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	8. IS THERE A BLIND OR DISABLED DEPENDENT
☐ YES ☐ NO	☐ 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