

FORM NH-1

REPORT AND REMITTANCE are due within 30 days



FOR TREASURY USE ONLY

**LYNN FITCH
TREASURER**

**STATE OF MISSISSIPPI
NURSING HOME
UNCLAIMED PROPERTY REPORT
(Medicaid Patients)**

REPORT YEAR _____

<i>Name of Holder:</i> _____	<i>Contact Person</i> _____	<i>Phone</i> _____
<i>Mailing Address</i> _____	<i>City, State, Zip</i> _____	

Pursuant to Mississippi Code Annotated, Section 43-13-120 of the Laws of Mississippi the above holder hereby reports the following property subject to the Act:

OWNER'S LAST NAME, FIRST NAME STREET ADDRESS / CITY, STATE, ZIP CODE (LIST ALPHABETICALLY BY LAST NAME)	OWNER'S SOCIAL SECURITY NUMBER	NAME & LAST KNOWN ADDRESS OF EACH PERSON WHO MAY POSSESS AN INTEREST IN SUCH FUNDS	AMOUNT REPORTED AS DUE OWNER

AFFIDAVIT

State of _____ County/City of _____

I, _____ of the company, or holder, for which this report is made,
(Type in name of officer, owner, etc., signing) (Type in title of person signing)
being duly sworn (or affirmed) according to 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 to (or affirmed) and subscribed before me this _____ day of _____, _____

(Notary Public)

TOTAL

MAIL REPORT & CHECK PAYABLE TO:

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