District of Columbia
Department on Disability Services
Developmental Disability Administration

Mortality Notification Form

Report Date & Time: ___/___/___ : ____ m Death Date & Time: ___/___/___ : ____ m
Person's Name: _____ MCIS # _____ DOB ___/___/___
Gender: ☐ Male ☐ Female
Address: _____
Residence Type: _____ Provider: _____ Phone No.: ____ - ____ - ____

Location of death: _____
Cause of Death: _____
Was death anticipated as the result of a known condition? ☐ Yes ☐ No DNR Order? ☐ Yes ☐ No
Was death accidental? ☐ Yes ☐ No
OCME contacted: ☐ Yes ☐ No Date: ___/___/___ OCME# _____
Accepted jurisdiction? ☐ Yes ☐ No Funeral Home:: _____
Autopsy requested? ☐ Yes ☐ No

Is Abuse or Neglect Suspected? ☐ Yes ☐ No Was an Abuse/Neglect Report Completed? ☐ Yes ☐ No

(NOTIFICATION) ALL DEATHS

____ Service Coordinator – Name: _____ Date: ___/___/___
____ Family: ____ Guardian: ☐ Advocate ☐ Name: _____ Date: ___/___/___
____ DDA (on call mgr) - Name(s): _____ Date: ___/___/___
____ Health and Wellness Manager – Name: _____ Date: ___/___/___
____ DOH/HRLA (if applicable)
____ Office of the Inspector General

FOR UNEXPECTED DEATHS

1. Police involvement: Yes ☐ No ☐
2. Secure records/environment: Yes ☐ No ☐
3. Conduct on-site visit: Yes ☐ No ☐
4. Complete Immediate Safety Assessment Form: Yes ☐ No ☐

OTHER DETAILS

_____
_____
_____
_____
_____
_____
_____
_____

Completed by: (Name & Title): _____ Date: ___/___/___

Reporter's Name, Title, & Agency: _____ Date: ___/___/___
Address: _____
Phone: ____ - ____ - ____ City: _____ State: _____ Zip Code: _____

Distribution: Original: Person's Master File/Case Manager; Copies: Health and Wellness Manager; IMEU Manager; QE/I Manager; Service Coordinator Supervisor; Quality Management Division Director; OAG