STATE OF MINNESOTA **_____ JUDICIAL DISTRICT**
DISTRICT COURT

COUNTY OF _____ **PROBATE DIVISION**

Court File No. _____

Estate of

_____,
Decedent

CERTIFICATE OF CLEARANCE FOR MEDICAL ASSISTANCE CLAIM

1. There _____ claim for recovery of medical assistance arising under Minnesota Statutes section 256B.15, as amended, against the following decedent named in the application for this Certificate (if there is no claim write "none" in the claims column; if there is a claim fill in the total amount of the claim in the claims column):

Name	Date of Birth	Amount of Claim

2. There _____ claim for recovery of medical assistance arising under Minnesota Statutes section 256B.15, as amended, against the following predeceased spouse of the decedent named in the application for this Certificate (if there is no claim write "none" in the claims column; if there is a claim fill in the total amount of the claim in the claims column):

Name	Date of Birth	Amount of Claim

Dated: _____

_____
Name of County Agency

_____
Street Number

_____
City, State and Zip Code

(_____)_____
Telephone Number

By: _____
Director of County Agency/Director's Designee

IF A CLAIM APPEARS ABOVE CONTACT THIS PERSON AT THE COUNTY AGENCY TO ARRANGE FOR PAYMENT AND SATISFACTION OF THE CLAIM

_____
Name

(_____)_____
Telephone Number