

Fax Cover Sheet

To:
Fax number:

From:

Agency
Address (number and street)
City, State, ZIP Code
Name of contact person (name and title)
Telephone number ()

RESIDENCE INFORMATION

Name of deceased:

Date of birth (month, day, year)

Age at death

Social Security number

Gender

Male Female

Race

MRC number (BDDS office use only)

Address of deceased (number and street, city, and ZIP code)

PROGRAM INFORMATION

Service type (check the appropriate service type):

A&D Waiver
 Autism Waiver
 SDC
 Traumatic Brain Injury Waiver
 CHOICE
 SGL
 SL
 Nursing Home
 Medically Fragile Children Waiver
 Other:
 SGL
 DD Waiver
 SS Waiver
 Assisted Living Waiver

Was the deceased ever resident of one of the following State Operated Facility?

Yes No

If Yes, Indicate facility and discharge date (month, day, year)

Fort Wayne State Developmental Center Date of discharge: _____
 Muscat tuck State Developmental Center Date of discharge: _____
 New Castle State Developmental Center Date of discharge: _____

REPORTING CONTACT VERIFICATION

Date of this report (month, day, year)

CONTACT	DATE	TIME	NAME OF PERSON CONTACTED	HOW NOTIFID	NOTIFIED BY WHOM*
BDDS (required)					
APS (required)					
Law Endowment					
Case Manager					
Legal Guardian					