DOUGLAS COUNTY, NV
Rec:$40.00
Total:$40.00
KELLEN DIMITRI

2024-1007798
05/14/2024 04:48 PM
Pgs=12

00181231202410077980120125
SHAWNYNE GARREN, RECORDER

APN# ______________________________

Recording Requested by/Mail to:

Name: Kellen Dimitri

Address: PO Box 247

City/State/Zip: Genoa, NV 89411

Mail Tax Statements to:

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Durable Power of Attorney Healthcare decisions

Title of Document (required)

Please complete the Affirmation Statement below:

The undersigned hereby affirms that the document submitted for recording DOES contain personal information as required by law: (check applicable)

☐ **Affidavit of Death** – NRS 440.380 (1)(A) & NRS 40.525 (5) ☐ **Military Discharge** – NRS 419.020 (2)

☐ **Other** NRS__________________ (state specific law)

-OR-

☒ I the undersigned hereby affirm the attached document, including any exhibits, hereby submitted for recording does NOT contain the personal information of any person(s). (Per NRS 239B.030)

[signature]
Signature

Kellen Dimitri
Printed Name

This document is being (re-)recorded to correct document #______________________, and is correcting

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COPY

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR ATTORNEY-IN-FACT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE CONSENT, REFUSAL OF CONSENT, OR WITHDRAWAL OF CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

4. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

5. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED IF YOU OBJECT.

6. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.

7. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS

FOR YOU BY NOTIFYING THE TREATING PHYSICIAN, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

8. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

10. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

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POWER OF ATTORNEY FOR HEALTH CARE DECISIONS PURSUANT TO NEVADA REVISED STATUTE CHAPTER 162A

You can use this form if you wish to name someone to make health care decisions for you in case you cannot make them for yourself. This is called giving the person you name a power of attorney for health care. The person you name is called your agent.

PART ONE: NAMING AN AGENT

You can also use this form to state your wishes, preferences, and goals for health care, and to say if you want to be an organ donor after you die.

1. YOUR NAME AND DATE OF BIRTH

I, KIFKA DIMITRI do hereby designate and appoint the following person(s) to make health care decisions for me if I cannot make decisions for myself.

By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

This Power of Attorney is intended to, and does, revoke any prior Power of Attorney for health care matters I have previously executed.

2. DESIGNATION OF AGENT

Name: KELLEN DIMITRI
Address: 230 Genoa Lane
Genoa, NV 89411
Telephone No: 775-450-5290

I appoint KELLEN DIMITRI as my agent to make health care decisions for me and in my name, place, and stead and for my use and benefit and to exercise the powers as authorized in this document.

(Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care, (2) an employee of your treating provider of health care, (3) an operator of a health care facility, or (4) an employee of an operator of a health care facility.)

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3. DESIGNATION OF ALTERNATE AGENT(S).

(You are not required to designate any alternative agent, but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 2, in the event that they are unable or unwilling to act as your agent. Also, if the agent designated in paragraph 1 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my agent is unable to make health care decisions for me, then I designate the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

First Alternate Agent

Name:	DRAGI DIMITRI
Address:	230 Genoa Lane Genoa, NV 89411
Telephone No:	775-450-6844

Second Alternate Agent

Name:
Address:

Telephone No:

4. SPECIAL PROVISIONS AND LIMITATIONS OF AGENT.

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on his or her attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitations: _______________

____

____

(If you do not add any limitations here, your agent will be able to make all health care decisions that an agent is permitted to make under state law.)

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5. DURATION.

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

I wish to have this power of attorney end on the following date: At Death

PART TWO: HEALTH CARE INSTRUCTIONS

6. STATEMENT OF DESIRES CONCERNING HEALTH CARE.

(With respect to decisions to withhold or withdraw life-sustaining treatment, your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests.)

(1) INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT

This section gives you the opportunity to say how you want your agent to act while making decisions for you. You may mark or initial each item. You may also leave any item blank.

Medical treatment needed to keep me alive but not needed for comfort or any other purpose should (mark all that apply):

[X] Always be given to me.

[ ] Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.

[X] Not be given to me if I am unconscious and I am not expected to be conscious again.

[X] Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself and recognizing family and friends.

[X] Other (write what you want or do not want):

At Kellen Dimitri's discretion

COPY

If I cannot swallow and staying alive requires me to get liquid or food through a tube or other means for the rest of my life, liquid or food should (mark all that apply):

[X] Always be given to me.
[ ] Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
[X] Not be given to me if I am unconscious and I am not expected to be conscious again.
[X] Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself and recognizing family and friends.
[X] Other (write what you want or do not want):

At Kellen Dimitri's discretion

If I am in significant pain, care that will keep me comfortable but is likely to shorten my life should (mark all that apply):

[ ] Always be given to me.
[ ] Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
[ ] Not be given to me if I am unconscious and I am not expected to be conscious again.
[ ] Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself and recognizing family and friends.
[X] Other (write what you want or do not want):

At Kellen Dimitri's discretion

(2) INSTRUCTIONS ABOUT PRIORITIES

You can use this section to indicate what is important to you, and what is not important to you. This information can help your agent make decisions for you if you cannot. It also helps others understand your preferences.
You may mark or initial each item. You may also leave any item blank.

Staying alive as long as possible even if I have substantial physical limitations is:
[ ] Very Important
[ ] Somewhat Important
[ ] Not Important

COPY

Staying alive as long as possible even if I have substantial mental limitations is:

[ ] Very Important
[ ] Somewhat Important
[ ] Not Important

Being free from significant pain is:

[ ] Very Important
[ ] Somewhat Important
[ ] Not Important

Being independent is:

[ ] Very Important
[ ] Somewhat Important
[ ] Not Important

Having my agent talk with my family before making decisions about my care is:

[ ] Very Important
[ ] Somewhat Important
[ ] Not Important

Having my agent talk with my friends before making decisions about my care is:

[ ] Very Important
[ ] Somewhat Important
[ ] Not Important

(3) OTHER INSTRUCTIONS

You can use this section to provide any other information about your goals, values, and preferences for treatment, including care you want or do not want. You can also use this section to name anyone who you do not want to make decisions for you under any conditions.

____

____

PART THREE: OPTIONAL SPECIAL POWERS AND GUIDANCE

This part allows you to give your agent additional powers and to provide your agent with more guidance about your wishes. You may mark or initial each item. You also may leave any item blank.

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(1) **OPTIONAL SPECIAL POWERS**

My agent can do the following things ONLY if I have initialed or marked them below:

[ ] Admit me as a voluntary patient to a facility for mental health treatment for up to
7 days [ ]
14 days [ ]
30 days [ ]

(If I do not mark or initial this, my agent MAY NOT admit me as a voluntary patient to this type of facility).

[ ] Place me in a nursing home for more than 100 days even if my needs can be met somewhere else, I am not terminally ill, and I object.

(If I do not mark or initial this, my agent MAY NOT do this).

(2) ACCESS TO MY HEALTH INFORMATION

My agent may obtain, examine, and share information about my health needs and health care if I am not able to make decisions for myself. If I initial or mark below, my agent may also do this at any time they think it will help me.

[ ] I give my agent permission to obtain, examine, and share information about my health needs and health care whenever they think it will help me.

(3) GUIDANCE FOR MY AGENT

The instructions I have stated in this document should guide my agent in making decisions for me (initial or mark one of the below items to tell your agent more about how to use these instructions):

[ ] I give my agent permission to be flexible in applying these instructions if they think it would be in my best interest based on what they know about me.

[ ] I want my agent to follow these instructions exactly as written if possible, even if they think something else is better.

(4) NOMINATION OF GUARDIAN.

Here you can say who you would want as your guardian if you need one. A guardian is a person appointed by a court to make decisions for someone who cannot make decisions.

Filling this out does NOT mean you want or need a guardian right now.

If a court appoints a guardian to make personal decisions for me, I want the court to choose:

[ ] My agent named in this form. If my agent cannot be a guardian, I want my alternate agent named in this form.

[ ] Other (write who you would want and their contact information):

____

____

PART FOUR: ORGAN DONATION

This part allows you to donate your organs when you die. You may mark or initial each item. You may also leave any item blank.

Even if it requires maintaining treatments that could prolong my dying process and might be in conflict with other instructions I have put in this form, upon my death:

[ ] I donate my organs, tissues, and other body parts, except for those listed below (list any body parts you do not want to donate:

____

[X] I do not want my organs, tissues, or body parts donated to anybody for any reason.

Organs, tissues, or body parts that I donate may be used for:

[ ] transplant
[ ] therapy
[ ] research
[ ] education
[ ] all of the above

//

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//

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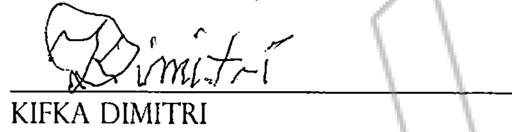
[SIGNATURE PAGE TO FOLLOW]

COPY

PART FIVE: SIGNATURES REQUIRED ON THIS FORM

I sign my name to this Power of Attorney pursuant to NRS 162A on 5-4-2024.



KIFKA DIMITRI

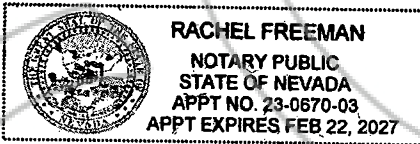
STATE OF NEVADA)
)ss
COUNTY OF douglas)

On 5/4/2024, before me, the undersigned, a Notary Public in and for said County and State, personally appeared KIFKA DIMITRI known to me (or proved to me on the basis of satisfactory evidence) to be the persons whose name is subscribed to the within Power of Attorney, and acknowledged to me that they executed the same.

I certify under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct.

WITNESS my hand and official seal. My Commission Expires: 2/22/27

Notary Public



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PART SIX: IMPORTANT INFORMATION FOR AGENT

1. If this form names you as an agent, you can make decisions about health care for the person who named you when they cannot make their own.

2. If you make a decision for the person, follow any instructions the person gave, including any in this form.

3. If you make a decision for the person and you don't know what the person would want, make the decision that you think is in the person's best interest. To figure out what is in the person's best interest, consider the person's values, preferences, and goals if you know them or can learn them. Some of those preferences might be in this form. You should also consider any behaviors or communications from the person that indicate what they currently want.

4. If this form names you as an agent, you can also get and share the individual's health information. But unless the person has said so in this form, you can only get or share this information when the person cannot make their own decisions about their health care.

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