

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**MICHIGAN ESTATE RECOVERY QUESTIONNAIRE**

**Instructions: (Print or typewritten)**

- Complete each section and sign at the end of this form.
- Provide a copy of the deceased Medicaid member's death certificate and any other documentation requested on this form. *(No exceptions; a copy must accompany this questionnaire.)*
- Mail completed form and all requested documentation in the enclosed (postage paid) envelope provided to:

Michigan Department of Health and Human Services  
 Third Party Liability  
 P.O. Box 30435  
 Lansing, Michigan 48909

If you have any questions about how to complete this form, you may call the TPL Division toll-free at 1-844-TPL-MDCH.

<b>Person Completing this Form</b>	
(Check one)	Name: _____
<input type="checkbox"/> Personal Representative	Address: _____
<input type="checkbox"/> Attorney for Estate	_____
<input type="checkbox"/> Other (Specify) _____	Telephone: _____
_____	
<b>Court Information</b>	
Has a petition for probate of the estate been filed? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If YES, provide a copy of the inventory.	
If YES, provide:	Probate Case Number: _____ Date Filed: _____
County Probate Court: _____	
If No, do you anticipate a petition for probate being filed? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	
Have there been any third party lawsuits filed on behalf of the estate? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	
If YES, provide:	Case Number: _____ Date Filed: _____
County Court: _____	
If NO, do you anticipate any third party lawsuits being filed? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	
<b>Deceased Medicaid Member Information</b>	
Last Name: _____	Date of Birth: _____
First Name: _____	Date of Death: _____
Middle Name: _____	Social Security Number: _____
Marital Status: (at time of death) <i>Check appropriate status</i> <input type="checkbox"/> <b>Married</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Never Married</b>	
<b>If checked married, provide a copy of the marriage license.</b>	
Is the deceased Medicaid member's spouse still living? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	
Spouse Last Name: _____	Date of Birth: _____
Spouse First Name: _____	Date of Death: _____
Spouse Middle Name: _____	Social Security Number: _____

**AUTHORITY:** MCL 400.112g  
**COMPLETION:** Completion is voluntary, but is required for an Estate Recovery exemption.

The Department of Health and Human Services is an equal opportunity employer, services and programs provider.

**Statutory Exemption Information**

A. Is the deceased Medicaid member survived by a child under the age of 21 OR a child of any age who has been deemed blind or permanently disabled by the Social Security Administration?  **Yes**  **No**

If Yes, provide a copy of the child's birth certificate and recent Social Security Administration determination of disability, and:

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Child's Social Security Number: \_\_\_\_\_

B. Is there a caretaker relative residing in the home that has been residing in the home for at least 2 years prior to the deceased Medicaid member's admission to a facility?  **Yes**  **No**

Caretaker's Name: \_\_\_\_\_

If YES, provide copies of driver's license and bank statements to show residence for the 2 year period, AND a statement from a physician stating that the care provided allowed the deceased Medicaid member to reside at home rather than in an institution.

C. Was there a sibling residing in the home for 1 year prior to the deceased Medicaid member's admission to a nursing facility with an equity interest in the home?  **Yes**  **No**

Sibling's Name: \_\_\_\_\_

If YES, provide copies of driver's license and bank statements to show residence for the 1 year period, AND a statement of equity interest in the home.

**Asset Information**

D. Did the deceased Medicaid member own a home or other real property at the time of death?  **Yes**  **No**

If YES, complete Homestead and/or Other Real Property and provide a copy of the deed showing ownership.

**Homestead**

Address:	Approximate Market Value: \$
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Type of ownership (i.e., tenants in common, life estate, joint tenants, fee simple, etc.)

**Other Real Property**

Address:	Approximate Market Value: \$
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Type of ownership (i.e., tenants in common, life estate, joint tenants, fee simple, etc.)

E. Did the deceased Medicaid member have any bank accounts at the time of death?  **Yes**  **No**

If YES, provide a copy of the bank statement and complete the information below:

**Bank Name:**

\_\_\_\_\_

Is this a joint account? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	Account Number:	Account Balance:
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F. Did the deceased Medicaid member own other personal property (i.e., vehicles, jewelry, other personal items of value)?  **Yes**  **No**

List any other personal property :

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that the information contained in this form is true and complete to the best of my knowledge. I understand that the Michigan Department of Health and Human Services is relying on this information when determining the value of Medicaid's claim and/or granting an exemption from Estate Recovery.

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Date