Estate Recovery Program Referral

As required by 441 IAC 76.12(7), complete this form at the time of death for all Medicaid members who:

- Were aged 55 years and older, or
- Were under age 55, were residents of a long-term care facility, and were not expected to return home.

To: Estate Recovery Program
Phone: (515) 246-9841 or
Toll-free: (888) 513-5186 or
Fax: (515) 246-0155
E-mail this form to:
DHS, IME Estates@dhs.state.ia.us

From:

You are hereby notified of the death of:

Name	Date of Death	Date of Birth	State ID #	Social Security #
Last Known Address				

Check if applicable: ☐ Surviving spouse ☐ Blind child ☐ Disabled child ☐ Minor child

The name and address of the contact person who is handling the affairs for the deceased is:

Name	Relationship to Deceased	Phone	
Street Address	City	State	Zip

The member used or the member's estate may use the services of the following (if known):

Bank	City	Account #	Amount
Funeral Home	City	Burial Fund Amount	
Attorney	City	Estate #	County

The member had the following assets, not described above, at the time of death:

Real estate, e.g., house, life estate, joint interest:	Value	Location
Insurance payable to estate:	Value	Company
Medical Assistance Income Trust (MAIT): ☐ Yes ☐ No	Value	Location of Funds
Special Needs Trust: ☐ Yes ☐ No	Value	Location of Funds
Annuities, potential litigation, inheritance, or other type of trust:		
Date above information was last verified:		
Other information that may be helpful or other assets:		