State of California—Health and Human Services Agency
Department of Health Services
Third Party Liability Branch, Recovery Section
MS-4720, PO Box 997425
Sacramento, CA 95899-7425

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

MEDI-CAL ESTATE RECOVERY QUESTIONNAIRE

TO SATISFY LEGAL REQUIREMENTS, FILL OUT AND RETURN THIS FORM

BENEFICIARY'S NAME: _____

BENEFICIARY'S SOCIAL SECURITY #: _____

ADDRESS: _____

CITY _____ ST _____ ZIP _____

Under California law (Probate Code Sections 215, 9202 and 19202), the person(s) settling the financial affairs of a deceased person who received, or may have received, health care under the Medi-Cal program must notify the Department of Health Services (DHS) of the decedent's death. The law requires that notice be provided to DHS no later than 90 days from the date of death. Notification to the Social Security Office or the County Welfare Office does not satisfy this legal requirement. Our records show that the decedent named above was enrolled in the Medi-Cal program; therefore, to satisfy this legal requirement, please complete and return this document, **with a copy of the death certificate**, to DHS at the address shown above.

Please answer the following questions, **even if the decedent had no assets**, and return this form in the enclosed envelope along with a copy of the death certificate.

1. Is the decedent's spouse (husband or wife) still living? NO____ YES____ If no, date of death____/____/____
   List spouse's name _____
   Spouse's Social Security number_____-_____-_____ Spouse's date of birth____/____/____

2. Is the decedent survived by a child under the age of 21? NO___ YES___
   (If 'yes', attach a copy of the child's birth certificate.)

   Is the decedent survived by a child of any age who is blind? NO___YES___

   Is the decedent survived by a child of any age who is disabled? NO___YES___

   (If a child has been deemed blind or disabled by the Social Security Administration, attach a copy of the award letter from the Social Security Administration, along with a copy of the child's birth certificate.)

Staff Use Only

RECIPIENT:
MEDI-CAL #:
SSN:

IND:
SDX:
RUN:

VER:

3. Cash and bank accounts at time of death (after burial expense)? NO_____ YES_____ $_____VALUE

   Did you pay funeral/burial expenses from your personal funds? NO_____ YES_____ (if yes, attach receipts)

   List other assets: stocks, bonds, annuities, retirement account, etc. _____ $_____VALUE

   List other personal property_____$_____VALUE

If any of the above assets were checked 'yes', please provide <u>copies</u> as verification, i.e., bank or other financial statement, registration form, stock certificates, etc. If you paid funeral/burial expenses, please attach a copy of the receipts.

4. Is the estate being probated? NO_____YES_____

   If 'yes', list the probate number_____and county of filing _____

5. List the name, address, and telephone number of the attorney or person handling the estate.

   Name_____ Phone number (_____)_____

   Address_____

MARKET

6. Did the decedent own any of the following: house/land/mobile home? NO_____YES_____$_____VALUE

   If 'yes', list property address_____

ATTACH A COPY OF THE TITLE/GRANT DEED

List the name, address and telephone number for each heir (person receiving a portion of the assets) or co-owner of the decedent's assets and the portion of decedent's assets they received.
ATTACH A SEPARATE PAGE IF MORE SPACE IS NEEDED

Name: _____Phone number(_____)_____

Address: _____

Asset: _____ Share of estate_____%

Name: _____Phone number(_____)_____

Address: _____

Asset: _____ Share of estate_____%

ENCLOSE A COPY OF THE DEATH CERTIFICATE

If you have questions, please call our recorded message available 24 hours a day at (916) 323-4836.

Print Name_____Telephone No (_____)_____-_____
(Person completing this form)

Signature_____ Address:_____

Date: _____ City, State & Zip: _____

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