Wisconsin's New Patient's Representative Law: Frequently Asked Questions

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2025 Wisconsin Act 115 became law on March 20, 2026. The new law amends existing law to create an alternative track to allow a family member or close friend to admit an incapacitated hospital patient to post-inpatient care without having to seek guardianship first.

In addition to the information in this document, Legislative Council has provided an Act Memo explaining the new law. The Department of Health Services has also created a new website that includes the new forms and an informational webinar (available on YouTube and Vimeo).

I. Overview

a. What does this law do?

This law creates an alternative track for admissions to post-inpatient care. If a patient in a hospital inpatient unit is incapacitated and does not have a valid health care power of attorney (HCPOA), the law allows a family member or close friend (a "patient's representative") to consent to admission from the inpatient setting to a skilled nursing facility (SNF) or community-based residential facility (CBRF). The law allows the patient's representative to make health care decisions and authorize medical expenditures related to the care and treatment at the care facility to the same extent that a guardian would be able to make those decisions.

The law does not require that the patient's representative petition for guardianship or protective placement at any point and does not have a time limit on the patient's representative's authority.

b. How is it different from previous law?

Before this law, if an incapacitated hospital patient did not have a valid power of attorney for health care, a family member or close friend could consent to post-inpatient facility admission

[1] See last page for a description of the most recent changes.

after filing petitions for guardianship and protective placement. The family member or friend's authority was limited to 60 days or until a guardian was appointed, whichever happened first, although it could be extended another 30 days if necessary to plan for discharge from the facility.

The new law did not eliminate this process; it provides an alternative track. This process is still available if guardianship and protective placement is still appropriate or necessary for the patient. The patient's representative's may still consent to admission and make health care decisions and financial decisions related to care while the petitions are pending.

c. When is it effective?

June 1, 2026.

d. Does it have an end date?

The law includes a three-year sunset date, meaning that as of June 1, 2029, no patients may be admitted to post-inpatient care via the alternative process.

e. Does this law replace the need for Powers of Attorney or other advance planning?

No. Powers of Attorney for Health Care and Finances offer a number of benefits to the individual beyond what this law allows, including the right to choose who will make decisions and choose alternates, the right to decide what types of decisions their agent will make, the right to have their wishes be followed, and the right to revoke the POA.

II. Incapacity

a. What does incapacity mean in this law?

As defined in this law, incapacity means "unable to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions, including decisions about his or her post-hospital care." In plain English, this means a person lacks the ability to make their own healthcare decisions. This is slightly different from the definition of "incapacity" for the purposes of a healthcare power of attorney, which does not mention decisions about post-hospital care.

b. How is incapacity determined?

Two physicians, or one physician and one advanced practice clinician (a physician assistant, a nurse practitioner, or a psychologist), must personally examine the individual and sign a statement of incapacity. The statement must include the date and location where the provider examined the patient, any medical conditions that led them to conclude that the patient is incapacitated, the provider's office address and contact information, and any other information identified by the Department of Health Services.

c. Is there going to be a standard form for an incapacity statement?

The Department of Health Services has created a Medical Statement of Capacity form that may be used both to document a finding of incapacity and to document that the patient has regained capacity. The form number is F-03435.

d. What happens to the form once it's signed?

The form must be added to the person's hospital medical record and must be sent to the accepting facility within 72 hours of admission. It must also be filed with the Register in Probate and sent to Adult Protective Services (APS) for the patient's county of residence.

Note: the new law adds registers in probate to the list of individuals to whom certain medical records may be released without patient consent. *See* Wis. Stat. § 146.82(2)(a)7m.

e. Can this form be used to activate health care POAs?

No. The Department of Health Services form is intended only for use with post-inpatient facility admissions under Wis. Stat. § 50.06.

Note that the state does not have a standard form to activate health care POAs. Many health systems and providers have created their own. A letter from the examining clinician is also acceptable to activate a health care POA.

f. If a provider or hospital already has their own form to activate health care POAs, can that be used for this?

No. The incapacity evaluation for this law requires more information from the providers than activating a healthcare POA. For a POA, the medical providers only need to state that they personally examined the patient and found that the patient is incapacitated. As noted above, the statement of incapacity for this law will also require the provider to state the date and location where the provider examined the patient, any medical conditions that led them to conclude that the patient is incapacitated, the provider's office address and contact information, and any other information identified by the Department of Health Services.

g. Are there any exceptions to the types of patients who can have a patient's representative appointed under this bill?

This process may not be used if:

1. The patient is diagnosed as developmentally disabled or as having a mental illness at the time of the proposed admission. (Note: this is the same standard as for both previous 50.06 and health care POA admissions.)
2. The patient has a valid health care POA or a guardian of person.

3. Certain family members object to the admission. See Section III.b. below.
4. The patient objects to the admission. Note that the law still allows the patient to be admitted, but requires that the facility contact Adult Protective Services to assess whether discharge is possible or whether guardianship/protective placement may be necessary. See Section V.c (Patient's Rights) and Section VII.a. (County Responsibilities) below; see also Wis. Stat. 50.06(2)(d).

III. Decision-Makers

a. Who is allowed to make decisions?

In order of priority, the people who can serve as patient's representative are the incapacitated person's:

1. Spouse or registered domestic partner
2. Adult child
3. Parent
4. Adult brother or sister
5. Grandparent
6. Adult grandchild
7. Adult close friend

b. What happens if family members can't agree on who should make decisions or what the decisions should be?

If a family member at the same level of priority or higher disagrees with the family member who is making the decision to admit to post-inpatient care, then the patient cannot be admitted. Additionally, any person who lives with the patient and is anywhere in the priority list essentially has veto power over the admission, unless the person consenting to the admission lives with the patient or is the patient's spouse.

Examples:

1. Two adult children disagree on whether to admit. Neither lives with the patient. The patient will not be admitted.

2. A spouse (higher priority) wants to admit, and an adult child (lower priority) does not want to admit. The patient will still be admitted over the adult child's protest.

3. An adult child (higher priority) wants to admit, but an adult grandchild (lower priority) *who lives with the patient* does *not* want to admit. The patient will *not* be admitted, because the adult grandchild lives with the patient.

c. Once a family member or close friend agrees to serve, is there something they have to sign?

The patient's representative will have to sign a sworn declaration acknowledging that they:

1. Agree to make health care decisions regarding admission and care at the admitting facility;
2. Agree to make these decisions with care, diligence, and good faith;
3. Agree to authorize medical expenditures at the admitting facility;
4. To the best of their knowledge, no higher priority family member is willing or able to serve;
5. To the best of their knowledge, the incapacitated person does not have a POA agent or guardian of the person; and
6. Understand their role and responsibilities as the patient's representative.

This declaration must also include a list of all of the patient's family members to whom the representative will send the declaration.

d. What does "sworn declaration" mean? Does that mean the statement must be notarized?

The patient's representative must sign the form under penalty of law for false swearing. The form does not require notarization.

e. Is there a standard form?

The Department of Health Services has created a standard form for the Patient's Representative's Declaration. The form number is F-03436.

f. What happens to the form once it has been signed?

The signed declaration must be given to the discharging hospital, the admitting facility, all of the patient's family members that can reasonably be identified, and Adult Protective Services for the patient's county of residence. It must also be filed with the Register in Probate.

Note: the new law states that the patient's representative must be the one to send their declaration to family members. The law does not specify who is responsible for filing the form with the Register in Probate or providing it to the discharging hospital, admitting facility, or Adult Protective Services. No specific timeframe is given for distributing the form; it must be done "promptly."

g. How will the patient's representative show they are the patient's representative?

The sworn declaration itself, or a copy thereof, will likely serve as the patient's representative's statement of authority.

h. When does the patient's representative's authority end?

The patient's representative's authority ends if any of the following occurs:

1. A guardian is appointed;
2. The patient is discharged to a non-facility setting;
3. A healthcare POA is discovered that was not previously known; or
4. The patient is no longer incapacitated.

Note: the law does not provide any guidance on whether the patient's representative's authority ends if the patient is subsequently able to create a health care POA.

i. Can a patient's representative relinquish their responsibilities, and if so, how? What happens?

The law does not provide any guidance on whether or how a patient's representative can step down or relinquish their responsibilities. The law does not provide for an alternate or allow another family member to step up. If the patient's representative is no longer willing or able to serve and the individual has not regained capacity and is not capable of creating a health care POA, it may be necessary to pursue guardianship.

IV. Authority

a. What types of decisions are covered?

The patient's representative can consent to the patient's transfer from a hospital to a skilled nursing facility or community-based residential facility. Once the patient is admitted to the facility, the patient's representative can make health care decisions regarding the admission, care, and treatment of the patient to the same extent as the guardian of the person. The patient's representative can also authorize expenditures related to health care to the same extent as a guardian of the estate. Note, however, that the patient representative likely cannot authorize a transfer or admission to a different facility; the authority to consent to facility admission applies only when the patient is coming from a hospital inpatient setting.

b. Does this include hospital decision-making?

No. The patient's representative may consent to a post-inpatient care facility and may make health care decisions at that care facility. They may not make any other decisions while the patient remains in the hospital.

c. If the individual is discharged home, can the patient's representative continue to make health care or financial decisions?

No. The patient's representative's authority is limited to health care and financial decisions at the care facility only. If the patient continues to need a decision-maker post-discharge and is

unable to create a health care POA, it may be necessary to pursue guardianship.

d. Can the patient's representative sign a Medicaid application or renewal?

Yes. The Division of Medicaid Services has released an Operations Memo with more information, DMS Operations Memo 26-16, effective June 1, 2026.

e. Can the patient's representative request a functional screen for community long-term care programs?

Yes.

f. Can the patient's representative access bank accounts or other financial assets?

The law allows the patient's representative to "authorize expenditures" related to the patient's care. It is not clear whether banks and other financial institutions will interpret this as allowing access to funds or information about the patient's assets. Additionally, while the law says a patient's representative has all the powers of a guardian of estate, a guardian of estate cannot do things like handle marital property, or retirement accounts, or take action related to real estate, unless they have very specific court authority. As a result, the patient's representative's authority to handle these matters may also be limited.

V. Patient Rights

a. Can the patient designate their own decision-maker?

It is the GSC's stance that it may be possible for an individual to create a health care POA after incapacity, depending on the individual's specific circumstances. For additional legal analysis, please see the Wisconsin Board on Aging & Long-Term Care's *Position on Revocation and Re-Execution of POA-HC Documents*.[2]

If the patient is still capable of creating a health care POA, they may designate their own decision-maker through that process and the patient's representative process will not apply.

If the patient is not capable of creating a health care POA, they are not able to designate their own patient's representative. The decision-maker will be determined by the priority list of family members.

b. Can the patient object to the choice of decision-maker?

The law does not state that the patient may object to the choice of patient's representative.

c. Can the patient object to the decision to admit to post-inpatient facilities?

[2] https://tinyurl.com/BOALTCPOAPositionPaper

Yes. The process will work as it has in the existing Wis. Stat. § 50.06; the additional track for admission does not change the patient's right to object.

If the patient objects to the admission, the patient may still be transferred to the facility, but the facility must immediately contact county Adult Protective Services. APS must meet with the patient within 72 hours and determine next steps. If the objection persists and the person cannot safely be discharged to a non-facility setting, guardianship and protective placement orders may be necessary.

d. Can the patient ask for their capacity to be reassessed?

Yes. Any person, including the patient, may ask for a reassessment of capacity. Per DHS, only one physician or advanced practice clinician is required to find that the patient has regained capacity.

e. Can the patient ask for the patient's representative's decisions to be reviewed?

Yes. Any person, including the patient, may ask a court to review whether the patient's representative is acting in accordance with the known wishes of the patient or in the best interest of the patient.

f. What can the court do in a patient's representative review?

The court may order a hearing, but is not required to do so. The court may also issue any order that the court determines necessary to protect the patient, with or without a hearing. This may include directing the patient's representative to act in the patient's best interests, directing the patient's representative not to make certain decisions or authorize certain expenditures, requiring an accounting of expenditures, and/or requiring periodical check-ins with the patient's representative.

g. Does the incapacitated person have a right to counsel?

The law does not state that the individual has a right to counsel or that they may request court-appointed counsel. They may retain counsel on their own if they wish.

h. Can the court appoint a guardian *ad litem*?

Yes. The court may appoint a guardian *ad litem* (GAL) to represent the best interests of the patient throughout a court proceeding.

i. Who is required to receive notice of a court review of the patient's representative's decisions?

The list of individuals who must receive notice of a hearing to review the decisions of the patient's representative includes:

1. The patient;
2. The patient's counsel, if any;
3. The patient's guardian *ad litem*, if one is appointed;
4. The patient's presumptive adult heirs;
5. Any public or private agency from which the individual is receiving aid or assistance;
6. Any other interested persons, unless waived by the court.

All of the above must be served at least 10 days before the time set for a hearing. The patient must be notified via personal service. The person who serves the patient must inform them of the complete contents of the petition and hearing notice. All others in the list above may be served via personal service or certified mail.

j. Who is responsible for any costs?

If a GAL is appointed, the court can order that the GAL's fees be paid from the patient's funds, if sufficient. If the patient does not have sufficient funds, the court may order that the GAL's fees be paid by the county. If the court finds that the patient's representative is not acting appropriately, the court can require that the patient's representative pay the GAL's fees. The court can also require the patient's representative to personally pay for the costs of the entire proceeding.

VI. Facility Responsibilities

a. What are the hospital's responsibilities?

The hospital must store the statements of incapacity and the patient's representative's declaration in the patient's medical records. Note: the new law adds registers in probate to the list of individuals to whom certain medical records may be released without patient consent. *See* Wis. Stat. § 146.82(2)(a)7m.

b. What are the receiving facility's responsibilities?

The receiving facility must store the statements of incapacity and the patient's representative's declaration in the patient's medical records. The facility must also include the signed patient's representative declaration in the patient's medical records. Additionally, if a skilled nursing facility admits a patient under this law and believes the patient's representative is not making decisions in the best interests of the patient, the facility must report those concerns as required by state law.

VII. County Responsibilities

a. What are APS's responsibilities?

The statements of incapacity and patient's representative declaration must be sent to Adult

Protective Services, but APS is not required to take any specific actions. If the patient objects to the admission, the facility must notify APS and APS must still review the admission within 72 hours, as previously required by Wis. Stat. § 50.06. Likewise, if APS receives reports of abuse, neglect, or exploitation, they must still assess those as they would any other report.

VIII. Role of the Courts

a. What is the role of the courts?

The registers in probate will file these documents for safekeeping. In addition, the Department of Health Services may request that the Register in Probate report on the number of patients admitted using this process.

b. Is there a filing fee? Who is responsible for filing the forms?

There is an $8 filing fee. The law does not specify who must file the statements of incapacity or the patient's representative's declaration.

c. Who will have access to court records?

These court filings will not be confidential, but the documents in them will be.

Certain people can access them upon request, including:

1. A petitioner in a temporary guardianship proceeding for the patient;
2. A family member listed in the priority list above (but not including an adult close friend);
3. A medical provider examining the patient for a permanent guardianship proceeding;
4. Any court or county corporation counsel;
5. Any other person the court may order, if the person can demonstrate good cause to request the records.

d. How long must the Register in Probate maintain these records?

The Register in Probate must maintain these records until the patient's death, in accordance with any protocols established by the Department of Health Services for verifying the death of the individual and destruction of the statements of incapacity and patient declaration.

e. Are there any changes to temporary guardianship procedures under this law?

Yes. Any person filing a petition for temporary guardianship for a patient admitted under the new process must request a copy of any statements of incapacity filed with the register in probate in the ward's county of residence prior to the admission. They must make the request as soon as possible after filing the petition and before any hearing on the petition. They must then submit to the court copies of any statements they receive or a statement that they requested the statements and no statements were found.

If these statements are located and submitted to the court, the court will inspect them in chambers prior to a hearing. The statements may be taken as evidence that the patients' particular situation requires immediate appointment of a temporary guardian without further corroboration from the examining provider. If the court determines that they will be used in the temporary guardianship proceeding, the court will order the petitioner to serve copies on the patient, their counsel (if any), the guardian *ad litem* for the temporary guardianship proceeding, and the petitioner's attorney (if any).

If the patient's circumstances have changed (e.g., a statement has been submitted showing they have regained capacity), the court may exclude the initial incapacity statements from consideration as part of the temporary guardianship.

If the court includes the statements in the temporary guardianship hearing, the finding of incapacity based on these statements can be rebutted if there is a good reason for the court to not take these statements at face value or if there is evidence that the patient's circumstances have changed.

f. Are there any changes to permanent guardianship procedures under this law?

Yes. Any physician or psychologist who examines an individual for permanent guardianship must request and review any statements of incapacity filed with the register in probate prior to providing their competency report to the court. They may also review the patient's representative's declaration.

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Documentation of Changes

06/01/2026:

- Added DHS website and form links and DMS Ops Memo on who may sign Medicaid/Long-Term Care program forms.

05/21/2026:

- Updated terminology to “patient’s representative” throughout (this is the term used in the new statute).
- Updated II.c. with more information about the DHS form to document capacity findings.
- Updated II.d. to add the timeframe for distribution of the capacity statement.
- Updated II.e. to clarify that the DHS capacity form is intended for use only with Wis. Stat. § 50.06 and may not be used to activate a health care POA.
- Updated II.g. to clarify the procedure when a patient objects to admission.
- Updated II.d. to clarify that the form does not require notarization, per DHS Office of Legal Counsel.
- Updated III.f. to clarify that there is no specific timeframe in the statute for filing the patient’s representative’s declaration.
- Updated IV.a. to indicate that per DHS, the patient’s representative’s authority is limited to consenting to admissions coming from a hospital inpatient setting and likely does not include authority to transfer or admit to a second facility following the initial post-inpatient admission.
- Updated V.d to indicate that per DHS, a statement that the patient has regained capacity only requires one clinician’s signature, not two.