NOT AN OFFICIAL DOCUMENT

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TOTAL FEES: 25.00
BY: SP
PG #: 2

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
GINA PIMENTEL
RECORDER

GENERAL DURABLE POWER OF ATTORNEY
WITH HEALTH CARE POWERS

I, **Jackson Bologna**, being at least eighteen (18) years of age and mentally competent, do hereby designate and appoint my mother, **Catherine Bologna**, my true and lawful attorney-in-fact.

I. POWERS. I give to my attorneys-in-fact the powers herein specified to be used on my behalf. I am incorporating by reference herein those powers which comply with my wishes in accordance with the manner prescribed by I.C., 30-5-5. The powers given herein shall be considered limited so that my attorneys-in-fact shall not have any power which would cause my attorneys-in-fact to be treated as the owner of any interest in my property and which would cause that property to be taxed as owned by the attorneys-in-fact, it being my intention not to grant any beneficial interests in my estate by this instrument. My attorneys-in-fact shall have the following powers:

A. Health Care Powers. Authority with respect to health care powers pursuant to I.C. 30-5-5-16.

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate my health care representative may make such a decision for me, after consultation with my physician or physicians or other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

II. EFFECTIVE DATE AND INCAPACITY.

A. This Power of Attorney shall be effective upon the date of execution hereof.
B. My disability or incompetence shall not affect or terminate this Power of Attorney.
C. This Power of Attorney shall terminate upon the execution and recordation with the Recorder's Office of the County of my domicile a written revocation hereof.

JB

Property of Lake County Recorder

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IN WITNESS WHEREOF, I have hereunto set my hand this 18th Day of October, **2022.**

____
Jackson Bologna

STATE OF INDIANA)
) **SS:**
COUNTY OF LAKE)

BEFORE ME, the undersigned, a NOTARY PUBLIC in and for said County and State, this 18th Day of October, **2022.,** personally appeared **Jackson Bologna,** and acknowledged the execution of the foregoing document as her free and voluntary act.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal

My Commission expires: ______________

Notary Public ______________________
A Resident of Lake County

Prepared By: Michael D. Kvachkoff, Attorney at Law
325 N Main Street, Crown Point, IN 46307 - (219) 661-9500

Property of Lake County Recorder

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.
Mary Kaletta