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

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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