ATTORNEY OR PARTY WITHOUT ATTORNEY (NAME, STATE BAR NUMBER AND ADDRESS)		FOR COURT USE ONLY
TELEPHONE NUMBER:	FAX NO. (Optional):	
EMAIL ADDRESS (Optional):		
ATTORNEY FOR (Name):		
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN LUIS OBISPO STREET ADDRESS: 1035 Palm Street, Room 385 MAILING ADDRESS: Same as above CITY AND ZIP CODE: San Luis Obispo, CA 93408 BRANCH NAME: San Luis Obispo Division		
ESTATE OF:		CASE NUMBER:

NOTICE TO DEPARTMENT OF HEALTH CARE SERVICES
Probate Code §§ 215, 9202 (a), 19202

1. You are hereby given notice of administration of the estate of the following person:

   a. Decedent's Name:_____.

   b. Date of Death:_____.

   c. Social Security Number:_____.

2. A copy of the decedent's death certificate is attached.

3. The decedent received or may have received health care under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or had a predeceased spouse or registered domestic partner who received or may have received health care.

4. The decedent:

   a. ☐ Did not have a predeceased spouse or registered domestic partner (or)

   b. ☐ Did have a predeceased spouse or registered domestic partner, a copy of whose death certificate is attached.

Insert case name:	CASE NUMBER

5. The party providing you with this notice is as follows:

   a. Name:_____.

   b. Address:_____.

   c. Telephone:_____.

   d. Capacity: ☐ Estate Attorney ☐ Personal Representative ☐ Beneficiary/ Heir ☐ Trustee

      ☐ Person in Possession of the Property of Decedent.

6. If you have a claim against the above mentioned estate, please forward documentation to the address indicated in item 5 above.

   Date:_____ _____
   (Signature of party providing notice)

Insert case name:	CASE NUMBER

PROOF OF SERVICE

1. I am over the age of 18 and am not a party to this case. I live or work in the county where the mailing occurred.

2. My (the servers) home or business address is as follows:

3. I served the foregoing NOTICE TO DEPARTMENT OF HEALTH CARE SERVICES, by enclosing a copy in an envelope addressed to:

   Department of Health Care Services
   Estate Recovery Unit
   P.O. Box 997425, MS 4720
   Sacramento, California 95899-7425

4. Date mailed: _____, Place mailed (city, state): _____ .

   I declare under penalty of perjury under the laws of the State of California that the information above is true and correct.

_____ _____ _____
(Date signed) (Type or Print Name) (Signature)