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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 020562

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MICHAEL A. BROWN
RECORDER

LIVING WILL DECLARATION
and
COMBINED DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE REPRESENTATIVE APPOINTMENT

I. LIVING WILL DECLARATION

Declaration made this 24th day of February, 2013, I, Chloris Backstrom, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

A. STATEMENT OF DECLARANT. If at any time my attending physician certifies in writing that (1) I have an incurable injury, disease, or illness or a permanently unconscious condition; (2) my death will occur within a short period of time or that I will remain in a permanently unconscious condition; and (3) the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration):

C.B. (Initials) I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

C.B. (Initials) I do not wish to receive artificially supplied nutrition and hydration if the effort to sustain life is futile or excessively burdensome to me.

C.B. (Initials) I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

B. OTHER REQUESTS. If there is no brain activity, no life support, otherwise life support.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences from such refusal.

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II. COMBINED DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE REPRESENTATIVE APPOINTMENT

A. DESIGNATION OF HEALTH CARE AGENT. I, Chloris Backstrom, appoint:

Agent Name:	Ashley D. Walton
Address:	6003 Barren Drive Olive Branch, MS 38654
Phone:	Home: (219)805-5109 Work: _____
Relation, if any:	Niece

as my Attorney-in-Fact and Health Care Representative ("Agent") to make any and all health care decisions for me if I become unable to make such decisions for myself, except to the extent I state otherwise in this document.

B. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a Durable Power of Attorney for Health Care. This power of attorney shall take effect upon my disability, incapacity, or incompetency, and shall continue during such disability, incapacity, or incompetency.

C. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so, including the power to direct the withdrawal or withholding of artificially provided food and fluids. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way.

In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent. If my desires regarding a particular health care decision are not known to my Agent, then my Agent shall make the decision for me based upon what my Agent believes to be in my best interests.

D. AUTOPSY, ANATOMICAL GIFTS, DISPOSITION OF REMAINS. I authorize my Agent, to the extent permitted by law, to make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains.

E. DURATION. The appointment of my Health Care Agent does not commence until I am incapable of consenting to health care treatment, and such appointment is not effective if I later become capable of consenting.

F. DESIGNATION OF ALTERNATE AGENT. If the person designated as my Agent is not

available or unable to act, I designate the following persons to serve as my Agent to make health care decisions for me as authorized by this document, who serve in the following order:

FIRST ALTERNATE AGENT

Agent Name: Anthony Walton

Address: 6303 Baren Drive
Olive Branch, MS 38654

Phone: Home: (219)378-8725 Work: _____

G. NOMINATION OF GUARDIAN. If a Guardian of my person is to be appointed for me, I nominate

Name: Ashley D. Walton

Address: 6303 Baren Drive
Olive Branch, MS 38654

to serve as my Guardian.

III. GENERAL PROVISIONS

A. HOLD HARMLESS. All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend and indemnify them.

B. SEVERABILITY. If any provision of this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

C. STATEMENT OF INTENTIONS. It is my intent that this document be legally binding and effective. If the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period in which I am unable to make such decisions.

(YOU MUST SIGN THIS DOCUMENT IN THE PRESENCE OF TWO WITNESSES AND A NOTARY PUBLIC)

I have read and understand the contents of this document and the effect of this grant of powers to my Agent. I am emotionally and mentally competent to make this declaration.

Signed on 24th day of February 2012.

Signature: Chloris Backstrom

Name: Chloris Backstrom
Address: Merrillville
Lake County
Indiana
SSN:
Birthdate: March 05, 1949

Chloris Backstrom has been personally known to me and I believe him/her to be of sound mind. I did not sign Chloris Backstrom's signature above for or at the direction of Chloris Backstrom. I am not a parent, spouse, or child of Chloris Backstrom. I am not entitled to any part of Chloris Backstrom's estate or directly financially responsible for Chloris Backstrom's medical care. I am competent and at least eighteen (18) years old.

Witness Signature: Irving D Wallace

Name: Irving D. Wallace
Address: 2525 West 59th Place
Merrillville, Indiana 46410

Date: 2/24/2012

Witness Signature: Evelyn Wallace

Name: Evelyn Wallace
Address: 2525 West 59th Place
Merrillville, Indiana 46410

Date: 2/24/2012

State of Indiana,

County of Lake ss:

On this 24th day of February 2012, Chloris Backstrom, known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public, within and for the said State and County, and acknowledged that he/she freely and voluntarily executed the same for the purposes stated in the document.

My commission expires: July 8, 2016

Evelyn Wallace
Notary Public

NOTICE TO ATTORNEY-IN-FACT

The Attorney-in-Fact shall ascertain whether Chloris Backstrom has notified Chloris Backstrom's health care providers that a power of attorney has been executed. If Chloris Backstrom has not notified Chloris Backstrom's health care providers of the existence of a power of attorney, the Attorney-in-Fact shall notify the health care providers of the existence of the power of attorney.