

ESTATE RECOVERY PROGRAM HEIR INFORMATION

****To be used whenever money is sent to anyone or anywhere other than to the Estate Recovery Program****

Personal identifiable information will be used only in the administration of the Estate Recovery Program

Name of Deceased Resident	Social Security Number	Date of Death
Total Amount of Funds at Nursing Home (including patient account and excess patient liability) <input type="checkbox"/> Patient Account <input type="checkbox"/> Excess Patient Liability	Dates Resident Resided in Nursing Home From	To

Does the deceased have a surviving spouse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Does the deceased have any surviving minor children under the age of 21?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Does the deceased have any surviving disabled children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

INFORMATION ABOUT THE PERSON OR PLACE TO WHOM THE FUNDS WERE CONVEYED

Name of Heir, Guardian or Place	Address	City, State and Zip Code
Relationship to deceased resident	Telephone Number	

INFORMATION ABOUT THE PERSON WHO CONVEYED THE FUNDS

Name of Person Who Conveyed Funds	Title	Amount Conveyed
Name of Nursing Home/Facility	Address	City, State, and Zip Code
Telephone Number		

Please mail this completed form to:

Division of Health Care Access and Accountability
Estate Recovery Program
P.O. Box 309
Madison, WI 53701-0309