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

A. DESIGNATION OF HEALTH CARE AGENT. I, Andriana Clotis Clark, appoint:

Agent Name:	Sabrina Moore	**2020-054729**		STATE OF INDIANA LAKE COUNTY FILED FOR RECORD MICHAEL B BROWN RECORDER
Address:	459 Concord Ave. Crown Point, IN 46307	2020 Aug 21	8:54 AM	
Phone:	Home: 7082500706 Work: n/a			
Relation, if any:	Mother			

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. LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT: no limits

E. 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 including executing a funeral planning declaration on behalf of the principal in accordance with IC 29-2-19.

F. 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.

G. 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: Andre Laurent

Address: 459 Concord Ave.
Crown Point, IN 46307

Phone: Home: 773-738-6181 Work: _____

SECOND ALTERNATE AGENT

Agent Name: Anastasia Lize Clark

Address: 459 Concord Ave.
Crown Point, _____ 46307

Phone: Home: 773-459-8939 Work: _____

H. GENERAL PROVISIONS.

1. 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.

2. 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.

3. 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.

"I AFFIRM, UNDER THE PENALTIES FOR PERJURY THAT I HAVE TAKEN REASONABLE CARE TO REDACT EACH SOCIAL SECURITY NUMBER IN THIS DOCUMENT, UNLESS REQUIRED BY LAW."
PREPARED BY: S.M.

(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 19th day of August, 2020.

Signature: Andriana Clotis Clark

Name: Andriana Clotis Clark
Address: Crown Point
IN County
Indiana
Birthdate: August 07, 2020

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

Witness Signature: [signature]

Name: Sean Allen
Address: 3449 Franklin St
Highland IN 46322

Date: 8-19-2020

Witness Signature: Alex Fields

Name: Alex Fields
Address: 127 Harrington Ave 2D
Crown Point IN 46307

Date: 8-19-2020

State of In,

County of Lake ss:

On this 19th day of August, ____, Andriana Clotis Clark, 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: 10/26/2022

Almita Venese Johnson
Notary Public Seal State of Indiana
Lake County
My Commission Expires 10/26/2022

Almita Venese Johnson
Notary Public

NOTICE TO ATTORNEY-IN-FACT

The Attorney-in-Fact shall ascertain whether Andriana Clotis Clark has notified Andriana Clotis Clark's health care providers that a power of attorney has been executed. If Andriana Clotis Clark has not notified Andriana Clotis Clark'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.

CERTIFICATE OF PROOF

WITNESS to the signature (s) on the foregoing instrument to which this Proof is attached.

Witness Signature

Monica Bly
Witness Printed Name

PROOF:

STATE OF INDIANA

COUNTY OF LAKE

Before me a Notary Public in and for said County and State, Dated on 08/21/20), personally appeared the above-named WITNESS to the foregoing instrument, who, being by me duly sworn, did depose and say that he/she knows WITNESS- Monica Bly to be the individual(s) described in and who executed the foregoing instrument: that said WITNESS was present and saw said GRANTOR(S)- Johnna Moore execute the same: and the said WITNESS at same time subscribed his/her name as a witness thereto

NOTARY PUBLIC SIGNATURE

EVONNE N. Carrillo
NOTARY PRINTED NAME

Notary Name exactly as Commission
Notary Public- State of
Seal
My Commission Expires: 03/21/22
Commission No:

EVONNE N. CARRILLO
Notary Public, State of Indiana
Lake County
Commission Number NP0651467
My Commission Expires
March 21, 2022