

REPORT AND REMITTANCE due November 1

Mail Report & Check Payable to:

Office of the State Treasurer
Unclaimed Property Division
P.O. Box 138
Jackson, MS 39205-0138



DAVID MCRAE
STATE TREASURER

**Nursing Home Unclaimed Property Report
(One form per decedent – Complete in full)**

Name of Holder/Care Center _____ Contact Person & Phone _____

Mailing Address _____ Email Address _____

City, State, Zip _____ Federal ID # _____

Pursuant to Mississippi Code Annotated, Section 43-13-120 and Section 89-12-1, et. seq., the above holder hereby reports the following property:

Owner's Name (Last, First, MI) _____	Medicaid Patient? Yes <input type="checkbox"/> No <input type="checkbox"/>
Owner's SSN _____	Amount due owner _____
Owner's Date of Birth _____	Owner's Date of Death _____
Last known address before entering care center _____	
City, State, Zip _____	
Information on any person who may possess an interest in such property (Continue on back if necessary):	
Person's Name _____	Relation to Decedent _____
Phone _____	Email Address _____
Address _____	

AFFIDAVIT State of _____ County/City of _____

I, _____, of the company/holder for which this report is made, being duly sworn (or affirmed) according to the law do depose and say that this report is true and contains all facts required by law to be reported.

Signature of officer, owner, etc.

Sworn and subscribed before me this _____ day of _____, 20____.
Notary Public: _____