IN THE COMMON PLEAS COURT OF HIGHLAND COUNTY, OHIO
PROBATE DIVISION

ESTATE OF :_____, DECEASED

CASE NO.:_____ DATE OF DEATH:_____

NOTICE OF DECEDENT'S MEDICAID STATUS

The undersigned hereby certifies to the Court the following:
(Mark all applicable choices)

[ ] The decedent WAS NOT over the age of 55 years.

[ ] The decedent WAS over the age of 55 years.

[ ] The decedent WAS NOT a permanently institutionalized individual.

[ ] The decedent WAS a permanently institutionalized individual.

[ ] The decedent WAS NOT a Medicaid recipient at any time during his/her life.

[ ] The decedent WAS a Medicaid recipient at any time during his/her life.

[ ] Notice of the fact that a decedent was 55 years of age or older, OR a permanently institutionalized individual, AND was a Medicaid recipient during his/her lifetime was provided to the Administrator of the Ohio Medicaid Estate Recovery Program.

_____ _____
Date Signature and Title of Applicant

STATE OF OHIO
COUNTY OF HIGHLAND, SS:

Sworn to by _____ as to the Medicaid status of the deceased, before me, a notary public, in and for said State, this _____ day of _____, _____.

_____
Notary Public