SUPERIOR COURT OF CALIFORNIA, COUNTY OF RIVERSIDE

☐ **PALM SPRINGS** 3255 E. Tahquitz Canyon Wy., Palm Springs, CA 92262 ☐ **RIVERSIDE** 4050 Main St., Riverside, CA 92501

☐ **TEMECULA** 41002 County Center Dr., Ste. 100, Temecula, CA 92591

RI-PR036

ATTORNEY OR PARTY WITHOUT ATTORNEY (*Name, State Bar Number and Address*) TELEPHONE NO.: FAX NO. (Optional): E-MAIL ADDRESS *(Optional)*: ATTORNEY FOR *(Name)*:		*FOR COURT USE ONLY*
IN THE MATTER OF:		CASE NUMBER:
Hearing Date:	Time:	Department:

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

1. You are hereby given notice of the death 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. a. ☐ The decedent did not have a predeceased spouse or registered domestic partner (or)
   b. ☐ The decedent did have a predeceased spouse or registered domestic partner, a copy of whose death certificate is attached.
5. The party providing you with this notice is as follows:
   a. Name: _____
   b. Address: _____
   c. Telephone: _____
   d. Capacity: ☐ Estate Attorney ☐ Beneficiary/Heir ☐ Personal Representative ☐ Person in Possession of Property of the Decedent ☐ Trustee
6. This notice is being provided by a general personal representative, trustee, or the attorney who represents a general personal representative or trustee. If you have a claim against the above-mentioned estate or trust please forward documentation to the address indicated in item 5 above within the period provided in Probate Code 9202(a) or 19202(b).

Date: _____ _____
(PARTY PROVIDING NOTICE)

IN THE MATTER OF:	CASE NUMBER:

PROOF OF SERVICE BY MAIL

1. I am over the age of 18 and am not a party in this cause. I am a resident of or employed in the county where the mailing occurred.

2. My (the servers) home or business address is: _____
(STREET ADDRESS)

_____
(CITY, STATE, ZIP)

3. I served the forgoing 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, CA 95899-7425

   and depositing the sealed envelope with the United States Postal Service with the postage fully prepaid.

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

Date: _____ _____
(SIGNATURE OF DECLARANT)