



INITIAL AGENCY DEATH REVIEW FORM

An Initial Agency Death Review shall be completed within five (5) business days of the death of a person supported who is

1. Receiving a residential service through an HCBS waiver program or other DIDD community program;
2. A resident of a DIDD ICF/ID; or
3. A resident of a private ICF/ID when such residence is state-funded or funded by TennCare/Medicaid.

Providers and private ICFs/ID shall submit the form to the DIDD Regional Director. DIDD ICF/ID shall submit the form to the DIDD Commissioner or designee.

INFORMATION OF PERSON SUPPORTED

Name (last, first, middle) _____ SSN _____

Home Address _____

Date of Birth ____/____/____ Date of Death ____/____/____ Age at Death ____

Name of Service Provider _____

Name of Director of Provider Agency, Administrator of Private ICF/ID, or Director of DIDD ICF/ID or Chief Officer: _____

Name(s) of Next of Kin and/or Legal Representative: _____

1. Please circle "Yes" or "No".

- a. **YES** **NO** Person supported was discharged from a developmental center within the past 12 months.
- b. **YES** **NO** Person supported resided in the current community placement less than 12 months.
- c. **YES** **NO** The family or conservator of the person supported was involved in care/treatment and .

2. Briefly describe the functional independence in daily living for the person supported.

3. Briefly describe the need for special custodial care and supervision of the person supported.

4. Briefly describe the physical limitations of the person supported.

5. List the medical diagnoses or conditions of the person supported.

6. Please indicate whether "End of Life" issues were discussed at the most recent annual Individual Support Plan Meeting, and describe any "End of Life" plans.

CIRCUMSTANCES SURROUNDING THE DEATH

1. Briefly describe the situation or circumstances surrounding the death of a person supported:

2. Specify the location where person supported died or was found dead: _____

3. Please circle "Yes" or "No".

a. YES NO Cause of death of the person supported was known.

b. YES NO Person supported died in a hospital. If "Yes", specify hospital and date of admission:

c. YES NO An autopsy was done.

<hr/> Print Name of Person Completing This Form	<hr/> Title
<hr/> Signature	<hr/> Date