



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
ESTATE NOTICE

1. DECEDENT NAME		2. MO HEALTHNET PARTICIPANT NUMBER (IF KNOWN)	
3. DATE OF BIRTH	4. DATE OF DEATH		5. SOCIAL SECURITY NUMBER
6. SURVIVING SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO Name: _____			
7. CHILDREN UNDER AGE 21 IN HOME <input type="checkbox"/> YES <input type="checkbox"/> NO		8. IS THERE A BLIND OR DISABLED DEPENDENT IN THE HOME <input type="checkbox"/> YES <input type="checkbox"/> NO	
9. COUNTY OF ESTATE FILING	10. DATE ESTATE FILED		11. BALANCE OF ASSETS
12. ATTORNEY NAME			
13. STREET ADDRESS, CITY, STATE, ZIP CODE			
14. TELEPHONE NUMBER		15. FAX NUMBER	
16. EXECUTOR, PERSONAL REPRESENTATIVE, OR CONSERVATOR NAME			
17. STREET ADDRESS, CITY, STATE, ZIP CODE			
18. SIGNATURE OF ATTORNEY			19. DATE
<p style="margin-left: 40px;">FAX: (573) 526-1162</p> <p>Mail: Department of Social Services MO HealthNet Division ATTN: Cost Recovery Unit PO Box 6500 Jefferson City, MO 65102-6500</p> <p style="margin-left: 40px;">TELEPHONE: (573) 751-2005</p>			
FOR MO HEALTHNET DIVISION USE ONLY			
<input type="checkbox"/> Decedent was a MO HealthNet Participant. Case will be reviewed to determine if referral to be made to Attorney General Office for filing claim.			
<input type="checkbox"/> Decedent was not a MO HealthNet Participant. Waiver issued on: _____			
MO HEALTHNET DIVISION SIGNATURE			DATE