ATTACHMENT III

SAMPLE
(amend as appropriate)

NOTICE OF MEDICAL ASSISTANCE LIEN

Pursuant to Social Services Law, Section 369
and Book 18 of the New York Codes Rules and Regulations, Section 360-7.11

LIENOR : _____, Commissioner,
_____ County Department of Social Services
Street Address,
City, State, zip Code

To: The Clerk of _____ County, New York
and to all others to whom it may concern:

Please take Notice that the _____ County Department of Social Services has and claims a Medical Assistance Lien, pursuant to Social Services Law Section 369 and 18 NYCRR 360-7.11, upon the house, building and appurtenances, and upon the lot, premises and parcel of land upon which the same may stand, hereinafter mentioned, for Medical Assistance paid or to be paid on behalf of the owner of said real property, pursuant to Title 11 of Article 5 of the Social Services Law of the State of New York, and hereby states:

OWNER OF THE PROPERTY: _____ _____ _____
First Name Middle Name Last Name

ADDRESS OF PROPERTY: _____, _____
Street Address City
_____, _____
State Zip Code

The interest of the owner so far as is known to lienor, is: _____
(e.g.: as tenant by entirety, joint tenant, or appropriate designation)

The real property described above on which lienor claims a lien is listed in the _____ County, in _____ State, and is described in the _____ County Clerks Office in:

Deed Dated: _____ Deed Recorded: _____

Liber and Page: _____ Grantor: _____

Grantee: _____ Tax Map Number: _____

This lien is for Medicaid coverage for care in a medical institution. The Medical Assistance lien is in the sum of $_____ for Medical Assistance provided to the owner of the above described real property. This lien is not limited to the amount stated and shall include the cost of all Medicaid paid for care in a medical institution provided to the owner by the _____ Department of Social Services.

NAMES AND ADDRESSES OF NURSING FACILITIES:

The name and address of the nursing facility, intermediate care facility for the developmentally disabled, or other medical institution in which said owner is an inpatient and from which said owner is not reasonably expected to be discharged and to return home is/are:

[ ]	[ ]
[ ]	[ ]
[ ]	[ ]
[ ]	[ ]

LIENOR'S ATTORNEY: _____, _____
First Name Last Name

_____
Street Address

_____, _____
City State

_____
Phone Number

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DATED: _____ __, _____

_____ County
Department of Social Services

STATE OF NEW YORK)
)
) ss.:
COUNTY OF _____)

I, _____, being duly sworn, state that I am the Commissioner of the _____ County Department of Social Services; that I have read the foregoing Notice of Medical Assistance Lien and know the contents thereof; that the contents are true to the best of my knowledge and belief and that this lien is executed and filed pursuant to the Social Services Law and Regulations for Medical Assistance provided to the owner of the real property herein described.

(Commissioner's Name)
Commissioner

Sworn to before me this
_____ day of _____, year

_____
Signature of Notary Public