



*Lynn Fitch*  
STATE TREASURER  
UNCLAIMED PROPERTY

Dear Nursing Home Administrator,

Pursuant to Mississippi law (Miss. Code Ann. § 43-13-120 and § 89-12-1, et. seq.), your facility has a duty to report to the Office of the State Treasurer any property held by a recipient who dies intestate with no known heirs.

Please use the enclosed form for making your report until further notice. Please discard any previous forms used for this purpose. Any reports made on previous forms will be returned to you for re-completion on this form.

Important things to note:

- This new form needs to be completed in its entirety for **each** deceased patient or resident. One decedent per form.
- If you are aware of a spouse, child, or other heir, please speak with them first about the disposition of the decedent's property. This form is **only** to be used for patients who die without any known heirs.
- If you are aware of someone close to the decedent but you are unsure of their legal relationship, please report that person's name **and as much contact information as possible** on the form.

**Mail your report and remittance, made payable to:**

Office of the State Treasurer  
Unclaimed Property Division  
P O Box 138  
Jackson, MS 39205-0138

If you have any questions, please feel free to contact Robyn Louis in my office:

601-359-2513

[Robyn.Louis@treasury.ms.gov](mailto:Robyn.Louis@treasury.ms.gov)

Thank you for your assistance with this process.

Sincerely,

A handwritten signature in cursive script that reads "Lynn Fitch".

Lynn Fitch  
Treasurer  
State of Mississippi

**REPORT AND REMITTANCE due November 1**

**Mail Report & Check Payable to:**

Office of the State Treasurer  
Unclaimed Property Division  
P.O. Box 138  
Jackson, MS 39205-0138



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**Nursing Home Unclaimed Property Report  
(One form per decedent – Complete in full)**

Name of Holder/Care Center \_\_\_\_\_ Contact Person & Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_ Email Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Federal ID # \_\_\_\_\_

*Pursuant to Mississippi Code Annotated, Section 43-13-120 and Section 89-12-1, et. seq., the above holder hereby reports the following property:*

Owner's Name (Last, First, MI) _____	Medicaid Patient? Yes <input type="checkbox"/> No <input type="checkbox"/>
Owner's SSN _____	Amount due owner _____
Owner's Date of Birth _____	Owner's Date of Death _____
Last known address before entering care center _____	
City, State, Zip _____	
Information on any person who may possess an interest in such property (Continue on back if necessary):	
Person's Name _____	Relation to Decedent _____
Phone _____	Email Address _____
Address _____	

**AFFIDAVIT** State of \_\_\_\_\_ County/City of \_\_\_\_\_

I, \_\_\_\_\_, of the company/holder for which this report is made, being duly sworn (or affirmed) according to the law do depose and say that this report is true and contains all facts required by law to be reported.

\_\_\_\_\_  
Signature of officer, owner, etc.

Sworn and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
Notary Public: \_\_\_\_\_