Attachment IV

NOTICE OF POST DEATH MEDICAL ASSISTANCE LIEN

Pursuant to Social Services Law Section 369(6)
and Title18 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 Post Death Medical Assistance Lien, pursuant to Social Services Law Section 369(6) 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 (Medicaid) expenses paid for the benefit of the deceased ________________ , who had an interest in said real property at the time of their death, 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 deceased so far as is known to lienor, is: __________________
(e.g.: as tenant by entirety, joint tenant, life estate holder, 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 Clerk's Office in _______________________

Deed Dated: _______________ Deed Recorded: _________________

Liber and Page: ______________ Grantor: _________________

Grantee: _______________ Tax Map Number: _________________

This lien is for reimbursement of Medical Assistance provided on behalf of the deceased_______________________________ at a time when he or she was 55 years of age or older or was permanently institutionalized. As of the date of this notice, the amount of such assistance provided to the deceased by the ___________________ Department of Social Services is $_________________.

LIENOR'S ATTORNEY:

_________________	_________________
First Name	**Last Name**
Street Address	
City	**State**
Phone	

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 Post Death 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

Recording Requested by:

When Recorded Mail To: