

# 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 <input type="checkbox"/> Male <input type="checkbox"/> 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					