DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
MEDICAID ESTATE RECOVERY
CHECK RELEASE FORM

The Check Release form is to be utilized by a nursing facility:

1. When all attempts to locate a responsible party to receive the personal trust fund and/or patient liability refund has failed within a 30-day time frame; or
2. The responsible party releases the personal trust fund to MER

Use this form for residents who are DECEASED; AGE 55 or older; and a MEDICAID RECIPIENT WITHOUT A SURVIVING SPOUSE. This form MUST be completed and accompany any funds mailed to:

Division of Health Care Financing and Policy
Medicaid Estate Recovery
1000 E. William Street, Suite 102
Carson City, Nevada 89701

Date: _____

Facility Name: _____ Phone Number: _____

Address: _____

Name of Decedent: _____ SSN: _____

Date of Birth: _____ Date of Death: _____ Medicaid #: _____

Funds should be dispersed according to the priority listed in NRS 150.225. If funds were distributed, indicate to whom and give the amount.

Funds distributed to: _____

$_____

Reason for sending funds to Medicaid Estate Recovery:

☐ No responsible person

☐ Responsible person released funds to Medicaid Estate Recovery (sign below)

_____ _____
Responsible Person Name (print) Responsible Person Signature

By signing this form I am stating I have read and understood the proper payment of estate debts.

_____
Facility Representative Signature Date

If loss of contact is the reason for sending funds, contact the Welfare District Office in your area to locate the recipient. DO NOT SEND THESE CHECKS TO MEDICAID ESTATE RECOVERY.