**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services

F-01844 (05/2021)

**WISCONSIN**

**NOTIFICATION OF DEATH – ACCOUNTING OF ESTATE FUNDS**

This form is used whenever either of the following occurs:

* A deceased member’s funds that are being held at a nursing home or by a representative payee of the member are available to send directly to the Wisconsin Department of Health Services (DHS) Estate Recovery Program.
* A deceased member’s funds are being sent to a person or place other than the DHS Estate Recovery Program.

Providers should print (keep a copy for their records) and mail this completed form, along with all required documents to the following address:

Wisconsin Department of Health Services

Division of Medicaid Services

Estate Recovery Section

PO Box 309

Madison WI 53701-0309

Personally identifiable information will be used only in the administration of the Estate Recovery Program. Disclosure of the SSN of a Medicaid member is mandatory per 42 U.S.C. 1320b-7. Disclosure of the SSN of a non-Medicaid member is voluntary. The SSN will only be used for the identification of Medicaid, BadgerCare Plus, COP, and WCDP members and for the administration of the Estate Recovery Section.

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| --- |
| Name – Deceased Member      |
| Social Security Number (SSN)      | Date of Death      | Date of Birth      |
| Name – Surviving Spouse (If Any)      | SSN – Surviving Spouse      |
| Street Address – Surviving Spouse      |
| City      | State      | ZIP Code      |
| **A. Check the appropriate box below to provide information about the marital status of the deceased member.** |
|  | [ ]  The deceased member was married and was predeceased by a spouse. |
|  | Name – Predeceased Spouse      | SSN      | Date of Death      |
|  | [ ]  The deceased member was never married.[ ]  The deceased member was divorced at the time of death.[ ]  The deceased member’s marital status is unknown. |
| **B. Provide the following additional information.** |
|  | Is the deceased member survived by a disabled or blind child? [ ]  Yes [ ]  No [ ]  Unknown |
|  | Name – Disabled or Blind Child      |
|  | Street Address       |
|  | City      | State      | ZIP Code      |

*Continued*

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|  | Is the deceased member survived by a minor child (under age 21)? [ ]  Yes [ ]  No [ ]  Unknown |
|  | Name – Minor Child       |
|  | Minor’s Responsible Party and Street Address       |
|  | City      | State      | ZIP Code      |
| *Note:* Funds should not be sent to the Estate Recovery Program at the same time this form is submitted if there is a surviving spouse or disabled or minor child. |
| **C. The deceased member’s account information is as follows:** |
|  | Total Funds Available at Time of Death**$**      |
|  | Check one of the boxes below to indicate the status of the member’s funds. Provide any additional information requested. [ ]  Funds will be held until notice is received from the Estate Recovery Program.[ ]  Funds are being sent directly to the funeral home. |
|  | Name – Funeral Home      |
|  | [ ]  Funds are being sent to the heir or responsible party. |
|  | Name – Heir or Responsible Party      |
|  | Relationship to Deceased Member      | Phone Number      |
|  | Street Address       |
|  | City      | State      | ZIP Code      |
| If none of the three options above apply, explain below.      |
| **ATTENTION NURSING HOME/REPRESENTATIVE PAYEE/Managed Care Organization (MCO)/GUARDIAN:** Along with this form, provide a copy of the billing/client/bank statement that shows the balance in the member’s account on the date of death and any activity in the account past the date of death. |
| This Notification of Death is being submitted by: [ ]  Nursing Home [ ]  Representative Payee [ ]  MCO [ ]  Guardian |
| Name of Nursing Home/Representative Payee/MCO/Guardian      |
| Name of Person Completing This Form      |
| Street Address      |
| City      | State      | ZIP Code      |
| Phone Number      | Fax Number      |