

# 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.

<input checked="" type="checkbox"/>	SECTION I: SELECT TYPE OF WAIVER	NOTIFY THE OPERATING AGENCY:
<input type="checkbox"/>	Aged and Disabled Waiver	Attach form in ADW CareConnection© and submit Discharge
<input type="checkbox"/>	Intellectual/Developmental Disability Waiver	Email form to: <a href="mailto:WVIDDWaiver@kepro.com">WVIDDWaiver@kepro.com</a> –or Attach form in CareConnection© and submit discharge
<input type="checkbox"/>	Traumatic Brain Injury Waiver	Email form to <a href="mailto:WVTBIWaiver@kepro.com">WVTBIWaiver@kepro.com</a>

SECTION II: AGENCY/REPORTER INFORMATION	
SC, 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)
<input type="checkbox"/> Terminal <input type="checkbox"/> Natural <input type="checkbox"/> Disease <input type="checkbox"/> Accidental
<input type="checkbox"/> Other (describe): _____
↓↓ <input type="checkbox"/> *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: _____
<input type="checkbox"/> No further action required <input type="checkbox"/> Further action Required: _____