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. The information requested may confirm this case can be closed.
- Provide a copy of the deceased Medicaid member's death certificate and any other documentation requested on this form.
- 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.

Person Completing this Form

(Check one)

☐ Personal Representative
☐ Attorney for Estate
☐ Other (Specify) _____

Name: _____
Address: _____
_____
Telephone: _____

Court Information

Has a probate estate been opened? ☐ **Yes** ☐ **No** If YES, provide a copy of the inventory.

If YES, provide: Probate Case Number: _____ Date Filed: _____

County Probate Court: _____

If NO, do you anticipate probate being opened? ☐ **Yes** ☐ **No**

Have there been any third party lawsuits filed on behalf of the estate? ☐ **Yes** ☐ **No**

If YES, provide: Case Number: _____ Date Filed: _____

County Court: _____

If NO, do you anticipate any third party lawsuits being filed? ☐ **Yes** ☐ **No**

Deceased Medicaid Member Information

Last Name: _____ Date of Birth: _____
First Name: _____ Date of Death: _____
Middle Name: _____ Social Security Number: _____

Spousal Statutory Exemption Information

Marital Status (at time of death) (*Check appropriate status)*

☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Never Married** ☐ **Legally Separated**

If checked married, provide a copy of the marriage license.

Spouse Last Name: _____ Date of Birth: _____
Spouse First Name: _____ Date of Death: _____
Spouse Middle Name: _____ Social Security Number: _____

Statutory Exemption Information

A. Is the deceased Medicaid member survived by a child under the age of 21 OR by 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, recent Social Security Administration determination of disability, and:

Child's Name: _____ Child's Date of Birth: _____

Child's Social Security Number: _____

B. Other than a surviving spouse, is there a caretaker relative residing in the deceased Medicaid member's 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: _____ Relationship: _____

If YES, provide copies of their 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 a facility.

C. Did a brother or sister of the deceased Medicaid member reside in the member's home for 1 year prior to the member's admission to a facility and also own an equity interest in the member's 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 land at the time of death? ☐ **Yes** ☐ **No** If YES, complete Home and/or Other Land section. Provide a copy of the deed showing ownership.

Home

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

Other Land

Address:	Approximate Market Value: $
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 at the time of death and complete the information below:

Bank Name

Is this a joint account? ☐ **Yes** ☐ **No**	Account Number:	Account Balance: $

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

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

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.