Iowa Department of Health and Human Services

Medical Assistance Debt Response

Pursuant to Iowa Code Section 249A.53(2)

Estate Recovery Program, PO Box 36445, Des Moines, Iowa 50315
Phone: (515) 246–9841, Toll-Free: (888) 513–5186, Fax: (515) 246–0155

Instructions: Please answer the questions below about the deceased Medicaid member and fax or send the form and any other documents requested back in the enclosed envelope within 30 days.

Name of Deceased:_____ **Date of Death**:_____

List the Value of Assets of the Deceased at Time of Death			List Allowed Expenses of the Deceased	
Savings Account	For all accounts, send the first statement after date of death, which includes the name and address of the bank or institution and the account number.	$	**Court Costs or Other Costs of Administration** Send an itemized list of any amounts listed as costs of administration	$
Checking Account		$	**Attorney Fees**	$
Annuities/IPERS		$	**Executor Fees**	$
Home and Real Estate		$	**Taxes or Debts Still Owed to the Federal or State Governments**	$
Household Goods		$	**Medical Expenses of Last Illness**	$
Vehicles		$	**Mortgage or Lien Against any Real Estate**	$
Prepaid Burial Fund Amount		$	**Funeral and Burial Expenses**	$
			Enclose a statement of itemized expenses that include the funeral home's name and address. If the services were guaranteed, include proof from the funeral home.	
Did the deceased have a life estate, or other interest in real estate, trusts, litigation, or any other assets, including any jointly held bank accounts or property, that are not already listed above, at the time of death? ☐ Yes ☐ No If **Yes**, list type _____	If yes, list the estimated value.	$	**Amount Paid or Still Owed to the Nursing Home After Death** Nursing Home Name: Nursing Home Address:	$
Total of all Assets		$	**Total of all Expenses**	$

Total Assets - Total Expenses =	$

If assets remain after expenses are paid, and there is no spouse, disabled child, or hardship waiver requested, please enclose a check or money order payable to: **Iowa HHS. Send a separate check, if there are any Medical Assistance Income Trust or Special Needs Trust funds listed below.** If **Total Assets** minus **Total Expenses** is *greater than* the medical assistance debt, do not send any funds at this time. Please request an updated amount of the debt that will be provided to you.

Trusts: If the member had a Medical Assistance Income Trust (Miller Trust) or Special Needs Trust, send first bank statement after date of death, which includes the name and address of the bank and the account number. Additional information about trusts is enclosed.	**Medical Assistance Income Trust**	$
	Special Needs Trust	$

Please provide the following information regarding the deceased member's marital status.

The deceased was: ☐ married ☐ never married ☐ divorced and not remarried ☐ widowed

If married or widowed, spouse's name _____ Date of Birth ___/___/___ SSN _____

Spouse is surviving? ☐ Yes ☐ No If no, Date of Death: ___/___/___

I CERTIFY UNDER PENALTY OF PERJURY AND PURSUANT TO THE LAWS OF THE STATE OF IOWA THAT THIS PAGE WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE.

Signature	Date	Your Address
Print Name	Your Phone Number	Your relationship to the deceased