

DEPARTMENT OF

**DISABILITY AND AGING**

**NOTICE OF DEATH FORM**

**Within 4 hours** of the discovery of any death, the primary provider must provide notice of the death to the DDA Regional Director

for the Region where the deceased person resided at the email address listed below or, if applicable, the DDA ICF/IID Director or

Chief Officer or designee by telephone. Also, **within 4 hours** of the discovery of death that is or may be a Suspicious, Unexpected,

or Unexplained Death, the entity responsible for reporting the death shall report it to the DDA Investigator. A completed **Notice of**

**Death Form** must be sent to the DDA Regional Director and the person’s MCO at the email addresses below within **1 business day**

after discovery of the death.

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| East DDA Regional Director | | | | | | | | | | | | | | | Middle DDA Regional Director | | | | | | | | | | | | | | **West DDA Regional Director** | | | | | | | |
| Email: [Terry.Jordan-Henley@tn.gov](mailto:Terry.Jordan-Henley@tn.gov) | | | | | | | | | | | | | | | Email: [Levi.Harris@tn.gov](mailto:Levi.Harris@tn.gov) | | | | | | | | | | | | | | Email: [CJ.McMorran@tn.gov](mailto:CJ.McMorran@tn.gov) | | | | | | | |
| BlueCare | | | | | | | | | | | | | | | **Wellpoint** | | | | | | | | | | | | | | **United Health Care** | | | | | | | |
| Email: [reportableevents@bcbst.com](mailto:reportableevents@bcbst.com) | | | | | | | | | | | | | | | Email: [TN-REM@wellpoint.com](mailto:TN-REM@wellpoint.com) | | | | | | | | | | | | | | Email: [uhctnrem@uhc.com](mailto:uhctnrem@uhc.com) | | | | | | | |
| **PERSON SUPPORTED INFORMATION: DDA REGION:**  East  Middle  West **MCO:**  BlueCare  Wellpoint  UHC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NAME:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | **DATE OF BIRTH:** | | | | | | |  | | |
| **SOCIAL SECURITY NO:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | **AGE AT DEATH:** | | | | | | |  | | |
| **DATE OF DEATH:** | | | |  | | | | | | | | | | | | | | **DATE REPORTED:** | | |  | | | | | | **TIME REPORTED:** | | | | | | |  | AM PM | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RACE:** | White  Black  Hispanic  Other (list): | | | | | | | | | | | | | | | | | | |  | | | | | | | | **SEX:** Male  Female | | | | | | | | |
| **FUNDING STATUS:**  “Statewide” Waiver  “Self-Determination” Waiver  “CAC” Waiver  Private ICF/IID  State ICF/IID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| State-Funded  ECF CHOICES  Katie Beckett (KB) Part A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RESIDENCE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Supported Living | | | | | | | | | | | | | | | | | | Private ICF/IID | | | | | | | | | | | | Lived with Family | | | | | | |
| Residential Habilitation | | | | | | | | | | | | | | | | | | State ICF/IID | | | | | | | | | | | | Lived in Own Home with Support | | | | | | |
| Medical Residential/ Medical SL | | | | | | | | | | | | | | | | | | Nursing Facility | | | | | | | | | | | | Lived Independently | | | | | | |
| Family Model Residential Services | | | | | | | | | | | | | | | | | | Other (explain) | | | | |  | | | | | | | | | | | | | |
| **DID THE PERSON SERVED MOVE IN THE LAST 6 MONTHS?** No Yes | | | | | | | | | | | | | | | | | | | | | | | | | (Specify date: | | | | | |  | | | | | ) |
| **PLACE OF DEATH:** | | | | | Home | | | | | Hospital | | | | | | | Nursing/Rehab Facility | | | | | | | Psychiatric Facility  Community | | | | | | | | | | | | |
| **DETAILS OF DEATH:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **AUTOPSY REQUESTED?** | | | | | | | | | | | | | | | | | | No  Yes | | | | If so, by whom | | | |  | | | | | | | | | | |
| **MEDICAL EXAMINER CONTACTED?** | | | | | | | | | | | | | | | | | | No  Yes | | | | If so, by whom | | | |  | | | | | | | | | | |
| **CORONER CONTACTED?** | | | | | | | | | | | | | | | | | | No  Yes | | | | If so, by whom | | | |  | | | | | | | | | | |
| **REPORTABLE EVENT FORM SUBMITTED?** | | | | | | | | | | | | | | | | | | No  Yes | | | |  | | | | | | | | | | | | | | |
| **WHO HAS BEEN NOTIFIED:** Police (if applicable)  Investigations  ISC/Case Manager  Legal Representative  Family | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary Care Practitioner (PCP):** | | | | | | | | | | | | |  | | | | | | | | | | | | | | **Phone Number:** | | | | | | |  | | |
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| **NAME OF PERSON SUPPORTED:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **TYPE OF CASE MANAGER:**  ISC  State Case Manager  QMRP  MCO Case Manager/Support Coordinator/Care Coordinator | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NAME OF CASE MANAGER:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | **PHONE NO:** | | | | | |  | | | |
| **NAME OF ISC AGENCY:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | **PHONE NO:** | | | | | |  | | | |
| **NEXT OF KIN and/or LEGAL REPRESENTATIVE:** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **AMBULATION:**  Ambulatory | | | | | | | | | | | | | | | | | | **COMMUNICATION:**  Verbal | | | | | | | | | | | |  | | | | | | |
| Non-Ambulatory | | | | | | | | | | | | | | | | | | Non-Verbal | | | | | | | | | | | |  | | | | | | |
| **NUTRITION:** Eats Independently | | | | | | | | | | | | | | | | | | **WEIGHT IS:** Normal Weight | | | | | | | | | | | | WEIGHT: | | |  | | | |
| Eats w/ Assistance | | | | | | | | | | | | | | | | | | Overweight | | | | | | | | | | | | HEIGHT: | | |  | | | |
| Tube Fed | | | | | | | | | | | | | | | | | | Underweight | | | | | | | | | | | | | | | | | | |
| **INTELLECTUAL DISABILITY:** | | | | | | | | | Mild | | | | | | | | | Moderate | | | Severe | | | | | Profound | | | | | | | Unknown / Unspecified | | | |
| **BEHAVIORAL / PSYCHIATRIC DIAGNOSES:** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **GENERAL MEDICAL DIAGNOSES:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **HOSPITALIZATIONS / PROCEDURES** (over the past 12 months) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for Hospitalization / Procedure: | | | | | | | | | | | | | |  | | | | Treatment Location: | | | | | | | | |  | | | Date: | | | | | | |
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| **ADDITIONAL INFORMATION FROM PROVIDERS, ADVOCATES, FAMILIES, OR COMMUNITY MEMBERS FOR THE PDRC:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Name of Provider, Private ICF/IID, or DDA ICF/IID:** | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | **Phone Number:** | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | |
| **Person Completing this Form** (please print) | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | **Title:** | |  | | | | |
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| **Signature:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | |  | | | | |
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