trust&will

Instructions for Stacie Renee Clark Advance Healthcare Directive

Read & review

Make sure you understand it and ensure everything is correct.

Initial to Confirm Your Preferences

Review your document for any additional provisions that you need to initial to confirm your preferences. Add your initial beside the provisions that match your desires.

You may fill in the blank lines with any special instructions or limitations.

Sign

Find 2 witnesses that are at least 18 years old, not related to you, and not named in the document. Make sure that none of the bullet points under the Witness section apply to either witness.

Sign the document while the witnesses watch.

Have each witness sign and complete the Witness page while you and the other witness watch.

Note

Some states have additional requirements for residents of nursing homes or care facilities, including additional restrictions on who may be a witness. These additional requirements are not addressed in this document. This document may not be appropriate if you living in a nursing home or care facility in California, Connecticut, Delaware, New York, or Vermont.

Disclaimer

Trust & Will is not a law firm, and does not provide legal advice. While Trust & Will strives to ensure that all of its documents and services are complete, they are not a substitute for the advice of an attorney.

Advance Health Care Directive for Stacie Renee Clark

I, Stacie Renee Clark, make this Health Care Directive to designate a health care agent, specify the powers of my health care agent, and provide other instructions regarding my health care and the authority of my health care agent.

Personal Information

My name:	Stacie Renee Clark
My address:	2057 E Escondido Pl
	Casa Grande
	Arizona, 85122

Designation of Health Care Agent

I nominate the following individual to serve as my health care agent, proxy, surrogate, representative, and any other similar term ("Health Care Agent"):

Agent's name:	Clovis Clark
Agent's address:	2057 E Escondido Pl
	Casa Grande
	Arizona, 85122

If the primary agent, named above, is unwilling, unable, or ceases to act as my Health Care Agent for any reason, then I nominate the following individuals, in the order named to serve as my Health Care Agent:

First Alternate Agent:

Agent's name:	Paytra R Gessler
Agent's phone:	(419) 261-2032
Agent's email:	Paytragessler@gmail.com

Second Alternate Agent:

Agent's name:	Sophie R Gessler

Agent's phone: (419) 261-0376

Agent's email: Sgessler22@gmail.com

Effectiveness

This Health Care Directive shall become effective at any time that I am unable, in the opinion of my Health Care Agent and my attending physician, to make or communicate a choice about a particular health care decision. This Health Care Directive becomes effective upon the incapacity of the principal. This Health Care Directive shall be durable and shall remain in effect during any period of my incapacity or disability.

If I am able to make or communicate a choice about a particular health care decision, my Health Care Agent shall have any and all powers and authority to carry out and effectuate my decision.

Additional Provisions

I authorize and instruct any health care provider to rely on my Health Care Agent. No health care provider, other individual, or other institution who, in good faith, reasonably relies on any representations by my Health Care Agent will be liable to me, my estate, my heirs, or my assigns for recognizing the actual or apparent authority of my Health Care Agent.

I revoke and rescind any prior health care directive, power of attorney for health care, or other designation of agent to make health care decisions for me.

I complete and execute this form in the State of Arizona on the date indicated below. I intend this Health Care Directive to be universal and valid in any jurisdiction in which it is presented.

I authorize my Health Care Agent to make one or more copies of this Health Care Directive. I intend copies of this document to have the same effect as the original. My Health Care Agent is authorized to provide copies to any health care provider.

My Health Care Agent is not entitled to receive compensation for services performed under or in connection with this Health Care Directive. My Health Care Agent is entitled to reimbursement for reasonable expenses incurred in connection with or as a result of carrying out any provision of this Health Care Directive or in exercising any authority granted to my Health Care Agent by this document.

Instructions for Health Care

I intend this document to be a health care directive to my Health Care Agent, my doctors, and my other Health Care Providers. If the provisions are not enforceable as a health care directive, I intend these provisions be construed and given effect as a written expression of my intentions, desires, and preferences.

General Provisions for Health Care

I desire to remain in my home as long as possible. My Health Care Agent is authorized to take any actions necessary for me to remain in my home for as long as it is reasonable for me to do so. My Health Care Agent shall ensure that funds are available to pay for any in-home care provided, but my desire is to remain in my home regardless of the costs or expenses.

If it is necessary to receive Care and Treatment outside of my home, my Health Care Agent is authorized to arrange for my care at any medical facility, hospital, hospice care, nursing home, or other similar facility. My Health Care Agent shall ensure that all of my essential needs are provided for and that I maintain a comfortable standard of living and hygiene. My Health Care Agent is authorized to facilitate the reasonable payment for any such services.

My Health Care Agent is authorized to facilitate any activities and the involvement of any individuals in accordance with my established beliefs and customary activities known to my Health Care Agent. My Health Care Agent may facilitate the presence of any clergy or other individuals to support my beliefs and may facilitate any associated activities, materials, or services.

End of Life Decisions

I do not wish to receive life-sustaining Care and Treatment that will only delay the timing of my death without improving my condition.

I do not authorize the administration of life-sustaining Care and Treatment that will only prolong my life or delay the timing of my death without improving my condition.

I authorize and desire to receive nutrition and hydration by natural means, but I do not authorize the administration of artificial nutrition and hydration.

I authorize and desire Care and Treatment that will reduce or relieve my pain or discomfort, even if that Care and Treatment could or would result in physical damage, dependency, or hasten (but not intentionally cause) my death.

Definitions

"Care and Treatment" refers to any type of treatment or care related to my health care, including, but not limited to, any medical treatment, medical care, emergency care, surgical procedures, tests, examinations, or medications. Care and Treatment also refers to any type of treatment or care related to psychological or psychiatric care, dental care, or therapeutic care.

"Health Care Provider" refers to any individual, organization, institution, or entity providing or supporting any Care and Treatment. Health Care Providers include, but are not limited to, medical doctors and physicians of any type; mental health providers including psychologists and psychiatrists; therapists; dentists; nurses; hospitals, clinics, and emergency care facilities; pharmacists and pharmacies; laboratories; emergency care providers, first responders, and ambulance services; nursing facilities and residential care facilities; medical insurance companies, or any other medical provider.

Post-Death Authority of Health Care Agent

Autopsy

On my death, my Health Care Agent is authorized to authorize my autopsy.

Organ and Tissue Donation

My Health Care Agent is authorized to make an anatomical gift of my body or any of my organs, tissues, or other parts of my body under the Uniform Anatomical Gift Act or other relevant law, for transplant, therapy, research, education, or other purpose.

Final Arrangements

I have provided instructions for the disposition of my body and remains in my Will. My Health Care Agent is authorized to comply with any instructions from my executor or personal representative in carrying out these instructions and my Health Care Agent is authorized to take any actions that my Health Care Agent deems to be necessary and appropriate for my funeral and the disposition of my remains in the manner I have directed.

To the extent that no such instructions are provided in my Will or to the extent that the executor of my Will is unable to carry out the instructions provided in my Will for any reason, then my Health Care Agent is authorized to dispose of my body and remains as follows:

I direct that my body be cremated.

I direct that no ceremony be held.

My Health Care Agent is empowered to authorize or incur reasonable expenses in carrying out my final arrangements. Any such expenses shall be paid out of any trust for which I am a grantor and that authorizes such payment. If no such trust exists, then any such expenses shall be paid by the executor or personal representative of my estate. My Health Care Agent is entitled to seek reimbursement for any reasonable costs advanced by my Health Care Agent.

General Provisions

Authority of Health Care Agent

My Health Care Agent is authorized to commence, seek, continue, or deal with any judicial proceeding to determine the validity or interpretation of this document. My Health Care Agent is authorized to seek judicial remedies against any third party who is obligated to comply with this document or my Health Care Agent's instructions, but who fails to do so.

Limitations on Authority of Health Care Agent

My Health Care Agent is not authorized to consent to any of the following on my behalf: (1) commitment or placement in a mental health treatment facility; (2) electro-Convulsive therapy or shock therapy; (3) psychosurgery; (4) sterilization; or (5) abortion.

Release of Medical Information

I designate my Health Care Agent as a Personal Representative and authorize my Health Care Providers to disclose and release any Medical Information upon request of my Health Care Agent. This constitutes a full authorization to disclose any Medical Information or Individually Identifiable Health Information to my Health Care Agent, despite the protections of the Health Insurance Portability and Accountability Act of 1996 and relevant state law ("HIPAA").

As used in this section, the terms "Health Care Provider," and "Individually Identifiable Health Information" refer to the terms as defined by HIPAA and relevant state law. "Medical Information" refers to any information related in any way to my health care or Care and Treatment, including Individually Identifiable Health Information and Protected Medical Information as defined under HIPAA, and under relevant state law.

Compensation and Reimbursement of Health Care Agent

My Health Care Agent is not entitled to receive reasonable compensation for services provided pursuant to this document.

My Health Care Agent is entitled to reimbursement for all reasonable costs and expenses actually incurred and paid by my Health Care Agent on my behalf pursuant to this document.

Retention of my Rights

I retain the right to make my own medical and health care decisions so long as I am able to give informed consent. I reserve the right to refuse any treatment or medical procedures, and no treatment or medical procedures may be given to me over my objection or refusal.

Revocation of Document or Termination of Health Care Agent

I reserve the right to revoke this document, terminate the authority of my Health Care Agent, or remove my Health Care Agent, with or without replacing my Health Care Agent after removal.

Any such revocation, termination, or removal may be effectuated in any of the following ways:

1. By executing a written document confirming such action;
2. By destroying all copies of this document that relate to the designation of my Health Care Agent;
3. By crossing out, striking, otherwise negating the text of this document that relate to the designation of my Health Care Agent and signing such marks;
4. By conspicuously writing "Revoked," "Terminated," or other similar words or phrases over the text of this document that relate to the designation of my Health Care Agent and signing such marks; or
5. Any other manner permitted by law.

Any such revocation, termination, or removal may be total and remove all powers and authorities granted by this document or may be partial and remove some or all powers and authorities granted to some or all Health Care Agents by this document.

Resignation of Health Care Agent

My Health Care Agent may resign by providing a written notice of resignation to me or, if I am incapacitated, to any agent serving under my durable power of attorney. If there is no such agent, or if the resigning Health Care Agent is also serving as such agent, the notice may be provided to any person that has care and custody over me.

My Health Care Agent is deemed to have resigned upon 1) death, 2) adjudication of incapacity, or 3) diagnosis by two or more licensed physicians that my Health Care Agent is unable to manage his or her own personal or financial affairs.

Release of Health Care Agent

My Health Care Agent and the heirs, successors, assigns, and estate of my Health Care Agent are released and discharged by me, my heirs, successors, assigns, and estate, from any and all liability, claims, or demands related to or arising from the acts or omissions of my Health Care Agent in carrying out the duties and powers under any provision of this document, other than the willful misconduct or gross negligence of my Health Care Agent.

Copies and Effect of Copies

My Health Care Agent is authorized to make one or more copies of this document and provide such copies to Health Care Providers or other recipients, as deemed necessary by my Health Care Agent. My Health Care Agent is authorized to have a copy of this document placed in my medical records. A copy of this document has the same effect as the original.

Severability

If any part of this instrument is determined to be void or invalid, the remaining provisions will continue in full force and effect.

Powers of Health Care Agent

I give my Health Care Agent broad authority to make decisions regarding my health care wishes.

My Health Care Agent has full authority to make decisions for me about my health care. To the extent my Health Care Agent knows my goals, wishes, and desires based on any oral or written communications or any other written guidance, my Health Care Agent shall make decisions in accordance with my goals, wishes, and desires. In all other instances and in any instance in which it is unclear which decision I would make for myself, my Health Care Agent shall make decisions based on what my Health Care Agent believes to be in my best interests.

My Health Care Agent shall have broad authority to make decisions for me; to interpret my goals, wishes, and desires; and to determine what is in my best interests. The authority of my Health Care Agent shall include the following:

1. To agree to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedure, tests, medications, or other activity related to my health care.
2. To have access to medical records, health care information, protected medical information and individually identifiable health information as defined under the Health Insurance Portability and Accountability Act of 1996 and relevant state law, and any other information relevant to my Health Care Agent in carrying out the authority of my Health Care Agent, to the same extent that I am or would be entitled to, including the right to disclose any such records or information to others.

3. To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted-living, or other similar facility or service, even if such admission or discharge is against medical advice.

4. To contract for any health care related services or facilities for me and to apply for any public or private health care benefits. My Health Care Agent shall not be personally liable or financially responsible for any such contracts.

5. To hire and fire any medical, social service, or other support personnel who are responsible for or contribute to my care.

6. To authorize my participation in medical research related to my medical condition, including my participation in or with any experimental or trial treatments, procedures, or medications.

7. To agree to, refuse, or withdraw consent to using any medication, treatment, or procedure intended to relieve pain or discomfort, even if that use could or would result in physical damage, dependency, or hasten (but not intentionally cause) my death.

8. To decide about body, organ, or tissue donations, autopsy, and the disposition of my remains as permitted by law.

9. To take any other action necessary to do what I authorize or direct in this document or in other written instructions provided to my Health Care Agent, including signing any waivers or other documents, pursuing any dispute resolution process, or taking any action in my name.

_____ **By initialing here, I expressly confirm that the first enumerated power above includes making decisions about using mechanical or other procedures that may affect any bodily functions, including, but not limited to, artificial respiration, artificially-supplied nutrition and hydration, cardiopulmonary resuscitation, life support, or any type of medical support or procedure, even if the decision could or would result in my death, hasten my death, or otherwise alter the timing of my death.**

If I have crossed out, struck, or otherwise negated any portion of or the entirety of any power enumerated above, then such crossed out, struck, or negated text shall have no effect and shall convey no power to my Health Care Agent.

Special Instructions or Limitations

Notwithstanding any other provision of this document, my Health Care Agent shall abide by the following instructions. To the extent that any of the following provisions limit the authority of my Health Care Agent described above, the provisions here shall control and supersede any provisions listed above.

If we will have to rely on someone other than ourselves for long term care, proceed to DNR care only.

Signature

I understand the contents of this document and the effect of granting these powers to my Health Care Agent. I sign my name to this document and declare that it expresses my intent and desires. I sign willingly and as a free and voluntary act. I ask the persons who sign below to be my witnesses.

Stacie Renee Clark

4.21.1968

Date of birth:

Stacie R. Clark

Signature

11.14.2023

Date

Witnesses

We, the undersigned, state that, on the date written below, the Principal, Stacie Renee Clark, signed this document in our presence. We know the Principal or have reviewed adequate proof of the identity of the Principal. We both witnessed the Principal sign or acknowledge this Health Care Directive in front of us. We believe that the Principal is of sound mind; under no duress, fraud, or undue influence; and signed as a free and voluntary act.

Each of us is at least 18 years of age, of sound mind, and capable of being a witness. We are not any of the following:

- Nominated in this document as Health Care Agent or an alternate;
- Related to the Principal by blood, marriage, domestic partnership, or adoption or the spouse of any such person;
- A health care provider to the Principal, including the owner or operator of any health, long-term care, or other residential or care facility serving the Principal;
- An employee of any health care provider to the Principal;
- Financially responsible for the health care of the Principal;
- An employee of the life or health insurance provider of the Principal;
- A creditor of the Principal or entitled to any assets of the Principal under a Will or codicil, trust, insurance policy, or by operation of intestate succession laws;
- Entitled to benefit financially in any way after the death of the Principal.

We subscribe our names as witnesses.

Trina D. Washington	Keith R. Hayes
First Witness Signature	**Second Witness Signature**
Trina D. Washington	Keith R. Hayes
First Witness Printed Name	**Second Witness Printed Name**
11/14/2023	11/14/2023
Date	**Date**
2060 E Escondido Place	1533 E. Remain Dr.
First Witness Address	**Second Witness Address**
Casa Grande AZ 85122	Casa Grande AZ 85122
First Witness City, State, Zip	**Second Witness City, State, Zip**

Notary (Optional)

State of Arizona

County of Pinal

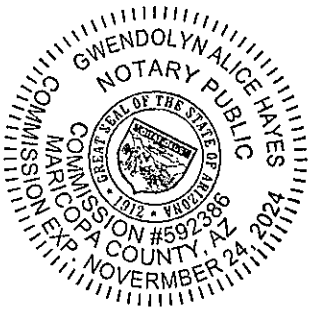
On this 14 day of November, 2023, before me, the undersigned notary, personally appeared Stacie R. Clark, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the foregoing instrument and acknowledged he or she signed the foregoing instrument.

In witness whereof I hereunto set my hand.

Gwendolyn Alice Hayes

Signature of Notary Public

(Seal)



Gwendolyn Alice Hayes

Printed Name of Notary Public

My Commission expires 11-24-2024