

## EXHIBIT A

Department of Health Services  
Division of Public Health  
F-03435 (06/2026-05/2029)

State of Wisconsin  
Wis. Stat. § 50.06 (4)  
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### Medical Certification of Capacity for Determining a Patient's Representative Authority to Act

#### Instructions

This form is the written statement prepared by a physician or advanced practice clinician who has determined that an individual is incapacitated pursuant to Wis. Stat. § 50.06. The purpose of this form is to determine if the patient's representative has authority to act.

Copies of this completed form should be included in the patient's health care records. Within 72 hours following admission to the post-hospital facility, this form is to be filed with the register in probate for the county in which the incapacitated individual resides and sent to the adult protective services agency for the county in which the incapacitated individual resides.

#### Patient information

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

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

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

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

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

Name of patient's representative: \_\_\_\_\_

Due to the patient's health care needs, will post-hospital facility placement be necessary?

☐ Yes ☐ No ☐ Other, specify: \_\_\_\_\_

Name of post-hospital receiving facility: \_\_\_\_\_

#### Medical determination of incapacity

On (date(s)) \_\_\_\_\_ at (location) \_\_\_\_\_

(Name of patient) \_\_\_\_\_

was personally examined by two physicians or a physician and advanced practitioner who have determined that the patient is incapacitated.

The medical conditions of the individual that led to the current assessment that the patient is incapacitated is/are:

#### Physician attestation

I have personally examined the patient and have determined that he or she is unable to receive and evaluate information effectively or 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 and that his or her incapacity is not due to mere old age, eccentricity, or physical disability, either singly or together.

I am not a relative, as defined in s. 242.01 (11), Wis. Stats., of the patient and, to the best of my knowledge, I am not entitled to or have a claim on any portion of the patient's estate.

**Physician 1**

**Signature** — Physician 1: \_\_\_\_\_

Name — Physician 1 (printed): \_\_\_\_\_

Date of attestation: \_\_\_\_\_

Office address and phone number: \_\_\_\_\_

**Physician 2/Advanced clinician**

**Signature** — Physician 2/Advanced clinician: \_\_\_\_\_

Name — Physician 2/Advanced clinician (printed): \_\_\_\_\_

Date of attestation: \_\_\_\_\_

Office address and phone number: \_\_\_\_\_

**Medical determination for regained capacity**

On (date) \_\_\_\_\_ at (location) \_\_\_\_\_

(Name of patient) \_\_\_\_\_

was personally examined by a physician or an advanced practitioner who has determined that the patient is no longer incapacitated.

The medical conditions or circumstances that led to the current assessment that the patient is no longer incapacitated is/are:

A copy of this statement will be placed in the patient's medical record and filed with the probate court and adult protective service unit for the county in which the individual resides within 72 hours of determination.

**Physician/Advanced clinician**

**Signature** — Physician/Advanced clinician: \_\_\_\_\_

Name — Physician/Advanced clinician (printed): \_\_\_\_\_

Date of attestation: \_\_\_\_\_

Office address and phone number: \_\_\_\_\_

## 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).  
○ **Spouse/domestic partner**  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
○ **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].

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