

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	*CM Name: *CM Signature and Date:	*Phone:
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	No
Was this an unexplained death (Cause of death undetermined at time of death)?		
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, fire marshal, Medicaid fraud, physician, IMS, Case Manager or RN, participant's legal representative/family).		