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| **INITIAL AGENCY DEATH REVIEW FORM** | | | | | | | | | | | | | | | | | | | | |
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| 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 1915(C) waiver, ECF CHOICES program, Katie Beckett (KB) Part A, or other | | | | | | | | | | | | | | | | | | | | |
| DDA community program; | | | | | | | | | | | | | | | | | | | | |
| 2. A resident of a DDA ICF/IID; or | | | | | | | | | | | | | | | | | | | | |
| 3. A resident of a private ICF/IID when such residence is state-funded or funded by TennCare/Medicaid. | | | | | | | | | | | | | | | | | | | | |
| Providers and ICF/IIDs shall submit this form to the DDA Regional Director and the person’s MCO at the email addresses below. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | | 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) |   ***INFORMATION OF PERSON SERVED*** (attachments may be added if additional space is needed) | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Name (first, middle, last) | | | | | | |  | | | | | | | | | | SSN | |  | |
| Home Address | |  | | | | | | | | | | | | | | | | | | |
| Date of Birth |  | | / |  | / |  | |  | | Date of Death |  | / |  | / |  |  | | Age at Death | |  |
| Name of Provider Agency or ICF/IID | | | | | | | | |  | | | | | | | | | | | |
| Name of Director of Provider Agency, Administrator of Private ICF/IID, or Director of DDA ICF/IID or Chief Officer: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| Name(s) of next of Kin and/or Legal Representative: |  |

|  |  |  |
| --- | --- | --- |
| 1. **Please check “Yes” or “No”** | | |
|  | | |
| **a.  YES  NO** Person Supportedresides in the current community placement less than 12 months. | | |
|  | | |
| **b.  YES  NO** The family or conservator of the person supported was involved in care and treatment. | | |
|  | | |
| 1. **Briefly describe the functional independence in daily living for the person supported.** | | |
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|  | | |
|  | | |
|  | | |
| 1. **Briefly describe the need for special custodial care and supervision of the person supported.** | | |
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|  | | |
| |  |  | | --- | --- | | Name of Person Served: |  |   **4. Briefly describe the physical limitations of the person supported.** | | |
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|  | | |
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|  | | |
| **5. 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.** | | |
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| ***CIRCUMSTANCES SURROUNDING THE DEATH*** | | |
|  | | |
| 1. **Please check “Yes” or “No”.** | | |
|  | | |
| **a.  YES  NO** Cause of death of the person supported was known. | | |
| **b.  YES  NO** An autopsy was done | | |
|  | | |
| **c.  YES  NO** Family or conservator/guardian declined to have an autopsy done. | | |
|  | | |
| **d.  YES  NO** Person supported received emergency medical procedures (e.g., CPR, Heimlich) | | |
| **e.  YES  NO** Death of the person supported was unexpected. If “Yes”, specify why: | | |
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| ***CIRCUMSTANCES ASSOCIATED IN TIME WITH THE DEATH*:** “Associated” as used here does not imply that the | | |
| circumstance “caused” the death, but rather that the circumstance was associated in time with the death. Please | | |
| Check “Yes” or “No”. For any “Yes” response, provide an explanation in the space provided. | | |
|  | | |
| 1. **YES  NO** An actual or suspected seizure | | |
|  | | |
| 1. **YES  NO** A choking incident or aspiration of food/liquids, vomit, or foreign bodies | | |
|  | | |
| 1. **YES  NO** A fall | | |
|  | | |
| 1. **YES  NO** An environmental problem or hazard | | |
|  | | |
| 1. **YES  NO** Self-injurious behavior (e.g., PICA, suicidal behavior) | | |
|  | | |
| 1. **YES  NO** A behavioral incident involving the service recipient | | |
| 1. **YES  NO** A lapse in staff supervision | | |
|  | | |
| 1. **YES  NO** A violent act by a staff person  |  |  | | --- | --- | | Name of Person Served: |  | | | |
|  | | |
| 1. **YES  NO** A violent act by any other individual | | |
|  | | |
| 1. **YES  NO** A “*Do Not Resuscitate*” order and/or *Physician Scope of Treatment* (POST FORM) | | |
|  | | |
| Provide a brief explanation for any “Yes” response to Items #1 to 10 above, attaching additional sheets if needed: | | |
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| ***FOLLOW-UP*** | | |
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| 1. **Please describe any Issues requiring further review or follow-up**: | | |
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|  |  |  |
| Print Name of Person Completing This Form |  | Title |
|  |  |  |
| Signature | | Date |
|  | | |