1. DECEDENT NAME		2. MO HEALTHNET PARTICIPANT NUMBER (IF KNOWN)		
3. DATE OF BIRTH	4. DATE OF DEATH		5. SOCIAL SE	CURITY NUMBER
6. SURVIVING SPOUSE  YES NO Name:				
7. CHILDREN UNDER AGE 21 IN HOME 8. IS THERE A BLIND OR DISABLED DEPENDENT IN THE HOME				
☐ YES ☐ NO		☐ YES ☐ NO		
9. COUNTY OF ESTATE FILING	10. DATE ESTATE FILED		11. BALANCE	OF ASSETS
12. ATTORNEY NAME				
12. AT TORNET IVAIVIE				
13. STREET ADDRESS, CITY, STATE, ZIP CODE				
14. TELEPHONE NUMBER		15. FAX NUMBER		
16. EXECUTOR, PERSONAL REPRESENTATIVE, OR CONSERVATOR NAME				
17. STREET ADDRESS, CITY, STATE, ZIP CODE				
18. SIGNATURE OF ATTORNEY 19. DATE				
16. SIGNATURE OF ATTORNET				19. DATE
FAX: (573) 526-1162				
Mail: Department of Social Services				
MO HealthNet Division ATTN: Cost Recovery Unit				
PO Box 6500				
Jefferson City, MO 65102-6500				
TELEPHONE: (573) 751-2005				
FOR MO HEALTHNET DIVISION USE ONLY				
Decedent was a MO HealthNet Participant. Case will be reviewed to determine if referral to be made to Attorney General Office for filing claim.				
□ Decedent was not a MO HealthNet Participant. Waiver issued on:				
MO HEALTHNET DIVISION SIGNATURE				DATE