***Disclaimer:*** *Verification of cause and time of death may not be available at time of report.*

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|  | **Section I: Select Type of Waiver** | **Notify the Operating Agency:** |
|  | Aged and Disabled Waiver | Attach form in ADW CareConnection© and submit Discharge |
|  | Intellectual/Developmental Disability Waiver | Email form to: [WVIDDWaiver@kepro.com](mailto:WVIDDWaiver@kepro.com) –or Attach form in CareConnection© and submit discharge |
|  | Traumatic Brain Injury Waiver | Email form to [WVTBIWaiver@kepro.com](mailto:WVTBIWaiver@kepro.com) |

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| **Section II: Agency/Reporter Information** | |
| CM or F/EA Agency Name: |  |
| Contact Person Name: |  |
| Contact Person Phone #: |  |
| Contact Person Email: |  |

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| **Section III:** **Information about the deceased** | | | | | |
| Deceased Person’s Name: |  | Record ID#: |  | Medicaid #: |  |
| Last Known Address: |  | | | | |
| Date of Birth: |  | Date of Death: |  | Time of Death: |  |
| Location of Death: |  | | | | |
| Cause of Death: |  | | | | |
| How did you become aware of the death? |  | | | | |
| Medical Diagnoses and Conditions: |  | | | | |

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| **Section IV: Manner of Death**  **(mark the one box that is most applicable)** |
| Terminal Natural Disease Accidental  Other (describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **↓↓ \*Unexplained/Suspicious/Untimely: Section V must be completed ↓↓** |

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| **\*Section V: Must be completed if death was unexplained, suspicious or untimely**  **(Use additional pages as necessary)** |

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| Describe all life-saving measures attempted (if applicable) and why, if none were attempted:  (Example: CPR, 911, DNR, etc.) |  |
| Describe circumstances preceding death (if known): |  |
| Indicate applicable agencies or authorities who were notified, if necessary:  (Example: Adult/Child Protective Services, Police, Medicaid Fraud Control Unit, Physician, WV Incident Management System, SC Agency, Legal Representative/Family) |  |

Signature/Credentials of person completing this form Date Submitted

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| For BMS Use Only – Do not write in this section |
| Date of mortality Review Committee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No further action required  Further action Required: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |