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Jun 11 2026
SC Court of Appeals

From: Regina Ford
To: Court Of Appeals Filings
Subject: EMERGENCY MOTION FOR EXTENSION OF TIME TO PAY FILING FEE Appellate Case No. 2026-001200
Date: Wednesday, June 10, 2026 5:37:46 PM
Attachments: Power of attorney.pdf

EMERGENCY MOTION FOR EXTENSION OF TIME TO PAY FILING FEE

I respectfully request an extension of time to pay the $300 filing fee associated with my Motion and Appeal.

My mother, Mary Peguese, had a medical emergency and was admitted to the hospital on Sunday and remains hospitalized. I am her designated Health Care Agent and Health Care Power of Attorney. I am also her primary caregiver. Attached are copies of my Health Care Power of Attorney and a physician's letter confirming her diagnosis and need for assistance with her care.

In addition to my caregiving responsibilities, I am currently managing her household and my business financial obligations. My rent and other financial responsibilities are being paid on time and maintained, but the numerous unexpected expenses associated with my mother's hospitalization and care, also business have created a temporary financial hardship. Requiring immediate payment of the $300 filing fee at this time would impose a substantial burden.

I am pursuing this matter in good faith and have continued to meet my financial obligations, including my rent payments. I am not seeking to avoid payment of the filing fee, but rather a reasonable extension of time to allow me to satisfy the fee without causing further hardship during this family medical emergency.

For these reasons, I respectfully request that the Court grant a brief extension of time to pay the filing fee and allow my Motion and Appeal to proceed on the merits.

Respectfully submitted,

Regina Ford

McLeod

Center for Cancer
Treatment & Research

June 6, 2026

Attention: Florence Housing Authority

Reference: Mary L. Peguese / Daughter Regina Ford

To Whom it may Concern:

This letter is on behalf of Ms. Mary L. Peguese, who is currently under my care. She has been diagnosed with Cholangiocarcinoma, with metastasis to the liver. Mrs. Peguese needs assistance with ADLs and cooking and cleaning. She needs her daughter Regina Ford to live with her currently, to assist with her care.

Whatever you can do to support this would be greatly appreciated. If you have any further questions, please call me at 843-777-7951.

Thank you for your time,

X

Arrvind Raghunath, MD

843-777-7951

401 E. Cheves Street • Florence, SC 29506 • P.O. Box 100551 • Florence, SC 29502-0551
(843) 777-6385 • Fax: (843) 777-6389 • www.mcleodcancer.org

SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.

2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.

3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.

5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

A. YOUR SPOUSE, YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY

1. DESIGNATION OF HEALTH CARE AGENT

I, Mary Pegues (Principal), hereby appoint:

(Agent's Name) Regina Ford

(Agent's Address) 703 Mechanics st Apt A

Telephone: home: 803-518-0320 work: 803-846-9558 mobile: 803-518-0320

as my agent to make health care decisions for me as authorized in this document.

Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

a. First Alternate Agent: Nakima G Ford

Address: 854 Walden st

Telephone: home: 302 747-0986 work: _____ mobile: 843 739-0531

b. Second Alternate Agent: Shamika Renee Merriweather

Address: 2342 Shore View Court Suwanee GA 30024

Telephone: home: _____ work: _____ mobile: 678-386-8274

Unavailability of Agent(s): If at any relevant time the agent or successor agents named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

3. HIPAA AUTHORIZATION

When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Information Portability and

HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

9. ADMINISTRATIVE PROVISIONS

A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this 9th day of June, 2026. My current home address is: 703 Antebellum St

X Principal's Signature: Mavy Peguero

X Print Name of Principal: Mavy Peguero

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

Witness No. 1

Signature: Destiny Goodman

Date: 6/9/26

Print Name: Destiny Goodman

Telephone: 843-245-3441

Address: 1168 June Ln Florence SC 29506

Witness No. 2

Signature: Annette Alexis

Date: 6/9/26

Print Name: ANNETTE ALEXIS

Telephone: (786) 925-5641

Address: 2802 KINLOCH CT, APT G
Florence, SC 29501