West Virginia Home and Community-Based Waiver
Notification of Death

(This form is used to report the death of a person who receives ADW, TBI or I/DD Waiver services)

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

☒	**SECTION I: SELECT TYPE OF WAIVER**	**NOTIFY THE OPERATING AGENCY:**
☐	Aged and Disabled Waiver	Attach form in ADW CareConnection© and submit Discharge
☒	***The first to learn of the death (CM, RN, or RC), must complete the NOD form and enter the incident into the IMS. (If NOD and incident report are completed by RN/RC, notify CM to submit discharge/closure).***	***The CM must complete member discharge request form and submit request for discontinuation of services in CareConnection.***

SECTION II: AGENCY/REPORTER INFORMATION	
CM, RN 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: _____