MINNESOTA MEDICAL ASSISTANCE PROGRAM
NOTICE OF LIEN IMPOSITION
Minnesota Statutes 1993, sections 514.980 to 514.985

George Roy
c/o Lyngblomsten Care Center
1415 Almond Ave.
St. Paul, MN. 55108

Date: February 20, 2018
Lien No. 18522
Social Security: 6806

Dear Mr. Roy::

This is to notify you that the Minnesota Department of Human Services will place a lien on your real property. This is based on your receipt of medical assistance payments made for your benefit by the Minnesota Medical Assistance Program beginning June 1, 2017. It is also based on medical verification from your attending physician that you are not reasonably expected to be discharged from the medical institution you are in.

Your interest in the real property you own, and that of your spouse, if still living, is subject to or affected by the rights of this agency to be reimbursed for medical assistance benefits.

The Medical Assistance lien will be filed against your real property 30 days from receipt of this notice. Following is/are the legal description (s) of your real property subject to a lien:

COUNTY: Ramsey ABSTRACT: X TORRENS: Ctf. No.

All of your right, title and interest in and to:

Lot 9, Block 6, Fletcher's Subdivision of Brewsters A, except the West 5 feet for alley.

APPEAL RIGHTS:

If you do not agree with this action, you may appeal. To initiate an appeal, send a very short letter to the Appeals Office stating your disagreement with the state filing a lien on your real property. You must submit this letter within 30 days of receiving this notice. (The agency can accept your appeal for up to 90 days after the date of this notice if you show good cause for not appealing within the 30-day limit.)

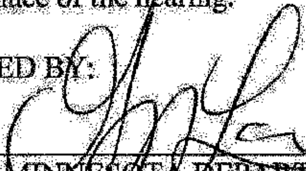
If you do not appeal within 30 days (or 90 days if you have good cause), you may not appeal anything concerning this lien later on.

If you decide to appeal, send your letter to this address:

Appeals Office
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3813

An appeal hearing will be held in your county or over the telephone. You will receive a notice telling you the date, time, and place of the hearing.

THIS LIEN FILED BY:



On behalf of the MINNESOTA DEPARTMENT OF HUMAN SERVICES

THIS FORM DRAFTED BY:

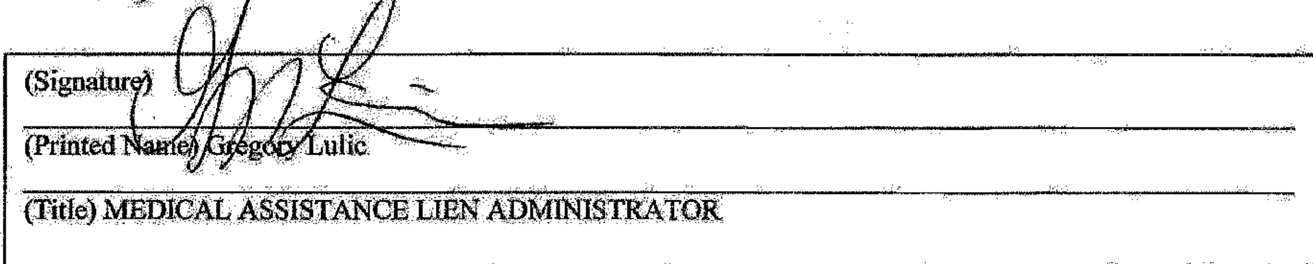
Gregory Lulic
Minnesota Department of Human Services
P.O. Box 64995
St. Paul, MN 55164-0995
651-431-3152

CERTIFICATE OF MAILING AND OF NO APPEAL

I, Gregory Lulic, hereby certify that on the 2 day of February, 2018, I mailed copies of the Notice above to the Medical Assistance recipient named and to the named authorized representative of the Medical Assistance recipient (if any) by certified mail to the last known address (es) set out above:

I further certify that the applicable time to appeal the imposition of this lien has expired and no appeal has been taken, or that all appeals have been decided in favor of the State's imposition of this lien.

Dated this 29 day of MARCH, 2018.



(Signature)

(Printed Name) Gregory Lulic

(Title) MEDICAL ASSISTANCE LIEN ADMINISTRATOR