

AGED AND DISABLED WAIVER NOTIFICATION OF ADW PARTICIPANT DEATH

Directions: Attach completed report to CareConnection©. * = **unexplained deaths only**.

Disclaimer: Verification of cause and time of death may not be available at time of report.

Case Management Agency/PPL	*CM/RC Name:		
	*Phone:		
	*CM/RC Signature and Date:		
INFORMATION ABOUT THE DECEASED			
ADW Participant Name		Date Sent to BoSS	
Medicaid #		Date of Birth	
Date of Death		Time of Death	
Participant Address			
Location of Death			
Cause of Death (Include source of notification)			
MEDICAL DIAGNOSES AND MEDICAL CONDITIONS			
STOP			
<i>Continue for Unexplained Deaths only.</i>			
Type of Death			Yes
Was this an unexplained death (Cause of death undetermined at time of death)?			No
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 (APS, police, Medicaid fraud, physician, IMS, CM or RN, RC, legal representative/family).			

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