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

|  |  |  |
| --- | --- | --- |
| [x]   | **Section I: Select Type of Waiver**  | **Notify the Operating Agency:** |
| [ ]   | Aged and Disabled Waiver | Attach form in ADW UMC’s web portal and submit Discharge |
| [ ]   | Intellectual/Developmental Disability Waiver | Email form to: WVIDDWaiver@kepro.com –or Attach form in UMC’s web portal and submit discharge |
| [ ]   | Traumatic Brain Injury Waiver | Email form to WVTBIWaiver@kepro.com  |

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

|  |
| --- |
|  **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: |  |

|  |
| --- |
| **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 ↓↓** |

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

|  |  |
| --- | --- |
| 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

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