

**MEDICAID / FAMILY CARE / PARTNERSHIP / BADGERCARE PLUS  
ESTATE RECOVERY NOTIFICATION OF DEATH**

**\*\*To be used when the money is going to the Estate Recovery Program\*\***  
Personal identifiable information will be used only in the administration of the Estate Recovery Program.

Mail this completed form to the following address:

Division of Health Care Access and Accountability  
Estate Recovery Program  
PO Box 309  
Madison WI 53701-0309

Name — Deceased Resident	Social Security Number	Date of Death
Total Amount of Funds at Nursing Home (including Patient Account and Excess Patient Liability)	Dates Resident Resided in Nursing Home From	To

**Do not complete this form if a "yes" response is appropriate for any of the following questions.**

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

Name — Nursing Home	
Address — Nursing Home (City, State, ZIP Code)	Telephone Number
Name — Person Completing Form	Title / Position