

## **Patient's Representative Declaration**

### **Instructions**

The patient's representative of an incapacitated individual must complete this Declaration and promptly submit copies of the signed declaration to the discharging hospital and the accepting facility, to the adult protective services agency for the county in which the incapacitated person resides, to all of the incapacitated individual's family members that can be reasonably contacted following admission of the incapacitated individual to a facility (i.e., nursing home or community based residential facility), and to the register in probate for the county in which the incapacitated individual resides for filing. Wis. Stat. § 50.06(8)(a)(2)

### **Patient's representative role and authority**

Under Wisconsin Statute § 50.06(8)(a), a patient's representative may consent to an incapacitated individual's admission directly from a hospital inpatient unit to a nursing home or community-based residential facility if the individual is not diagnosed as developmentally disabled or as having a mental illness and the individual does not have a power of attorney for health care or a guardian. A patient representative may also:

1. Make health care decisions to the same extent as a guardian of the person,
2. Enroll the incapacitated individual in the Medicaid program to the same extent as a guardian of the estate, and
3. Authorize expenditures related to health care to the same extent as a guardian of the estate.

### **Who can act as a patient's representative?**

An Individual, in the following order of priority, may act as a patient's representative and consent to an incapacitated individual's admission directly from a hospital inpatient unit to a nursing home or community-based residential facility:

- (a) The spouse or domestic partner under ch. 770 of the incapacitated individual.
- (b) An adult son or daughter of the incapacitated individual.
- (c) A parent of the incapacitated individual.
- (d) An adult brother or sister of the incapacitated individual.
- (e) A grandparent of the incapacitated individual.
- (f) An adult grandchild of the incapacitated individual.
- (g) An adult close friend of the incapacitated individual.

### **When does the patient's representative authority to act end?**

The patient's representative authority to make health care decisions to the same extent as a guardian of the person, enroll the incapacitated individual in the Medical Assistance program to the same extent as a guardian of the estate, and authorize expenditures related to health care to the same extent as a guardian of the estate ends if any of the following occurs:

1. A court appoints a guardian for the incapacitated individual.
2. The incapacitated individual is discharged to a setting that is not a nursing home or community-based residential facility.
3. A previously executed health care power of attorney that was not identified at the time the patient's representative was established is found.
4. A physician or advanced practice clinician has determined the individual is no longer incapacitated.

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**Information regarding the incapacitated individual:**

Name (Last, First, MI): \_\_\_\_\_

Date of birth: \_\_\_\_\_

Permanent address – Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Name of the accepting facility: \_\_\_\_\_

Address of the accepting facility – Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Information regarding the patient’s representative:**

Name (Last, First, MI): \_\_\_\_\_

Date of birth: \_\_\_\_\_

Relationship to the incapacitated individual: \_\_\_\_\_

Address – Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

**Patient’s representative declarations**

As the patient’s representative for (name of incapacitated individual) \_\_\_\_\_,  
I declare that:

1. As the patient’s representative, I acknowledge that I may make health care decisions to the same extent as a guardian of the person may and authorize expenditures related to health care to the same extent as a guardian of the estate, including enrolling in the Medicaid program on their behalf. Wis. Stat. § 50.06 (8)(a)(2)(a).  
 Yes  No
  
2. I agree to make health care decisions regarding the admission to and care and treatment at the accepting facility (a nursing home or community based residential facility), on the incapacitated individual’s behalf and agree to authorize expenditures related to health care received at the accepting facility on the incapacitated individual’s behalf. Wis. Stat. § 50.06 (8)(a)(2)(b).  
 Yes  No

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3. To the best of my knowledge, the incapacitated patient does not have a health care agent (power of attorney for health care) as defined in s. 155.01 (4), stats., or guardian of the person, as defined in s. 54.01 (12), stats. Wis. Stat. § 50.06 (8)(a)(2)(c).

Yes  No

4. To the best of my knowledge, I do not have an activated power of attorney for health care and have not been adjudicated incompetent in this state. Wis. Stat. §50.06 (8)(a)(2)(d).

Yes  No

5. When acting on behalf of the incapacitated individual to make health care decisions, enroll in the Medicaid program on their behalf, and authorize expenditures related to health care, I agree to exercise the degree of care, diligence, and good faith that an ordinarily prudent person exercises in his or her own affairs. Wis. Stat. § 50.06 (8)(a)(2)(e).

Yes  No

6. I understand my role and responsibilities as the incapacitated individual's patient's representative, including when my authority to act as the incapacitated individual's patient's representative ends and that I may not authorize expenditures related to health care if the incapacitated individual has an agent under a durable power of attorney, as defined in s. 244.02 (3), stats., who may authorize expenditures related to health care. Wis. Stat. § 50.06 (8)(a)(2)(f).

Yes  No

7. To the best of my knowledge, a family member in a higher priority class, see below, does not exist, or no family member in a higher priority class is willing to make health care decisions on the incapacitated individual's behalf. Wis. Stat. § 50.06 (8)(a)(2)(g).

The following individuals, in the following order of priority, may consent to the role of patient representative:

(a) The spouse or domestic partner under ch. 770 of the incapacitated individual.

(b) An adult son or daughter of the incapacitated individual.

(c) A parent of the incapacitated individual.

(d) An adult brother or sister of the incapacitated individual.

(e) A grandparent of the incapacitated individual.

(f) An adult grandchild of the incapacitated individual.

(g) An adult close friend of the incapacitated individual.

Yes  No

8. A list of family members that can be reasonably contacted that will receive a copy of this signed declaration include: Wis. Stat. § 50.06 (8)(a)(2)(h).

o **Spouse/domestic partner**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

o **Adult children**

Name(s): \_\_\_\_\_

Address(es): \_\_\_\_\_

Phone number(s): \_\_\_\_\_

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- **Parent(s)**  
 Name(s): \_\_\_\_\_  
 Address(es): \_\_\_\_\_  
 Phone number(s): \_\_\_\_\_
  
- **Adult sibling(s)**  
 Name(s): \_\_\_\_\_  
 Address(es): \_\_\_\_\_  
 Phone number(s): \_\_\_\_\_
  
- **Grandparent(s)**  
 Name(s): \_\_\_\_\_  
 Address(es): \_\_\_\_\_  
 Phone number(s): \_\_\_\_\_
  
- **Adult grandchild(ren)**  
 Name(s): \_\_\_\_\_  
 Address(es): \_\_\_\_\_  
 Phone number(s): \_\_\_\_\_

Additional space for listing family members from the next of kin categories can be listed on page 5 of this document.

**I declare under penalty of false swearing under the law of Wisconsin that the foregoing is true and correct.**

►Signature: \_\_\_\_\_

Name (printed or typed): \_\_\_\_\_

Signed on the \_\_\_\_\_ day of \_\_\_\_\_ [month], \_\_\_\_\_ [year], at \_\_\_\_\_ [city or other location, and state or country].

