

2021-018090

Klamath County, Oregon



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12/06/2021 01:32:57 PM

Fee: \$137.00

OREGON DURABLE FINANCIAL POWER OF ATTORNEY

I, Willard D Hill, the principal, of Klamath County, State of Oregon, hereby designate Antonio M. Herrera of Klamath County, State of Oregon, my attorney-in-fact (hereinafter my "attorney-in-fact"), to act as initialed below, in my name, in my stead and for my benefit, hereby revoking any and all financial powers of attorney I may have executed in the past.

EFFECTIVE DATE

(Choose the applicable paragraph by placing your initials in the preceding space)

WH - A. I grant my attorney-in-fact the powers set forth herein immediately upon the execution of this document. These powers shall not be affected by any subsequent disability or incapacity I may experience in the future.

or

_____ - B. I grant my attorney-in-fact the powers set forth herein only when it has been determined in writing, by my attending physician, that I am unable to properly handle my financial affairs.

POWERS OF ATTORNEY-IN-FACT

My attorney-in-fact shall exercise powers in my best interests and for my welfare, as a fiduciary. My attorney-in-fact shall have the following powers:

(Choose the applicable power(s) by placing your initials in the preceding space)

WH **BANKING** - To receive and deposit funds in any financial institution, and to withdraw funds by check or otherwise to pay for goods, services, and any other personal and business expenses for my benefit. If necessary to effect my attorney-in-fact's powers, my attorney-in-fact is authorized to execute any document required to be signed by such banking institution.

_____ **SAFE DEPOSIT BOX** - To have access at any time or times to any safe-deposit box rented by me or to which I may have access, wheresoever located, including drilling, if necessary, and to remove all or any part of the contents thereof, and to surrender or relinquish said safe-deposit box; and any institution in which any such safe-deposit box may be located shall not incur any liability to me or my estate as a result of permitting my attorney-in-fact to exercise this power.

_____ **LENDING OR BORROWING** - To make loans in my name; to borrow money in my name, individually or jointly with others; to give promissory notes or other obligations therefor; and to deposit or mortgage as collateral or for security for the payment thereof any or all of my securities, real estate, personal property, or other

property of whatever nature and wherever situated, held by me personally or in trust for my benefit.

W H **GOVERNMENT BENEFITS** - To apply for and receive any government benefits for which I may be eligible or become eligible, including but not limited to, Social Security, Medicare and Medicaid.

 RETIREMENT PLAN - To contribute to, select payment option of, roll-over, and receive benefits of any retirement plan or IRA I may own, except my attorney-in-fact shall not have power to change the beneficiary of any of my retirement plans or IRAs.

W H **TAXES** - To complete and sign any local, state and federal tax returns on my behalf, pay any taxes and assessments due and receive credits and refunds owed to me and to sign any tax agency documents necessary to effectuate these powers.

W H **INSURANCE** - To purchase, pay premiums and make claims on life, health, automobile and homeowners' insurance on my behalf, except my attorney-in-fact shall not have the power to cash in or change the beneficiary of any life insurance policy.

W H **REAL ESTATE** - To acquire, purchase, exchange, lease, grant options to sell, and sell and convey real property, or any interests therein, on such terms and conditions, including credit arrangements, as my attorney-in-fact shall deem proper; to execute, acknowledge and deliver, under seal or otherwise, any and all assignments, transfers, deeds, papers, documents or instruments which my attorney-in-fact shall deem necessary in connection therewith.

W H **PERSONAL PROPERTY** - To acquire, purchase, exchange, lease, grant options to sell, and sell and convey personal property, or any interests therein, on such terms and conditions, including credit arrangements, as my attorney-in-fact shall deem proper; to execute, acknowledge and deliver, under seal or otherwise, any and all assignments, transfers, titles, papers, documents or instruments which my attorney-in-fact shall deem necessary in connection therewith; to purchase, sell or otherwise dispose of, assign, transfer and convey shares of stock, bonds, securities and other personal property now or hereafter belonging to me, whether standing in my name or otherwise, and wherever situated.

 POWER TO MANAGE PROPERTY- To maintain, repair, improve, invest, manage, insure, rent, lease, encumber, and in any manner deal with any real or personal property, tangible or intangible, or any interests therein, that I now own or may hereafter acquire, in my name and for my benefit, upon such terms and conditions as my attorney-in-fact shall deem proper.

W H **GIFTS** - To make gifts, grants, or other transfers (including the forgiveness of indebtedness and the completion of any charitable pledges I may have made) without consideration, either outright or in trust to such person(s) (including my attorney-in-fact hereunder) or organizations as my attorney-in-fact shall select, including, without limitation, the following actions: (a) transfer by gift in advancement of a bequest or devise to beneficiaries under my will or in the absence of a will to my spouse and

descendants in whatever degree; and (b) release of any life interest, or waiver, renunciation, disclaimer, or declination of any gift to me by will, deed, or trust

LEGAL ADVICE AND PROCEEDINGS - To obtain and pay for legal advice, to initiate or defend legal and administrative proceedings on my behalf, including actions against third parties who refuse, without cause, to honor this instrument.

SPECIAL INSTRUCTIONS: On the following lines are any special instructions limiting or extending the powers I give to my attorney-in-fact (Write "None" if no additional instructions are given):

I further give to my Attorney-in-fact the power to confer, instruct, and carry out my requests surrounding my burial AND placement of my remains, with mortuary businesses

AUTHORITY OF ATTORNEY-IN-FACT: Any party dealing with my attorney-in-fact hereunder may rely absolutely on the authority granted herein and need not look to the application of any proceeds nor the authority of my attorney-in-fact as to any action taken hereunder. In this regard, no person who may in good faith act in reliance upon the representations of my attorney-in-fact or the authority granted hereunder shall incur any liability to me or my estate as a result of such act. I hereby ratify and confirm whatever my attorney-in-fact shall lawfully do under this instrument. My attorney-in-fact is authorized as he or she deems necessary to bring an action in court so that this instrument shall be given the full power and effect that I intend on by executing it.

LIABILITY OF ATTORNEY-IN-FACT: My attorney-in-fact shall not incur any liability to me under this power except for a breach of fiduciary duty.

REIMBURSEMENT OF ATTORNEY-IN-FACT: My attorney-in-fact is entitled to reimbursement for reasonable expenses incurred in exercising powers hereunder, and to reasonable compensation for services provided as attorney-in-fact.

AMENDMENT AND REVOCATION: I can amend or revoke this power of attorney through a writing delivered to my attorney-in-fact. Any amendment or revocation is ineffective as to a third party until such third party has notice of such revocation or amendment.

STATE LAW: This Power of Attorney is governed by the laws of the State of Oregon.

PHOTOCOPIES: Photocopies of this document can be relied upon as though they were originals.

IN WITNESS WHEREOF, I have on this 4th day of DEC, 2021, executed this Financial Power of Attorney.

Stephanie Hie
Principal's Signature

We, the witnesses, each do hereby declare in the presence of the principal that the principal signed and executed this instrument in the presence of each of us, that the principal signed it willingly, that each of us hereby signs this Power of Attorney as witness at the request of the principal and in the principal's presence, and that, to the best of our knowledge, the principal is eighteen years of age or over, of sound mind, and under no constraint or undue influence.

[Signature]
Witness's Signature

1250 Lakeshore Dr. Klamath Falls, OR 97601
Address

[Signature]
Witness's Signature

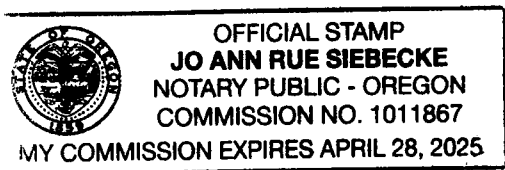
1250 Lakeshore Dr. Klamath Falls, OR 97601
Address

STATE OF OREGON
KLAMATH County, ss.

On this 4th day of DEC, 2021, before me appeared WILFORD D. HILL, as Principal of this Power of Attorney who proved to me through government issued photo identification to be the above-named person, in my presence executed foregoing instrument and acknowledged that (s)he executed the same as his/her free act and deed.

[Signature]
Notary Public

My commission expires: 4/28/25



SPECIMEN SIGNATURE AND ACCEPTANCE OF APPOINTMENT

I, Antonio M. Herrera the attorney-in-fact named above, hereby accept appointment as attorney-in-fact in accordance with the foregoing instrument.

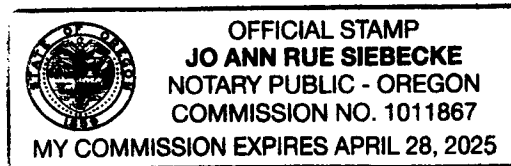
Antonio M. Herrera
Attorney-in-Fact's Signature

STATE OF OREGON
KLAMATH County, ss.

On this 4th day of DEC, 2021, before me appeared ANTONIO M. HERRERA as Attorney-in-Fact of this Power of Attorney who proved to me through government issued photo identification to be the above-named person, in my presence executed the foregoing acceptance of appointment and acknowledged that (s)he executed the same as his/her free act and deed.

Jo Ann Rue Siebecke
Notary Public

My commission expires: 4/28/25



What To Do Now

Here are some suggestions to help ensure your final health care wishes are followed:

- Keep your signed original Advance Directive and Individual Worksheet where they can be easily found. Do not put them in a safe deposit box which requires a key or combination to open. Tell your Health Care Representative and other loved ones where to find your original documents.
- Give copies of your Advance Directive and Individual Worksheet to your Health Care Representative, Alternate Representative, and anyone else you think should know what you want (family members, lawyer, spiritual advisor, etc.). Keep a list of the people you give them to in case you change your mind.
- Tell your doctor you have completed an Advance Directive and discuss your decisions with him or her. Give a copy of your Advance Directive to your doctor for your medical record.
- Use one of the Wallet Cards included in this booklet to indicate that you have completed an Advance Directive and where it can be found. Carry it with you.
- If you are being admitted to a hospital or nursing home, take a copy of your Advance Directive with you. Ask that it be placed in your medical record.
- Plan to review and update your Advance Directive and Individual Worksheet occasionally as the circumstances of your life change. Initial and date the forms each time you review them so your loved ones will know you have not changed your mind.
- If you are terminally ill and wish to die at home, you should talk to your doctor, other caregivers, and family members about situations when you may or may not want an ambulance called. If an ambulance is called, the emergency team must give you life-prolonging care unless you have a valid POLST form completed by your doctor or nurse practitioner. Comfort Care is always provided.
- If you become terminally ill, you can call hospice in your area and ask for information about the care they can give to you and your family. Many of these programs will work directly with your doctor to arrange for you to have hospice services in addition to your medical care.
- If you are traveling outside of Oregon, it is a good idea to take a copy of your Advance Directive with you. Most states will honor an out-of-state document, but some require that it conform to their own laws. If you are going to receive medical care out of state, ask the medical facility where you will be treated to give you information about their laws and requirements.

7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative.

HEALTH CARE REPRESENTATIVE:

Printed Name Antonio M. Herrera (Tony)

Signature or Other Verification of Acceptance Tony Herrera Date 12/04/2021

FIRST ALTERNATE HEALTH CARE REPRESENTATIVE:

Printed Name Tone D. Herrera

Signature or Other Verification of Acceptance Tone D. Herrera Date 12/04/2021

SECOND ALTERNATE HEALTH CARE REPRESENTATIVE:

Printed Name

Signature or Other Verification of Acceptance Date

ADVANCE DIRECTIVE (STATE OF OREGON)

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a Health Care Representative. If you do not have an effective Health Care Representative appointment and become too sick to speak for yourself, a Health Care Representative will be appointed for you in the order of priority set forth in *ORS 127.635 (2)*

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

- If you have completed an Advance Directive in the past, this new Advance Directive will replace any older Directive.
- You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.
- If your Advance Directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your Advance Directive at any time and in any manner that expresses your desire to revoke it.
- In all other cases, you may revoke your Advance Directive at any time and in any manner as long as you are capable of making medical decisions.

1. ABOUT ME

Name Willford DEAN Hill Date Of Birth 11/14/1937

Telephone Numbers (Home) (Work) (Cell) 541-591-1643

Address 5110 Weyerhaeuser Rd #9 Email

2. MY HEALTH CARE REPRESENTATIVE

I choose the following person as my *Health Care Representative* to make health care decisions for me if I can't speak for myself.

Name Tony (Antonio) Herrera Relationship Friend - Brother

Telephone Numbers (Home) (Work) (Cell) 541-891-8891

Address 1250 Lakeshore Dr Email WOVOKA61515@gmail.com

I choose the following people to be my *Alternate Health Care Representatives* if my first choice is not available to make health care decisions for me or if I cancel the first Health Care Representative's appointment.

First Alternate Healthcare Representative:

Name TRAE D. HERRERA Relationship grandson

Telephone Numbers (Home) (Work) (Cell) 541-274-1958

Address NYU, New York, NY Email tdh308@NYU.EDU
338 E 11th Street #4E NY, NY, 10003

Second Alternate Healthcare Representative:

Name Relationship

Telephone Numbers (Home) (Work) (Cell)

Address Email

3. INSTRUCTIONS TO MY HEALTH CARE REPRESENTATIVE

If you wish to give instructions to your Health Care Representative about your health care decisions, initial one of the following three statements:

WH.....To the extent appropriate, my Health Care Representative must follow my instructions.

.....My instructions are guidelines for my Health Care Representative to consider when making decisions about my care.

Other Instructions:

.....

.....

.....

4. DIRECTIONS REGARDING MY END OF LIFE CARE

In filling out these directions, keep the following in mind:

- The term "*as my health care provider recommends*" means that you want your health care provider to use life support if your health care provider believes it could be helpful, and that you want your health care provider to discontinue life support if your health care provider believes it is not helping your health condition or symptoms.
- The term "*life support*" means any medical treatment that maintains life by sustaining, restoring or replacing a vital function.
- The term "*tube feeding*" means artificially administered food and water.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will receive care for your comfort and cleanliness no matter what choices you make.

A) Statement Regarding End of Life Care

You may initial the statement below if you agree with it. If you initial the statement you may, but you do not have to, list one or more conditions for which you do not want to receive life support.

WH.....I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my health care provider to allow me to die naturally if my health care provider and another knowledgeable health care provider confirm that I am in any of the medical conditions listed below (part B).

B) Additional Directions Regarding End of Life Care

Here are my desires about my health care if my health care provider and another knowledgeable health care provider confirm that I am in a medical condition described below:

a) Close to Death: If I am close to death and life support would only postpone the moment of my death:

INITIAL ONE:

.....I want to receive tube feeding

.....I want tube feeding only as my health care provider recommends

W.H. I DO NOT WANT tube feeding

INITIAL ONE:

.....I want any other life support that may apply

.....I want life support only as my health care provider recommends

W.H. I DO NOT WANT life support

b) Permanently Unconscious: If I am unconscious and it is very unlikely that I will ever become conscious again:

INITIAL ONE:

.....I want to receive tube feeding

.....I want tube feeding only as my health care provider recommends

W.H. I DO NOT WANT tube feeding

INITIAL ONE:

.....I want any other life support that may apply

.....I want life support only as my health care provider recommends

W.H. I DO NOT WANT life support

c) Advanced Progressive Illness: If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

INITIAL ONE:

.....I want to receive tube feeding

.....I want tube feeding only as my health care provider recommends

W.H. I DO NOT WANT tube feeding

INITIAL ONE:

.....I want any other life support that may apply

.....I want life support only as my health care provider recommends

W.H. I DO NOT WANT life support

d) Extraordinary Suffering: If life support would not help my medical condition and would make me suffer permanent and severe pain:

INITIAL ONE:

.....I want to receive tube feeding

.....I want tube feeding only as my health care provider recommends

W.H. I DO NOT WANT tube feeding

INITIAL ONE:

.....I want any other life support that may apply

.....I want life support only as my health care provider recommends

W.H. I DO NOT WANT life support

C) Additional Instructions

You may attach to this document any writing or recording of your values and beliefs related to health care decisions. These attachments will serve as guidelines for health care providers. Attachments may include a description of what you would like to happen if you are close to death, if you are permanently unconscious, if you have an advanced progressive illness or if you are suffering permanent and severe pain.

You may attach your individual worksheet from the **KEYConversations™ Planning Guide** to your **Advance Directive**. The worksheet can serve as a guide for your loved ones should they have to make decisions for you.

5. MY SIGNATURE

My Signature Wilford Dean Hill Date X 12.4.21

6. DECLARATION OF WITNESSES -- COMPLETE EITHER A or B WHEN YOU SIGN

(must be notarized by a notary public in part A or witnessed by two adults in part B)

A) NOTARY:

State of: OREGON

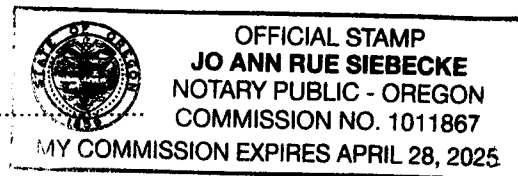
County of: KLAMATH

Signed or Attested Before Me on: DEC 4 2021,

by WILFORD DEAN HILL

Jo Ann Rue Siebecke

Notary Public – State of Oregon



B) WITNESSES:

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternate health care representative, and I am not the person's attending health care provider.

Witnessed by:

1) Witness Name (print)

Signature Date

2) Witness Name (print)

Signature Date

ADVANCE DIRECTIVE REGARDING THE DISPOSITION OF MY REMAINS

Upon my death I have entrusted to my Healthcare Representative Antonio (Tony) Herrera to; author my death notice and obituary, procur my cremation, and carry out the disposition of my remains, as he sees fit. We have discussed the disposition of my remains and it is with the utmost faith I have that my good friend and Brother Tony Herrera, will carry out those wishes in the manner we have discussed.

Wilford D. Hill
Wilford D Hill

12.4.21
date