DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-01844 (05/2021)

WISCONSIN

NOTIFICATION OF DEATH – ACCOUNTING OF ESTATE FUNDS

This form is used whenever either of the following occurs:

- A deceased member's funds that are being held at a nursing home or by a representative payee of the member are available to send directly to the Wisconsin Department of Health Services (DHS) Estate Recovery Program.
- A deceased member's funds are being sent to a person or place other than the DHS Estate Recovery Program.

Providers should print (keep a copy for their records) and mail this completed form, along with all required documents to the following address:

Wisconsin Department of Health Services
Division of Medicaid Services
Estate Recovery Section
PO Box 309
Madison WI 53701-0309

Personally identifiable information will be used only in the administration of the Estate Recovery Program. Disclosure of the SSN of a Medicaid member is mandatory per 42 U.S.C. 1320b-7. Disclosure of the SSN of a non-Medicaid member is voluntary. The SSN will only be used for the identification of Medicaid, BadgerCare Plus, COP, and WCDP members and for the administration of the Estate Recovery Section.

Name – Deceased Member		
Social Security Number (SSN)	Date of Death	Date of Birth
Name – Surviving Spouse (If Any)	SSN – Surviving Spouse	
Street Address – Surviving Spouse		
City	State	ZIP Code

A. Check the appropriate box below to provide information about the marital status of the deceased member.

☐ The deceased member was married and was predeceased by a spouse.

Name – Predeceased Spouse	SSN	Date of Death

☐ The deceased member was never married.
☐ The deceased member was divorced at the time of death.
☐ The deceased member's marital status is unknown.

B. Provide the following additional information.

Is the deceased member survived by a disabled or blind child? ☐ Yes ☐ No ☐ Unknown

Name – Disabled or Blind Child		
Street Address		
City	State	ZIP Code

Continued

Is the deceased member survived by a minor child (under age 21)? ☐ Yes ☐ No ☐ Unknown

Name – Minor Child

Minor's Responsible Party and Street Address

City	State	ZIP Code

Note: Funds should not be sent to the Estate Recovery Program at the same time this form is submitted if there is a surviving spouse or disabled or minor child.

C. The deceased member's account information is as follows:

Total Funds Available at Time of Death
$

Check one of the boxes below to indicate the status of the member's funds. Provide any additional information requested.

☐ Funds will be held until notice is received from the Estate Recovery Program.

☐ Funds are being sent directly to the funeral home.

Name – Funeral Home

☐ Funds are being sent to the heir or responsible party.

Name – Heir or Responsible Party

Relationship to Deceased Member	Phone Number

Street Address

City	State	ZIP Code

If none of the three options above apply, explain below.

ATTENTION NURSING HOME/REPRESENTATIVE PAYEE/Managed Care Organization (MCO)/GUARDIAN:
Along with this form, provide a copy of the billing/client/bank statement that shows the balance in the member's account on the date of death and any activity in the account past the date of death.

This Notification of Death is being submitted by: ☐ Nursing Home ☐ Representative Payee ☐ MCO ☐ Guardian

Name of Nursing Home/Representative Payee/MCO/Guardian

Name of Person Completing This Form

Street Address

City	State	ZIP Code

Phone Number	Fax Number

RESET FORM