

**WEST VIRGINIA ESTATE RECOVERY PROGRAM
NOTIFICATION OF DEATH**

***THE NURSING FACILITY ADMINISTRATOR OR COMMUNITY WAIVER PROGRAM
ADMINISTRATOR SHOULD COMPLETE THE FOLLOWING INFORMATION AND RETURN
THIS FORM WITHIN 3 DAYS OF DEATH.***

*******Please only fill this out if the decedent had Medicaid at time of death. *******

RECIPIENT INFORMATION

*NAME OF DECEASED MEDICAID RECIPIENT: _____

*DATE OF BIRTH: _____

*DATE OF DEATH: _____

*DATE OF ADMISSION: _____

*DATE OF DISCHARGE: _____

*PLACE OF DEATH: _____

*SOCIAL SECURITY NUMBER: _____

*MEDICAID NUMBER: _____

*MEDICAID START DATE: _____

*DID THE DECEDENT HAVE ASSETS? _____ IF YES, PLEASE INDICATE TYPE/ AMOUNT
*IF KNOWN _____

PREVIOUS ADDRESS: _____

******* PLEASE FILL OUT SECTIONS BELOW COMPLETELY. THE ADDRESS MUST BE
COMPLETE INCLUDING ZIP CODE*******

(1) DECEDENT'S POWER OF ATTORNEY OR LEGAL REPRESENTATIVE:

*NAME: _____

*ADDRESS: _____ PHONE: _____

*RELATION TO DECEDENT: _____

(2) DECEDENT'S SURVIVING SPOUSE OR SURVIVING MINOR/DISABLED CHILDREN:

NAME: _____

ADDRESS: _____ PHONE #: _____

(3) DECEDENT'S NEXT OF KIN:

NAME: _____

ADDRESS: _____ PHONE #: _____

RELATION TO DECEDENT: _____

*PREPARER'S NAME (PRINT) TITLE POSITION

*PREPARER'S SIGNATURE *DATE

*NURSING FACILITY NAME *PHONE NUMBER

*COMMUNITY WAIVER PROGRAM NAME

*ADDRESS

**If marked with an asterisk the information is required*

**PLEASE RETURN THIS FORM TO:
DHHR/ESTATE RECOVERY UNIT
405 CAPITOL STREET
SUITE 503
CHARLESTON, WV 25301
PHONE: (304) 342-1604
FAX: (304) 342-1605**