**MORTALITY NOTIFICATION**

(Updated March 2023)

He-M 1001.06 Health and Safety – In the event of death of an individual, provider agency shall notify the area agency immediately. The area agency shall notify the Bureau of Developmental Services (BDS) by phone within twelve (12) hours of death and submit the following to BDS within twenty-four (24) hours.

12-hour notification to BDS made by:

Phone #:  Email address:

Reported to:       Date:  Time:

Region:  Vendor name(s) (if applicable):

**Name of deceased individual:**

Date of birth:  Age:

Gender: [ ]  Male [ ]  Female Race/Ethnicity:

 *(if more than one, or other specify):*

Street Address:

City:

State:  Zip:

County where individual lived:

**Date of death:**

Place of death:  City where individual died:

*(If other describe)*

911 / EMS utilized: [ ]  Yes [ ]  No

Did the individual have a do not resuscitate (DNR) order: [ ]  Yes [ ]  No

Hospice involved: [ ]  Yes [ ]  No

*(If yes, please describe the situation)*

Living situation:  *(if other please specify)*

Change in living situation in the past six months: [ ]  Yes [ ]  No (*If yes, please describe)*

Eating ability:

Swallowing issues: [ ]  Yes [ ]  No (I*f yes, how addressed?)*

Mobility:  *(specify device(s))*

Please list all medical diagnoses:

**Describe the events surrounding the individual’s death** (*such as: what were the precipitating events prior to death, what happened, who was involved, where, how, why, and when etc.)* Please be as specific & detailed as possible and use as much space as needed.

**Apparent cause of death** (according to the attending physician):

Will an autopsy be performed: [ ]  Yes [ ]  No

Sentinel event: [ ]  Yes [ ]  No [ ]  Undetermined

***If yes****, follow Sentinel Event reporting procedure*

Was this person’s death anticipated or did it happen unexpectedly: [ ]  Anticipated [ ]  Happened unexpectedly

*If this person’s death happened* ***unexpectedly****, please follow with a Mortality Review*

Guardian name: *(if applicable)*

Phone Number:

Date Notified:

Family member name:

Phone Number:

Date Notified:

Service Coordinator name:

Phone number:

Email address:

Name and title of person completing this report:

 *(Signature and title of person completing this report)*

Email address:

Date:

Thank you for providing this information