OIDD DD 535-07/AHCCA FORM

Name: _____ DOB: _____

IDENTIFICATION OF AUTHORIZED PERSONS

The purpose of the form is to record a priority list of authorized persons pursuant to the Adult Health Care Consent Act of SC (SC Code Ann. § 44-66-10). For each priority category listed below, enter the name (s) of each person identified by the priority category and, as appropriate, the person's relationship to the person who is potentially unable to provide consent for health care. If the priority category does not identify anyone, enter "Not Applicable" or "n/a". All efforts to locate those identified by the priority category must be documented in the person's record.

PRIORITY CATEGORY	NAME(S)/ RELATIONSHIP
1. Guardian appointed by the court, pursuant to Article 5, Part 3 of the SC Probate Code, if health decisions are within the scope of guardianship.*	
2. An attorney-in-fact appointed by the person in a durable Power of Attorney executed pursuant to SC Code Ann. § 62-5-501 (Supp. 2017), if the decision is within the scope of his authority.*	
3. The spouse of the person, unless the spouse and the person are separated pursuant to one of the following: a. Entry of pendente lite order in a divorce or separate maintenance action; b. Formal signing of a written property or marital settlement agreement; or c. Entry of a permanent order of separate maintenance and support or of a permanent order approving a property or marital settlement agreement between the parties.	
4. Adult child or children of the person.	
5. Parent (s) of the person.	
6. Adult sibling (s) of the person.	
7. Grandparents (s) of the person.	
8. Adult relative (s) by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the person.	
9. Authorized designee of OIDD if the person is served under the OIDD eligibility categories of ID/RD including Autism. Not applicable to those served under the OIDD eligibility category of HASCI/SD.	
10. A person who has an established relationship with the person, who is acting in good faith on behalf of the person, and who can reliably convey the person's wishes; but, who is **not** a paid caregiver or a provider of health care services to the person. The person with an established relationship shall sign and date a notarized acknowledgement form, provided by the hospital or other health care facility in which the patient is located.	

** The person's record must contain legal documents supporting the authority of the person named in the priority category*

_____ _____

Name of Person Completing This Form Date of Completion

MUST BE COMPLETED/UPDATED ANNUALLY

PHYSICIAN CERTIFICATION/EFFORTS TO LOCATE PERSON FORM

These forms are to be used only by ICF/IID health care providers pursuant to the Adult Health Care Consent Act (SC Code Ann. § 44-66-10)

Individual's Name: _____ DOB: _____

Section I. Proposed Health Care and Timeframe for Initiation

Section II. Certification by Physician

A. Based on examination, it is my professional opinion that the person name above (choose one):

☐ IS able to give valid consent for the proposed health care

☐ IS TEMPORARILY NOT able to give consent for the proposed health care

☐ IS NOT able to give valid consent for the proposed health care

B. The person is noted to be: ☐ temporarily not able or ☐ not able to give valid consent *(indicate why)* He/She: *(check all that apply)*

☐ Is unable to appreciate the nature and implications of his/her conditions and the proposed health care;

☐ Is unable to make a reasoned decision concerning the proposed health care or;

☐ Is unable to communicate a decision concerning the proposed health care in an unambiguous manner.

C. The person is noted to be: ☐ temporarily not able or ☐ not able to give valid consent and the following facts and observation that support this medical opinion and conclusion include:

D. If noted to be temporarily unable to consent, will a delay in rendering the proposed health care beyond the time noted present a substantial risk of death, impairment of functioning of a bodily organ or other serious threat to the health and safety of the person name? : ☐ Yes ☐ No ☐ N/a

I, the undersigned, hereby state, that I am a licensed physician and have personally examined the above named person and my opinion and conclusions are stated above.

_____ _____

Signature of Physician Printed Name of Physician

Date: _____

EFFORTS TO LOCATE AUTHORIZED PERSON

When an adult is certified by two (2) physicians to be unable to consent to health care, an authorized person must be selected from the statutory list of priorities established by the SC Code Ann. § 44-66-10, et.seq. (2018) and OIDD Directive 535-07 DD: Obtaining Consent for Individuals Regarding Health Care. The priority categories in this documented are listed in priority order 1-10. When the person has been certified by two (2) physicians to be unable to consent to proposed health care, the person, among all who are listed, who is identified in the highest priority category and who is reasonably available, willing to make health care decisions for the person and is him/herself able to consent, will be considered the authorized person who can make the decision regarding the proposed health care.

The selected Authorized Person (s):

Name (s): _____

Relationship (priority category to the person): _____

Address (include zip code): _____

Phone Number (include area code): _____

If someone from any higher priority category was not selected as the authorized person, enter the person's name, the priority category, and the reason he/she was not selected (*e.g., not reasonably available, not willing, unable to consent*) .

Priority Category	Name	Reason Not Selected

_____ _____

Printed Name of Health Care Provider Title of Health Care Provider

_____ _____

Signature of Health Care Provider Date of Completion