ESTATE RECOVERY PROGRAM
NOTIFICATION OF DEATH

THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE NURSING FACILITY OR OTHER FACILITY RETURNED TO THE DEPARTMENT OF SOCIAL SERVICES WITHIN 15 DAYS OF THE DATE OF DEATH.

NAME OF DECEASED RESIDENT_____

MEDICAID NUMBER_____

DATE OF DEATH_____

FACILITY OF RESIDENCE_____

PLEASE ANSWER ALL THE FOLLOWING:
DOES THE DECEASED HAVE A:

(1) SURVIVING SPOUSE NO YES UNKNOWN

(2) SURVIVING MINOR CHILDREN NO YES UNKNOWN

(3) SURVIVING DISABLED CHILDREN NO YES UNKNOWN

PLEASE LIST BELOW THE NAME, MAILING ADDRESS, AND RELATIONSHIP OF FAMILY CONTACT OR CONTACT PERSON:

_____

(4) WILL NO YES UNKNOWN

EXECUTOR_____
EXECUTOR ADDRESS_____

(5) PRE PAID BURIAL FUND - REVOCABLE OR IRREVOCABLE BURIAL TRUST NO YES UNKNOWN

NAME OF PLAN_____
AMOUNT OF PLAN $_____
DATE FUNDS WERE REQUESTED FOR BURIAL EXPENSES_____

OVER

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FINAL TRUST FUND RECONCILIATION

AMOUNT IN PERSONAL TRUST ACCOUNT ON DATE OF DEATH $
ADD DEPOSITS AND/OR CREDIT BALANCES $

SUB TOTAL OF TRUST FUND $_____

LESS FINAL EXPENSES PAID FROM PERSONAL TRUST FUND
(ATTACH COPY OF CHARGES AND PROOF OF PAYMENT)

FUNERAL COSTS	$
HEADSTONE COST	$
CREMATORIUM COST	$
OTHER - PLEASE LIST:	
_____	$
_____	$
_____	$

TOTAL FINAL EXPENSES PAID. $_____
BALANCE FOR DSS $_____

(IN ACCORDANCE WITH SDCL 29A-3-817 AND SDCL34-12-38)

IF THERE IS A SURVIVING SPOUSE THERE IS NO RECOVERY BY DSS
IF FUNERAL EXPENSES HAVE BEEN PAID THE BALANCE MAY BE SENT IN.

COMPLETED BY: _____
SIGNATURE

_____
NAME (PRINT)/TITLE/POSITION

_____
NURSING FACILITY NAME

_____
NURSING FACILITY MAILING ADDRESS

_____
NURSING FACILITY PHONE NUMBER

DATE COMPLETED:_____

RETURN THIS FORM TO: DEPARTMENT OF SOCIAL SERVICES
OFFICE OF RECOVERIES AND FRAUD INVESTIGATIONS
ESTATE RECOVERY PROGRAM
700 GOVERNORS DRIVE
PIERRE SOUTH DAKOTA 57501-2291

FOR INFORMATION CONTACT: ESTATE RECOVERY PROGRAM AT 605-773-3653

The Facility must also notify the local eligibility caseworker of the death of a Medicaid recipient.