a supporter in such circumstances as may be specified in the agreement; and

(iii) Authorization for a supporter to share information with any other supporter named in the agreement, as a supporter believes is necessary.

(c) A supported decision-making agreement is valid only if all of the following occur:

(1) The agreement is in a writing that contains the elements of the form contained in § 33-15.3-11;

(2) The agreement is dated; and

(3) Each party to the agreement signed the agreement in the presence of two (2) adult witnesses, or before a notary public.

(d) The two (2) adult witnesses required by subsection (c)(3) of this section may not be any of the following:

(1) A supporter for the principal;

(2) An employee or agent of a supporter named in the supported decision-making agreement;

(3) A paid provider of services to the principal; and

(4) Any person who does not understand the type of communication the principal uses, unless an individual who understands the principal's means of communication is present to assist during the execution of the supported decision-making agreement.

(e) A supported decision-making agreement must contain a separate declaration signed by each supporter named in the agreement indicating all of the following:

(1) The supporter's relationship to the principal;

(2) The supporter's willingness to act as a supporter; and

(3) The supporter's acknowledgement of the role of a supporter under this chapter.

(f) A supported decision-making agreement may authorize a supporter to assist the principal to decide whether to give or refuse consent to a life sustaining procedure pursuant to the provisions of chapters 4.10 and 4.11 of title 23.

(g) A principal or a supporter may revoke a supported decision-making agreement at any time in writing and with notice to the other parties to the agreement.


(a) Except as otherwise provided by a supported decision-making agreement, a supporter may do all of the following:
(1) Assist the principal in understanding information, options, responsibilities, and consequences of the principal's life decisions, including those decisions relating to the principal's affairs or support services;

(2) Help the principal access, obtain, and understand any information that is relevant to any given life decision, including medical, psychological, financial, or educational decisions, or any treatment records or records necessary to manage the principal's affairs or support services;

(3) Assist the principal in finding, obtaining, making appointments for, and implementing the principal's support services or plans for support services;

(4) Help the principal monitor information about the principal's affairs or support services, including keeping track of future necessary or recommended services; and

(5) Ascertain the wishes and decisions of the principal, assist in communicating those wishes and decisions to other persons, and advocate to ensure that the wishes and decisions of the principal are implemented.

(b) Any of the following are disqualified from acting as a supporter:

(1) A person who is an employer or employee of the principal, unless the person is an immediate family member of the principal;

(2) A person directly providing paid support services to the principal, unless the person is an immediate family member of the principal; and

(3) An individual against whom the principal has obtained an order of protection from abuse or an individual who is the subject of a civil or criminal order prohibiting contact with the principal.

(c) A supporter shall act with the care, competence, and diligence ordinarily exercised by individuals in similar circumstances, with due regard either to the possession of, or lack of, special skills or expertise.


A decision or request made or communicated with the assistance of a supporter in conformity with this chapter shall be recognized for the purposes of any provision of law as the decision or request of the principal and may be enforced by the principal or supporter in law or equity on the same basis as a decision or request of the principal.


(a) A person, who in good faith acts in reliance on an authorization in a supported decision-making agreement, or who in good faith declines to honor an authorization in a supported decision-making agreement, is not subject to civil or criminal liability or to discipline for unprofessional conduct for any of the following:
(1) Complying with an authorization in a supported decision-making agreement based on an assumption that the underlying supported decision-making agreement was valid when made and has not been revoked;

(2) Declining to comply with an authorization in a supported decision-making agreement based on actual knowledge that the agreement is invalid.


(a) A supporter may assist the principal with obtaining any information to which the principal is entitled, including, with a signed and dated specific consent, protected health information under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191], educational records under the Family Educational Rights and Privacy Act of 1974 [20 U.S.C. § 1232g], or information protected by 42 U.S.C.A. § 290dd-2, 42 C.F.R Part 2.

(b) The supporter shall ensure all information collected on behalf of the principal under this section is kept privileged and confidential, as applicable; is not subject to unauthorized access, use, or disclosure; and is properly disposed of when appropriate.

33-15.3-10. Reporting of suspected abuse, neglect, or exploitation.

If a person who receives a copy of a supported decision-making agreement or is aware of the existence of a supported decision-making agreement has cause to believe that the principal, who is an adult with a developmental disability or an elder, is being abused, neglected, or exploited by the supporter, the person shall report the alleged abuse, neglect, or exploitation pursuant to §§ 40.1-27-02, and 42-66-8.

33-15.3-11. Form of supported decision-making agreement.

A supported decision-making agreement may be in any form not inconsistent with the following form and the other requirements of this chapter. Use of the following form is presumed to meet statutory provisions.

SUPPORTED DECISION-MAKING AGREEMENT

Appointment of Supporter

I, .....................................(insert your name), make this agreement of my own free will.

I agree and designate that:

Name:.............................

Address:.......................................

Phone Number:..............................

E-mail Address:..............................

is my supporter. My supporter may help me with making everyday life decisions relating to the following:
Y/N Obtaining food, clothing, and shelter

Y/N Taking care of my health

Y/N Managing my financial affairs

Y/N Other (specify):

______________________________________________________________________________

______________________________________________________________________________

I agree and designate that:

Name: .............................................

Address: .................................

Phone Number: ............................

E-mail Address: ..............................

is my supporter. My supporter may help me with making everyday life decisions relating to the following:

Y/N Obtaining food, clothing, and shelter

Y/N Taking care of my physical health

Y/N Managing my financial affairs

Y/N Other (specify):

My supporter(s) is (are) not allowed to make decisions for me. To help me with my decisions, my supporter(s) may:

(1) Help me access, collect, or obtain information that is relevant to a decision, including medical, psychological, financial, educational, or treatment records;

(2) Help me gather and complete appropriate authorizations and releases;

(3) Help me understand my options so I can make an informed decision; and

(4) Help me communicate my decision to appropriate persons.

Effective Date of Supported Decision-Making Agreement

This supported decision-making agreement is effective immediately and will continue until.........................(insert date) or until the agreement is terminated by my supporter or me or by operation of law.

Signed this ..................day of ............... , 20...........

Consent of Supporter

I, .................................... (name of supporter), consent to act as a supporter under this agreement, and acknowledge my responsibilities under chapter 15.3 of title 33.
(Signature of supporter)   (Printed name of supporter)

My relationship to the principal is: ................................................

1, ........................................ (Name of supporter), consent to act as a supporter under this agreement, and acknowledge my responsibilities under chapter 15.3 of title 33.

(Signature of supporter)   (Printed name of supporter)

My relationship to the principal is: ................................................

Consent of the Principal

(My signature)   (My printed name)

Witnesses or Notary

(Witness 1 signature)   (Printed name of witness 1)

(Witness 2 signature)   (Printed name of witness 2)

Or

State of ..............................

County of ..............................

This document was acknowledged before me on (date) by ................................................ and .................................................

(Name of adult with a disability)   (Name of supporter)

(Signature of notarial officer)

(Seal, if any, of notary)

(Printed name)

My commission expires: ................................................

SECTION 2. Section 33-15-47 of the General Laws in Chapter 33-15 entitled "Limited Guardianship and Guardianship of Adults" is hereby amended to read as follows:


The following forms shall be used for the purposes of this chapter:

STATE OF RHODE ISLAND   PROBATE COURT

OF THE COUNTY OF ____________________________
PETITION FOR LIMITED GUARDIANSHIP OR GUARDIANSHIP

[Name] hereby petitions the Probate Court of the city/town of [City/Town].

Petitioner [Name] to appoint a limited guardian/guardian for [Name], who currently resides at [Address], in the city/town of [City/Town], and whose date of birth is [Date of Birth].

Based upon an assessment conducted by [Assessor], on [Assessment Date], which functional assessment reflects the current level of functioning of [Name], it has been determined that [Name] lacks decision-making ability in one or more of the following areas as indicated:

- [ ] health care
- [ ] financial matters
- [ ] residence
- [ ] association
- [ ] other

Regarding each area indicated, please describe the specific assistance needed:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Indicate which of the following less restrictive alternatives to guardianship have been explored and deemed inappropriate as indicated:

- [ ] Durable Power of Attorney for Health Care
- [ ] Living Will
Please describe the basis for the determination that the alternative will not meet the needs of the respondent for each alternative explored and deemed inappropriate:

________________________________________________________

________________________________________________________

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The following individual/agency is willing to serve as guardian:

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Upon information and belief the above individual/agency has:

□ No conflict of interest that would interfere with guardianship duties.
☐ No criminal background that would interfere with guardianship duties.
☐ The capacity to manage financial resources involved.
☐ The ability to meet requirements of law and unique needs of individual.
☐ Demonstrated willingness to undergo training.

The Respondent has the following heirs at law:

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<th>RESIDENCE:</th>
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Subscribed and sworn to before me this as to the truth of the above facts by ________ in

_______ on the ________ day of ________, 19____.

__________________________
Notary Public

____________
Print Name

DECREES

Dated

__________________________
PROBATE JUDGE

This notice should be served at once and returned to the clerk of the court.
BY THE COUNTY OF ______________ AND STATE AFORESAID

To ______________________

Estate or ______________

Docket No. _____________

GREETING:

A petition for Limited Guardianship/Guardianship has been filed in the Probate Court of

the city/town of ______________________. ______________________ has requested that

the Probate Petitioner

Court appoint a limited guardian/guardian for you.

A hearing regarding this Petition shall be held

On: ____________________________________

date

At: ____________________________________

time

at the Probate Court for the town of ______________________.

_______________________________________________

Address

_______________________________________________

The Petition requests that the Probate Court consider the qualification of the following

individual/agency to serve as your limited guardian/guardian:

_______________________________________________

_______________________________________________

A guardian ad litem will be appointed by the Probate Court to visit you, explain the

process and inform you of your rights.

You have the right to attend the hearing to contest the petition, to request that the powers

of the guardian be limited or to object to the appointment of particular individual/agency limited

guardian/guardian. If you wish to contest the petition, you have the right to be represented by an

attorney, at state expense, if you are indigent.

If the Petition is granted and a limited guardian/guardian is appointed, the Probate Court

may give the limited guardian/guardian the power to make decisions about one or more of the

following:

Your health care; your money; where you live; and with whom you associate.

Copies of this Notice will be mailed to:

The administrator of any care or treatment facility where you live or receive primary
services;

your spouse, and heirs at law; any individual or entity known to petitioner to be
regularly
supplying protection services to you.

CERTIFICATION OF SERVICE

I certify that I hand-delivered and read this Notice to __________ on the
_______ day of __________, 19___.

___________________________________
Signature

___________________________________
Print Name

___________________________________
Address

CERTIFICATION OF NOTICE

I certify that, as required by Rhode Island General Laws § 33-15-17.1(e), I mailed a copy
of this Notice to the following persons, at the addresses listed, on the _______ day of _______.
19__. 

___________________________________
Signature

___________________________________
Print Name

____________________
____________________
Address

Subscribed and sworn to before me this _______ day of _______, 19___.

________________________________
Notary Public

WITNESS

Judge of the Probate Court of the _______ of _______ this _______ day of
__________, 19___.

________________________________
Clerk

DECISION-MAKING ASSESSMENT TOOL

Name of Individual being assessed: 
Current Address: 

___________________________________ 
___________________________________
Date of Birth: ____________________________ Permanent Address (if different): ____________________________

Instructions for Completion

This document will be used by a Probate Court to determine whether to appoint a guardian to assist this individual in some or all areas of decision-making.

This document has two parts. Please first complete the part which is right after these instructions, titled Assessment. Then complete the second section, titled Summary.

To a physician completing this document: The individual's treating physician must complete this document. If there is any information of which the treating physician completing this document does not have direct knowledge, he or she is encouraged to make such inquiries of such other persons as are necessary to complete the entire form. Those persons might include other medical personnel such as nurses, or other persons such as family members or social service professionals who are acquainted with the individual. If the physician has received information from others in completing the form, the names of those individuals must be listed on the Summary.

To a non-physician completing this document: Professionals or other persons acquainted with the individual being assessed may also complete this document. If there is information of which a non-physician completing this document does not have knowledge, such non-physician may either leave portions of the document blank, or also make inquiries or do such investigation as is necessary to complete the entire document. Again, the names of any individual from whom information is derived should be listed on the Summary.

The document must be signed and dated by the person completing it. It does not need to be notarized.

A. BIOLOGICAL ASSESSMENT

THE FOLLOWING IS BASED UPON A PHYSICAL EXAMINATION CONDUCTED BY ME ON __________________________

____________________________

(DATE)

1. DIAGNOSIS and PROGNOSIS:

______________________________________________________________________________

2. MEDICATION (PLEASE LIST):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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How do the above medications, if any, affect the individual's decision-making ability?

Please explain:

3. CURRENT NUTRITIONAL STATUS:

B. PSYCHOLOGICAL ASSESSMENT

1. MEMORY (CIRCLE ONE)

(A) Intact; (B) Mild Impairment; (C) Moderate Impairment; (D) Severe Impairment

2. ATTENTION (CIRCLE ONE)

(A) Intact; (B) Mild Impairment; (C) Shifting/Wandering; (D) Delirium; (E) Unresponsive

3. JUDGMENT (CIRCLE ONE)

(A) Intact; (B) Able to Make Most Decisions; (C) Impaired; (D) Gross Impairment

4. LANGUAGE (CIRCLE ALL THAT APPLY)

(A) Intact (B) Sensory Deficits (Hearing/Speech/Sight)

(C) Impairment In Comprehension/Speech: Mild/Moderate/Severe

(D) Completely Unresponsive

5. EMOTION (CIRCLE ALL THAT APPLY)

(A) ANXIETY/DEPRESSION: (1) None (2) History of Anxiety/Depression

(3) Moderate Symptoms of Anxiety/Depression

(4) Severe symptoms with sleep/appetite/energy disturbance

(5) Suicide/Homicidal

(B) OTHER: (1) Suspiciousness/Belligerence/Explosiveness

(2) Delusions/Hallucinations (3) Unresponsive
If you circled any of the above, other than (A) or (1) for any of the above categories, please explain whether the situation is treatable or reversible, and if so, how:

C. SOCIAL ASSESSMENT

1. MOBILITY (CIRCLE ALL THAT APPLY)
   (A) Intact/Exercises (B) Drives Car Or Uses Public Transportation
   (C) Independent Ambulation in Home Only; (D) Walker/Cane; (E) Requires Assistance
   If you circled (C), (D), or (E), is situation treatable or reversible? If so, how?

   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

2. SELF CARE (CIRCLE ALL THAT APPLY)
   (A) No Assistance Needed;
   (B) Requires Assistance with (1) Meals (2) Bathing (3) Dressing (4) Toileting/Feeding
   If you circled any of (B), is individual aware that assistance is required?

   __________________

   Is individual willing to accept assistance? ____________________________
   Is individual able to arrange for assistance? __________________________

3. CARE PLAN MAINTENANCE (CIRCLE ALL THAT APPLY)
   (A) No Active Problem; (B) Initiates Problem Identification; (C) Actively Cooperative;
   (D) Passively Cooperative; (E) Passively Uncooperative; (F) Actively Uncooperative

4. SOCIAL NETWORK RELATIONSHIPS
   (CIRCLE ONE IN (A) AND IN ONE IN (B))
   SUPPORT:
   (1) Very Good Supportive Network; (2) Some Support From Family And Friends; (3) No
   Or Limited Support From Family/Friends; (4) Needs Community Support; (5)
   Isolated/Homebound
   (B) SOCIAL SKILLS:
   (1) Very Good Social Skills; (2) Good Social Skills; (3) Interacts With Prompting; (4)
   Isolated

D. SUMMARY

I hereby certify that I have reviewed sections A, B, & C attached hereto and based on such assessments that the individual's decision-making ability is as follows:
(1) PLEASE DESCRIBE AS FULLY AS YOU CAN THE INDIVIDUAL'S DECISION-MAKING ABILITY IN EACH OF THE FOLLOWING AREAS:

A. FINANCIAL MATTERS

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

B. HEALTH CARE MATTERS

______________________________________________________________

______________________________________________________________

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C. RELATIONSHIPS

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

D. RESIDENTIAL MATTERS

______________________________________________________________

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______________________________________________________________

(2) PLEASE INDICATE YOUR OPINION REGARDING WHETHER THE INDIVIDUAL NEEDS A SUBSTITUTE DECISION-MAKER IN ANY OF THE FOLLOWING AREAS: (Circle one for each category. If you circle "limited" for any category, please explain.)

(1) FINANCIAL MATTERS

Yes  No  Limited
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<td>(5) OTHER: If there are any other areas in which you think the individual lacks decision-making ability or has limited decision-making ability, please explain.</td>
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Names and titles of others who assisted in Preparation of This Assessment.

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STATE OF RHODE ISLAND

PROBATE COURT

OF THE

COUNTY OF ________________

Estate of ________________________

Docket No. ______________

ANNUAL STATUS REPORT

(1) The residence of the ward is ________________________________

(2) The medical condition of the ward is:

______________________________________________________________

______________________________________________________________

______________________________________________________________

(3) I perceive the following changes in the decision making capacity of the ward:

______________________________________________________________

______________________________________________________________

______________________________________________________________

(4) The following is a summary of the actions I have taken and decisions I have made on behalf of the ward during the last year:

______________________________________________________________

______________________________________________________________

______________________________________________________________

(If more space is needed, please attach a supplement).

__________________________

Guardian

__________________________

Date

STATE OF RHODE ISLAND

PROBATE COURT OF

COUNTY OF ________________

THE _______________________

(Estate Name)
REPORT OF THE GUARDIAN AD LITEM

Now comes (Name of Guardian Ad Litem) for (Name of Proposed Ward) and reports that on (Date), I personally visited the proposed ward at (Address). I explained to (Name of Proposed Ward) the following:

* The nature, purpose, and legal effect of the appointment of a guardian;
* The hearing procedure, including, but not limited to, the right to contest the petition, to request limits on the guardian's powers, to object to a particular person being appointed guardian, to be present at the hearing, and to be represented by legal counsel;
* The name of the person known to be seeking appointment as guardian:

Based on such visit and the respondent's reaction thereto, I make the following determination regarding the respondent's desire to be present at the hearing, to contest the petition, to have limits placed on the guardian's powers and respondent's objection, if any, to a particular person being appointed as guardian.

Based on my review of the petition, the decision making assessment tool, my interview with the prospective guardian, my visit with the respondent, and interviews and discussions with other parties, I made the following additional determinations:

Regarding whether the respondent is in need of a guardian of the type prayed for in the petition:

Regarding whether the guardian ad litem has, in the course of fulfilling his or her duties, discovered information concerning the suitability of the individual or entity to serve as such guardian:
Respectfully submitted,

Date:______________________

(Name of Guardian Ad Litem)

SECTION 3. This act shall take effect upon passage.

LC005267
EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
AN ACT
RELATING TO PROBATE PRACTICE AND PROCEDURE -- SUPPORTED DECISION-MAKING ACT

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1 This act would establish the supported decision-making act which is a less restrictive
2 alternative to guardianship for utilization of the probate courts.
3 This act would take effect upon passage.

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