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 ☐ YES ☐ NO Name: _____		
7. CHILDREN UNDER AGE 21 IN HOME ☐ YES ☐ NO		8. IS THERE A BLIND OR DISABLED DEPENDENT IN THE HOME ☐ YES ☐ 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 OR EMAIL ADDRESS
16. EXECUTOR, PERSONAL REPRESENTATIVE, OR CONSERVATOR NAME		
17. STREET ADDRESS, CITY, STATE, ZIP CODE		
18. SIGNATURE		19. DATE

FAX: (573) 526-1162

Mail: Department of Social Services
MO HealthNet Division
ATTN: Cost Recovery Unit
PO Box 6500
Jefferson City, MO 65102-6500

TELEPHONE: (573) 751-2005

EMAIL: MHD.COSTRECOVERY@dss.mo.gov

FOR MO HEALTHNET DIVISION USE ONLY

☐ Decedent was a MO HealthNet Participant. Case will be reviewed to determine if referral to be made to Attorney General Office for filing claim.

☐ Decedent was not a MO HealthNet Participant. Waiver issued on: _____

MO HEALTHNET DIVISION SIGNATURE	DATE