



WISCONSIN DEPARTMENT  
*of* HEALTH SERVICES

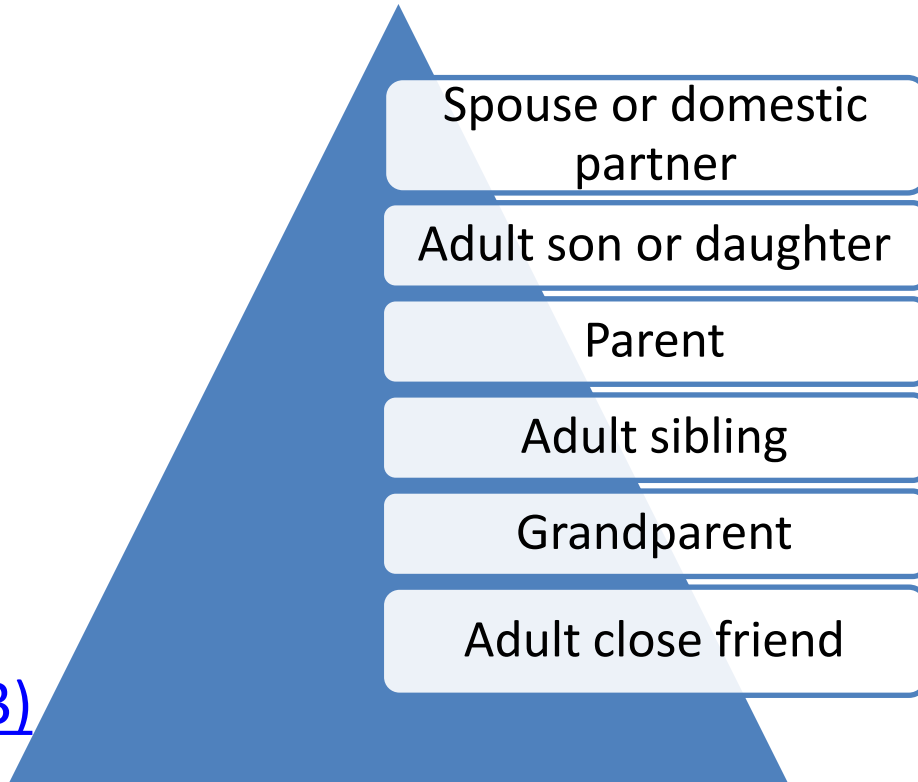
# Update on Wisconsin Act 115: Next-of-Kin Decision Making

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April 17, 2026

# Overview of Act 115

- Modifies [Wis. Stat. 50.06](#):
  - Establishes a new decision maker, Patient's Representative
  - Removes the requirement of guardianship and protective placement petitions to be filed
  - Allows for the authorization of expenditures related to health care, including Medicaid
- Goes into effect June 1, 2026
- Sundown date June 1, 2029

# Next of Kin Hierarchy



[Wis Stat 50.06\(3\)](#)

# Criteria for Use of Patient's Representative

- Patient is incapacitated, lacks legal decision maker, and requires post-hospital placement in nursing home or CBRF
- Facility admission directly from hospital inpatient unit
- Available next of kin resource

# Disqualifying Criteria for Use of Patient's Representative

- Incapacitated patient discharged to home
- Disagreement between family members regarding selection of patient representative
- Patient has primary mental health or intellectual disability diagnosis

# Patient's Representative Responsibilities

- Sign declaration and notify statutorily defined recipients
- Authorize admission to post-hospital facility
- Make health care decisions for the patient
- Manage the patient's finances and authorize resources to ensure access to health care
- Complete enrollment or annual updates for Medicaid

# Patient's Representative Authority

- Effective upon completion of declaration and patient admission to facility care
- Does not have a time limit
- Same authority as guardian for managing patient health and finances
- Conduct can be reviewed through court process

# Expiration of Patient's Representative Authority

- The patient regains decisional capacity
- The patient discharges to a non-facility setting
- A guardian is appointed
- A valid power of attorney document is found

# Comparison of Decision Makers



Supported  
Decision  
Making



Health Care  
Power of  
Attorney



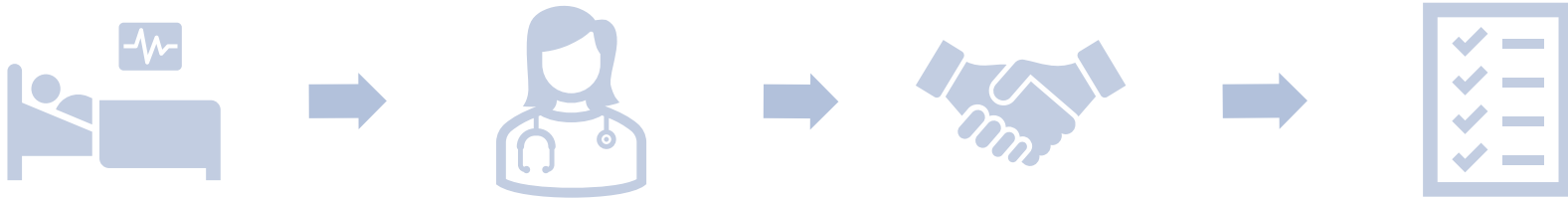
Patient's  
Representative



Guardianship



# Process to Establish Patient's Representative



## Incapacitated patient

- No advanced planning documents
- Discharge to facility-based care

## Two Doctors or doctor and advanced practice clinician complete statement of incapacity

- Copy in medical file
- Notification to County Probate and APS

## Hospital identifies Patient's Representative

- Follows Next of Kin hierarchy

## Patient's Representative signs declaration

- Notifies Next of Kin
- Files copy with County Probate, APS, and medical chart

# Statutory Safeguards

- Any person may request patient's capacity be reassessed
- Any person may petition the court to review the actions of the Patient's Representative
- Facilities must notify APS regarding concerns about the patient or the Patient's Representative
- The court can review and remove the Patient's Representative

# DHS Program Readiness

- Identify DHS programs that may interface with Patient Representative
- Develop educational resources for county and Tribal programs
- Update program area guidance, eligibility, and workflow
- Communicate updates regarding DHS workplan and program-specific updates

# DHS Patient's Representative Work Plan

Phase 1:  
By: June 1, 2026

- Engage DHS Leaders
- Establish workplan
- Develop required forms
- Post documents and resources to DHS website
- Develop a communication plan

Phase 2  
Q3,Q4 2026

- Coordinate with State Courts for data collection
- Update impacted programs
- Provide resources for partners
- Implement communications plan including website update

Phase 3  
Q4 2026, 2027

- Increase public awareness of advanced directives
- Collect Data and send report to legislature (April 2027)

# Questions





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# IRIS Program Policy: Service Authorizations

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May 12th, 2026

# Overview of Service Authorizations

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- IRIS Service Plan (ISP) is made up of many parts, including service authorizations.
  - Service authorizations contain all service-specific information and are the tool used to verify provider billing.
- Participant's have the right to change their service plan at any time.
  - Participant is responsible to ensure they inform their ICA of changes to their service plan in a timely manner.
  - Reporting is always required for changes in utilization, such as frequency of service, rate of services, or if a service is being ended altogether.



# Service Authorization Requirements

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- Authorizations cannot be modified or ended retroactively.
  - Providers have up to 365 days to submit their claims to the FEA.
  - Medicaid requires specific documentation and billing requirements.
- Authorizations that include funds from an approved budget amendment (BA) can be transferred under specific circumstances.
  - BA funds cannot be transferred to other services or provider types.



# Resources

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- IRIS Authorization policy ([IRIS Service Plan: Service Authorizations](#))
- IRIS Additional Funding Request policy ([IRIS Additional Funding Requests](#))
- CMS Technical Guide and Review Criteria ([Instructions Technical Guide and Review Criteria](#))

