State of Minnesota **District Court**

County: Carver	Judicial District: First
	Court File Number: 10-PR-16-46
	Case Type: probate

In the Matter of the Estate of:

Prince Roger Nelson
(Full Name) **Decedent**

WRITTEN STATEMENT OF CLAIM

FILED
JUN 14 2016
CARVER COUNTY COURTS

STATE OF MINNESOTA)
) SS
COUNTY OF Carver)

1. My name is: Nicole Patricia P. White and I have a valid claim against this estate.
2. My address and telephone number are: 490 Myrtle #2J BK NY 11205 718-717-9709.
3. The Estate is or will become indebted to me in the amount of $ 0-share.
4. The nature of the claim is: determine dna relationship
I would like to be included in the official DNA testing
I will be obtaining legal Counsel + representation.
5. The claim arose ☐ prior to the death of the Decedent on or about _____
or ☒ after the death of the Decedent, on or about 6/6/16.
6. The claim is ☒ unsecured, or
☐ secured by: Nicole P. White.
7. The claim ~~is~~ is not based on a contract which makes a provision for interest.
8. The claim was or will be due and payable on _____.
9. If the claim is contingent or unliquidated, the nature of the uncertainty is as follows: ___
10. Under penalties for perjury, I declare that I have read this document and I know or believe its representations are true and complete.

Dated: 6/16/16

N. White
Signature
Name: Nicole P. White
Street Address: 490 Myrtle 2J
City/State/Zip: BK NY 11205
E-mail address: n.white55@yahoo.com
718-717-9709

RECEIVED
JUN 10 2016
COURT ADMINISTRATION

Exhibit A

REQUEST FOR PARENTAGE INFORMATION

Special Administrator Bremer Trust requests that you provide answers to the following questions and requests for information by affidavit signed **under oath.**

1. What is your full name?
   Nicole Patrice White
2. What is your birth date?
   3-9-70
3. Where were you born?
   Phila. Penn
4. Please provide a certified copy of your birth certificate.
   incl.
5. What are the full names of your biological parents?
   Diana M. White / father unKnown
6. Were your biological parents married when you were born? (If yes, answer the subparts below.)
   a. When were your parents married?
      NO
   b. Where were your parents married?
      NO
   c. What was your biological mother's maiden name?
      White
   d. Please provide a certified copy of your parents' marriage certificate or other proof of marriage. N/A
   e. Were your parents divorced? If so, please provide the date of the divorce and a certified copy of the divorce decree or other proof of divorce.
      N/A
7. Were your biological parents married after you were born? (If yes, answer the subparts below.) N/A
   a. When were your parents married?
      N/A
   b. Where were your parents married?
      N/A
   c. What was your biological mother's maiden name?
      White
   d. Did the man who married your biological mother acknowledge his paternity of you in writing filed with a state registrar of vital records? NO
   e. Was the man who married your biological mother named as your father on your birth record with his consent? NO

f. Was the man who married your biological mother obligated to support you under a written voluntary promise or by court order? NO

g. Please provide a certified copy of your parents' marriage certificate or other proof of marriage. NO

h. Were your parents divorced? If so, please provide the date of the divorce and a certified copy of the divorce decree or other proof of divorce. N/A never married

8. If your parents were not married when you were born, had they attempted to marry each other by a marriage solemnized in apparent compliance with law, although the attempted marriage is or could be declared void, voidable or otherwise invalid? (If yes, answer the subparts below.) NO

a. What was the date of the attempted marriage?

b. Where did the attempted marriage take place?

c. Please provide proof of the attempted marriage.

d. If the invalid marriage was terminated by death, annulment, declaration of invalidity, dissolution or divorce, please provide the date of the termination and any proof of such termination. Not married

9. If your parents did not marry or attempt to marry, did any man receive you into his home and openly hold you out as his biological child? If yes, please name the man and provide details and other evidence (e.g. sworn statements, photographs, documents) to support your answer. NO I was not adopted raised in Chicago IL by Jessie Barnett + Jean Barnett

10. If your parents did not marry or attempt to marry, did any man and your biological mother acknowledge the man's paternity of you in a writing signed by both of them under Minn. Stat. § 257.34 (copy attached) and filed with the state registrar of vital records? If yes, please provide a certified copy of such writing. NO

11. If your parents did not marry or attempt to marry, did any man and your biological mother execute a recognition of parentage of you pursuant to Minn. Stat. § 257.75 (copy attached)? If yes, please provide a certified copy of such recognition of parentage. NO

12. Is any other man presumed to be your father under any of the presumptions found in Minn. Stat. § 257.55 (copy attached)? If yes, please provide details, and also whether the other man signed a written consent if your father and mother signed a written acknowledgment of paternity under Request No 10 above. NO

13. Was your biological mother married to any man other than your biological father when you were born or within 280 days before your birth? NO

Exhibit B

1. Copy of hippa form
2. Sworn Affidavit
3. Copy of Birth Certificate

14. Does a judgment or order exist determining a parent and child relationship between you and one or more parents? If so, please provide details and a certified copy of such judgment or order. NO

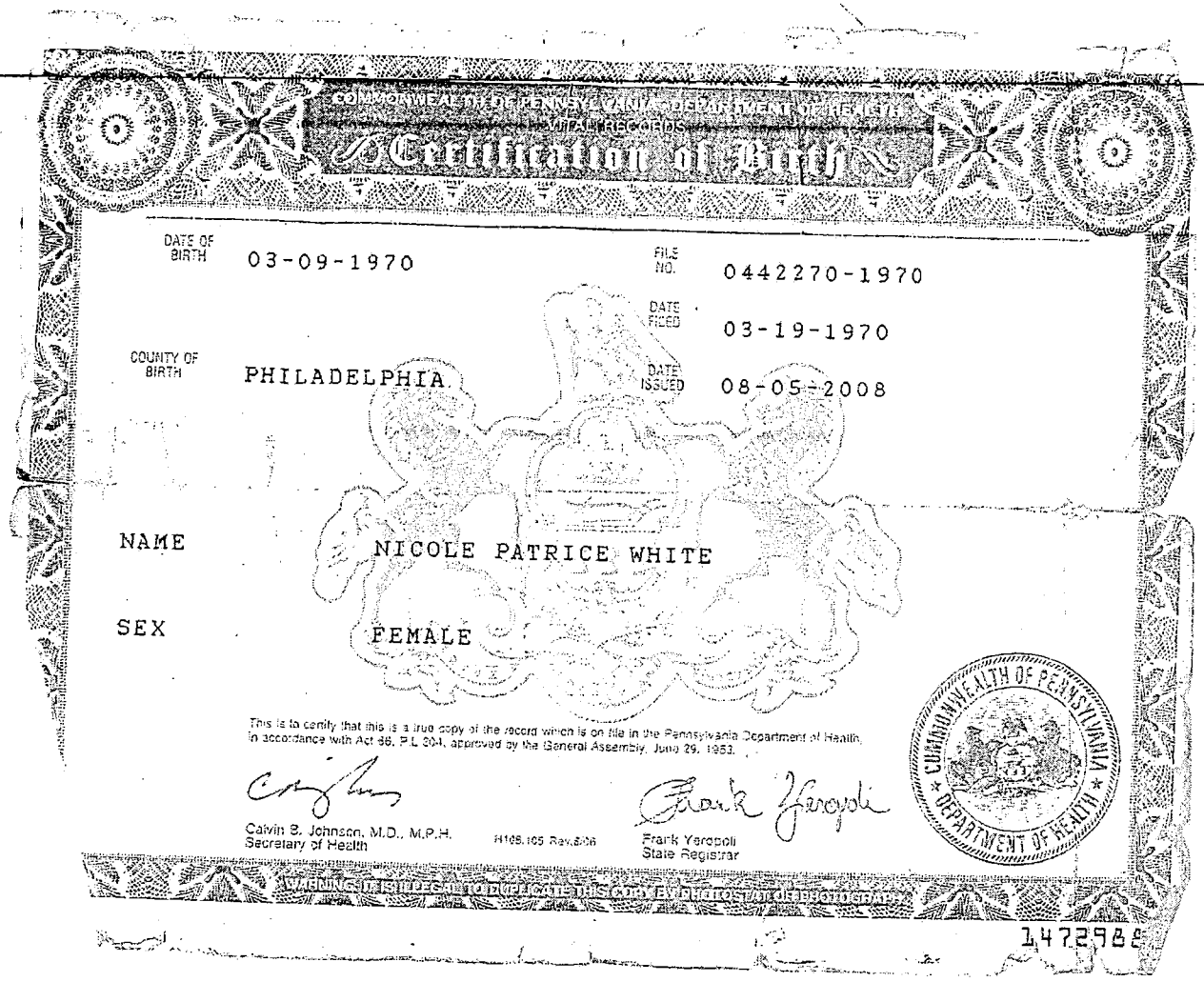
15. Detail the actions taken by you to confirm that the responses to the above requests are true and accurate. Yes

16. If you contend additional information is needed or should be considered by the Special Administrator to support your claim to be an heir, please provide such information.

I was raised Nicole Patrice Barnett 7736 S. Drexel Chicago Illinois 60619 by Jean + Jessie Barnett

My biological mother is Diana M. White born Chicago Il (father unknown)

I would like a complete full DNA testing done Paternity. Sibling. Ancestry. Any DNA testings that I and the deceased Prince Roger Nelson may share / ~~also mt DNA~~ as well as 4-5 str DNA



COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH

Certification of Birth

DATE OF BIRTH 03-09-1970

FILE NO. 0442270-1970

DATE FILED 03-19-1970

COUNTY OF BIRTH PHILADELPHIA

DATE ISSUED 08-05-2008

NAME NICOLE PATRICE WHITE

SEX FEMALE

This is to certify that this is a true copy of the record which is on file in the Pennsylvania Department of Health, in accordance with Act 66, P.L. 304, approved by the General Assembly, June 29, 1953.

Calvin B. Johnson, M.D., M.P.H.
Secretary of Health

H105.105 Rev.8/06

Frank Yaropoli
State Registrar

COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF HEALTH *

WARNING: IT IS ILLEGAL TO DUPLICATE THIS COPY. EVIDENCE WILL BE PROSECUTED.

1472986

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law, HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two and three (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or provider disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ Both (non-HIV medical and HIV-related information)
- ☒ My non-HIV medical information **

Information in the box below must be completed. Please make sure to cross out all unused fields by marking with an "X".

Name and address of facility/provider disclosing HIV-related and/or medical information:

_____

_____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____

_____

Relationship to person whose information will be released: _____

_____

Describe information to be released: Information on reason(s) for referral to the program, demographics, assessments, diagnoses, laboratory tests, medications, care plans, appointment-keeping, program services received, enrollment status, and reason for end of program services.

Reason for release of information: Coordination of Care between providers on HIV care team, when the team involves more than one agency.

Time Period During Which Release of Information is Authorized:

From: 6/9/16 To: _____ OR ☒ until case closure out of this program *(check if applicable)*

(today's date: mm/dd/yyyy) *(1-3 years following today's date: mm/dd/yyyy)*

Disclosures cannot be revoked once made. Additional exceptions to the right to revoke consent, if any:

The right to use the information already shared (for example, for program purposes such as to determine the quality of the services provided) cannot be revoked even if you are no longer participating in the program. Revoking consent requires notice in writing to the Care Coordinator (or Medical Liaison) and Primary Care Provider within this Care Coordination program.

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

If a Care Coordination program is carried out by two or more agencies working together under one contract, failure to consent to the sharing of HIV-related information and general medical information between the primary care and Care Coordination providers will prevent enrollment in the Care Coordination program. However, failing to consent and/or revoking your consent will not affect your access to regular medical care or treatment at this facility, and you may still receive other services at the agencies listed in this release. You may even still receive Care Coordination, through another agency or network. This form is only necessary if you want to take part in the Care Coordination program in this facility.

Please sign below only if you wish to authorize all facilities/providers listed on pages 1, 2 (and 3 and 4, if used) of this form to share information among and between themselves for the purpose of providing medical care and services.

Signature Nicole P. White Date 6/9/16

* Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV related medical information, you may use this form or another HIPAA-compliant general medical release form.

Please Complete Information on Page 2 and/or Pages 3 and 4.

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV[1] Related Information

Complete information for each separate facility/provider within a Care Coordination network with which general medical and/or HIV-related information will be shared. A "separate" facility or provider is one based at an organization other than the organization of the enrolling primary care physician. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of all facilities/providers with which general medical and/or HIV-related information will be shared. General medical and/or HIV-related information will be shared by your primary care providers with the following Care Coordination network facilities/providers as necessary.

1) Name: _____ Agency: _____
Address: _____
City/Borough: _____ State: _____ Zip Code: _____
Phone #: (_____) _____-_____

2) Name: _____ Agency: _____
Address: _____
City/Borough: _____ State: _____ Zip Code: _____
Phone #: (_____) _____-_____

3) Name: _____ Agency: _____
Address: _____
City/Borough: _____ State: _____ Zip Code: _____
Phone #: (_____) _____-_____

4) Name: _____ Agency: _____
Address: _____
City/Borough: _____ State: _____ Zip Code: _____
Phone #: (_____) _____-_____

5) Name: _____ Agency: _____
Address: _____
City/Borough: _____ State: _____ Zip Code: _____
Phone #: (_____) _____-_____

6) Name: _____ Agency: _____
Address: _____
City/Borough: _____ State: _____ Zip Code: _____
Phone #: (_____) _____-_____

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to the facility/provider obtaining this release. I authorize the facility/provider(s) noted on page one to release medical and/or HIV-related information of the person named on page one to the facilities/provider(s) listed.

Signature N. White Date 6/9/16
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name Nicole P. White

Client/Patient Number X4977967

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

Complete information for each non-Care Coordination facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information.

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information.

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to the facility/provider obtaining this release. I authorize the facility/provider(s) noted on page one to release medical and/or HIV-related information of the person named on page one to the facilities/provider(s) listed.

Signature N. White Date 6/9/16
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: Self

Print Name Nicole P. White

Client/Patient Number X4977967

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

Complete information for each non-Care Coordination facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information.

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information.

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information.

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general medical and/or HIV-related information.

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature [redacted] Date 6/9/16

Client/Patient Number XY977962

Filed in First Judicial District Court
7/20/2016 3:03:38 PM
Carver County, MN

State of Minnesota | **District Court**

County	Judicial District:
Carver	Court File Number: 10-PR-16-46
	Case Type: probate

In the Matter of the Estate of:

Prince Rogers Nelson,
(Full Name) **Decedent**

WRITTEN STATEMENT OF CLAIM

STATE OF MINNESOTA)
) SS
COUNTY OF Carver)

1. My name is: Nicole Patrice White and I have a valid claim against this estate.
2. My address and telephone number are: 490 Myrtle Ave 2S BK NY 11205 - 718.717.9709 or .
3. The Estate is or will become indebted to me in the amount of $ N/A .
4. The nature of the claim is: establish complete full DNA relationship testing. Paternity. sibling. Ancestry. mt. DNA testing. & Y-str DNA testing I have a right to know if there is any relationship between me & the deceased
5. The claim arose ☐ prior to the death of the Decedent on or about _____ .
   or ☒ after the death of the Decedent, on or about 6/9/16 .
6. The claim is ☐ unsecured, or
   ☒ secured by: Nicole P. White .
7. The claim ☐ is ☒ is not based on a contract which makes a provision for interest.
8. The claim was or will be due and payable on N/A .
9. If the claim is contingent or unliquidated, the nature of the uncertainty is as follows: If DNA determines a relationship & MN laws .
10. Under penalties for perjury, I declare that I have read this document and I know or believe its representations are true and complete.

Dated: 6/9/16

N. White
Signature

Name: Nicole Patrice White
Street Address: 490 Myrtle #2S
City/State/Zip: BK NY 11205
E-mail address: n.white53@yahoo.com

Filed in First Judicial District Court
7/20/2016 3:03:38 PM
Carver County, MN

ACKNOWLEDGEMENT BY INDIVIDUAL

STATE OF NEW YORK)
SS.:
COUNTY OF New York)

On this 9th day of June, 2016, before me personally came Nicole Patrice White, to me known and known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged to me that he/she executed the same.

Nicole Patrice White
N. White 6/9/16

Notary Public

DANIEL L. EVANS
NOTARY PUBLIC, State of New York
No. 02EV6146272
Qualified in Nassau County
Commission Expires May 15, 2019

ACKNOWLEDGEMENT BY UNINCORPORATED ASSOCIATION

STATE OF NEW YORK)
SS.:
COUNTY OF)

On this _____day of _____,20____, before me personally came _____, to me known and known to me to be the person described in and who executed the above instrument, who, being duly sworn by me, did for himself/herself depose and say that he/she is a member of the firm of _____ and that he/she executed the foregoing instrument in the firm name of _____, and that he/she had authority to sign same, and he/she did duly acknowledge to me that he/she executed the same as the act and deed of said firm of _____, for the uses and purposes mentioned therein.

_____
Notary Public

ACKNOWLEDGEMENT BY CORPORATION

STATE OF NEW YORK)
SS.:
COUNTY OF)

On this _____day of _____, in the year 20__, before me personally came_____, to me known, who, being by me duly sworn did depose and say that he/she resides in _____; that he/she is the _____ of the _____, the corporation described in and which executed the above instrument; that he/she knows the seal of said corporation; that the seal affixed to said instrument is such a corporate seal, that it was so affixed by the order of the Board of Directors of said corporation, and that he/she signed his/her name thereto by like order.

_____
Notary Public

STINSON
LEONARD
STREET

612.335.1627 **DIRECT**
612.335.1657 **DIRECT FAX**
david.crosby@stinson.com

June 16, 2016

Via Email
Nicole P. White
490 Myrtle Avenue, #2J
Brooklyn, NJ 11205

Re: Affidavit of Nicole P. White

Dear Ms. White:

Thank you for submitting the Affidavit of Nicole P. White.

With respect to the Protocol adopted by the Court, the Special Administrator's goal is to apply existing Minnesota law equally to all persons claiming to potentially be an heir of Prince Rogers Nelson (the "Decedent"). Such relevant law includes the Minnesota Probate Code (Minn. Stat. Ch. 524), the Minnesota Parentage Act (Minn. Stat. §§ 257.01 through 257.75) and Minnesota common law.

Under Minnesota law, if it is determined that Decedent is not the father of any living children (or their descendants), then Decedent's siblings and half-siblings (and descendants of any deceased siblings and half-siblings) may be determined to be heirs, in the event no Will is found. Minn. Stat. § 524.2-103(3). To be a sibling or half-sibling, a person must share at least one genetic parent with Decedent. *Id.* Because they were married when Decedent was born, Mattie Della (Shaw) ("Mattie") and John Lewis Nelson ("John") are presumed to be Decedent's genetic parents. Minn. Stat. § 257.55, subd. 1(a).[1] Only a very limited group of persons have standing to challenge that presumption, and, in any event, the time to make such a challenge passed long ago. Minn. Stat. § 257.57, subd. 1(b). As such, there is an irrebuttable presumption that John and Mattie are Decedent's genetic parents. *Id.*; Minn. Stat. § 524.1.201(22) and (23); *see also In re Estate of Jotham*, 722 N.W.2d 447, 455-56 (2006). Thus, to potentially qualify as an heir of Decedent as a sibling or half-sibling, the claimant must be a descendant of either Mattie or John (or both).

[1] Further, as part of Mattie and John's divorce, a Minnesota court adjudicated that they were Decedent's parents.

The materials you provided under oath do not provide any bases that you are a child, sibling or a half-sibling of the Decedent. Consequently, it is the Special Administrator's determination that the evidence you have presented is insufficient to warrant genetic testing.

Very truly yours,

STINSON LEONARD STREET LLP

David R. Crosby

DRC:mp