NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

GUIDANCE DOCUMENT

"This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Nebraska Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document."

Pursuant to
Neb. Rev. Stat. § 84-901.03

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Nebraska Department of Health and Human Services
Home and Community-Based DD Services

Notification of Death Provider Report

Please type or print all information.

Complete upon the death of a person who was receiving Home and Community Based Services through the Division of Developmental Disabilities. This report must be sent to the Department of Health and Human Services within ten (10) calendar days. Note: The person completing this form is not attempting to render a professional opinion and is operating based on the known facts immediately following the death. Additional information may be attached.

I. Reporter Information	
TO: NE Department of Health and Human Services P.O. Box 98947 Lincoln, NE 68509-8947 Attn: Mortality Committee Secure Communication (SComm) through Therap to: First Name: DHHSDDQuality and Last Name: Mailbox Fax: 402/471-5177	Date Completing Form: _____ Name of Person Completing Form: _____ Position/Title or Indpendent Provider: _____ Daytime Telephone: _____ Email Address: _____
Agency/Provider Name or Independent Provider:	Local Agency Name, if different:
Address:	City/NE:

II. General Information	
Deceased's Legal Name First: _____ Middle: _____ Last: _____	
Address:	City/State/Zip:
☐ Female ☐ Male	Date of Birth (MM/DD/YYYY): _____/_____/_____
Method of Communication ☐ Verbal, English ☐ Verbal, another language: _____ ☐ Non-Verbal	
Where did the Deceased live? (Check all that apply) ☐ Personal Home or Apartment ☐ Host Home ☐ Shared Living ☐ Group Home ☐ Medical Support Unit ☐ Nursing Facility ☐ Community ICF/MR ☐ Other: _____ Did the Deceased live alone? ☐ Yes ☐ No	
Funding Source (Check all that apply) ☐ Comprehensive Developmental Disabilities (CDD) Waiver ☐ Developmental Disabilities Adult Day (DDAD) Waiver ☐ Private-Pay Arrangement ☐ State Aid	

III. Information Regarding Death

a. Date (MM/DD/YYYY): _____/_____/_____ **Time:** _____ ☐ AM ☐ PM ☐ Estimated

b. Address where death occured
Street Address: _____ City/State/Zip: _____ County: _____

c. Place of death (Check all that apply)
☐ Deceased's Own or Family Home or Apartment (**not** agency-operated)
☐ Hospital: ☐ Inpatient ☐ Emergency Room
☐ Home or Apartment (agency-operated)
☐ Medical Support Unit (agency-operated)
☐ Hospice Facility
☐ Nursing Facility
☐ Other: _____

d. What was the apparent cause of death? (Please select one)
☐ Natural
☐ Accidental
☐ Choking
☐ Drowning
☐ Homicide
☐ Suicide
☐ Traffic Accident
☐ Undetermined
☐ Pending Investigation

Select one of the following: ☐ Expected ☐ Unexpected

e. Did the death occur in a setting where DDD services are provided? ☐ Yes ☐ No
If yes, what type of setting? ☐ Employer ☐ School ☐ Community Activity ☐ Day Service ☐ Residential Home

f. Did the death occur in a private residence when DDD contracted staff were present? ☐ Yes ☐ No
If no to one or both of the above, skip to question g.
If yes, list the names and titles of the staff that were present at the time of the death:

Describe the staff's actions on the scene immediately prior to the death:

Describe the staff's actions on the scene immediately following the death:

Describe the activities of the Deceased in the 24-hour period prior to death:

g. Did mental health issues contribute to the person's death? ☐ Yes ☐ No
If yes, explain:

h. Had the Deceased been ill in the 72-hour (3 days) period prior to death? ☐ Yes ☐ No
If yes, describe:

i. Was the Deceased in hospice care? ☐ Yes ☐ No
If yes, date hospice began (MM/DD/YYYY): _____/_____/_____

j. Was 911 called? ☐ Yes ☐ No ☐ Unknown
If yes, list name and position/title of caller: _____

k. Was CPR administered? ☐ Yes ☐ No ☐ Unknown
If yes, by whom? (i.e., provider staff, paramedics, doctor): _____

l. Was an autopsy requested? ☐ Yes ☐ No ☐ Unknown
If yes, by whom?: _____

(When autopsy is available, please submit a copy of the autopsy report.)

m. Was Law Enforcement called? ☐ Yes ☐ No ☐ Unknown **If no, skip to o.**
Date (MM/DD/YYYY): _____/_____/_____ Time: _____ ☐ AM ☐ PM ☐ Est.
If yes, name and position/title of caller: _____
If yes, which agency? ☐ Local Police ☐ County Sheriff ☐ State Patrol
If yes, name of department: _____
Did Law Enforcement investigate? ☐ Yes ☐ No ☐ Unknown
(When report is available, please submit a copy of the report.)

n. ***Call should occur only in cases of suspected Abuse or Neglect related to death.***
Was **Protection and Safety** called? ☐ APS ☐ CPS ☐ No ☐ N/A **If no, skip to p.**
Date (MM/DD/YYYY): _____/_____/_____ Time: _____ ☐ AM ☐ PM ☐ Est.
If yes, name and position/title of caller: _____
Did Protection and Safety indicate the report would be accepted? ☐ Yes ☐ No ☐ Unknown
(When report is available, please submit a copy of the Protection and Safety report.)

o. List concerns or other patient information regarding the death.

p. Was there or will there be a DDD provider internal investigation conducted? ☐ Yes ☐ No
(If yes, please submit a copy of the complete internal investigation documentation and report when done.)

IV. Medical Information

a. Was the Deceased treated by any doctors or other health care providers within 30 days of date of death?
☐ Yes ☐ No ☐ Unknown

Dates	Doctor/Type of Provider	Diagnosis and/or Recommendations

b. List any hospitalizations within 6 months of date of death, including readmissions and transfers.

Dates	Hospital	Diagnosis and/or Recommendations
_____/_____/_____		
_____/_____/_____		

c. Conditions existing prior to the person's death (Check all that apply)

☐ Allergies (type) _____
☐ Arthritis
☐ Alzheimer's/Dementia
☐ Anemia
☐ Bowel Obstruction (history of) List years: _____
☐ Cancer (type) _____
☐ Cardiac (Heart) Disease: ☐ Cardiopulmonary ☐ Congestive Heart Failure (CHF) ☐ Heart Attack
☐ Other: _____
☐ Diabetes: ☐ Insulin Dependent ☐ Non-Insulin Dependent
☐ Drug Toxicity: ☐ Elevated Medication Levels in Blood ☐ Substance Abuse (history of)
☐ Fracture(s) (type): _____
☐ Gastric Disease (stomach, intestines, etc.) Specify: _____
☐ Hypertension (high blood pressure)
☐ Hypotension (low blood pressure)
☐ Hypothyroidism
☐ Influenza
☐ Notifiable Condition/Communicable Disease Specify: _____
☐ Renal/Kidney Disease ☐ Dialysis
☐ Respiratory Disease ☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Pneumonia
☐ Recurrent Aspiration ☐ Tracheostomy ☐ Oxygen
☐ Seizures
☐ Sepsis/ Septicemia Origin: _____
☐ Smoking ☐ History ☐ Current
☐ List all major Surgical Procedures that occured in the last six months or would be relevant to this report:
1) _____ Reason for surgery: _____
2) _____ Reason for surgery: _____
3) _____ Reason for surgery: _____
☐ Swallowing Disorder ☐ G-Tube ☐ J-Tube
☐ Syndrome Specify: _____
☐ Thrombosis (blood clots)
☐ Other: _____

d. Events occuring within 30 days prior to death (Check all that apply)

☐ Aspiration
☐ Pneumonia
☐ Emergency Safety Intervention (physical hold)
☐ Choking Incident
☐ Infectious or Communicable Disease: _____
☐ Cellulitis or Decubitus Ulcer (pressure sore)
☐ Fall

V. Medications

a. Was the Deceased on prescribed medications? ☐ Yes ☐ No ☐ Unknown
Are medications available on Therap? ☐ Yes ☐ No ☐ Unknown

If medications are not available on Therap, attach most current MARS or medication record or medications by name, dosage, and frequency of dosage and reason/diagnosis if not available in Therap.

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Nebraska Department of Health and Human Services

Directions for the Notification of Death Form

The Notification of Death form is posted on the Division of Developmental Disabilities (DHHS-DD) website: http://dhhs.ne.gov/Pages/DD-Providers.aspx or can be requested from service coordination.

Please complete the Notification of Death form as completely as possible. Some of the information may not be available at the time of death. If unavailable when filling out the form, complete what is available and send a revision if more information becomes available.

Section I. Reporter Information

a. Complete the date of completion of the form.
b. Complete name of person completing form.
c. Complete position/title. If independent provider state this in the form.
d. Complete the daytime telephone number that can be called regarding any questions about the information.
e. Complete email address.
f. Complete agency / provider name / independent provider.
g. State the local agency name, if different than what is listed in Section I.f.
h. State the address of local agency including the city, state and zip code.

Section II. General Information

a. Complete the Deceased Person's full legal name.
b. Complete the address of the Deceased Person immediately prior to death, including the city, state and zip code.
c. Complete gender by checking female or male.
d. Complete date of birth (MM/DD/YYYY).
e. Complete method of communication by which the person communicated by checking the appropriate box.
f. Complete the information about where the deceased person lived. Check all that apply. If "Other" is checked, complete information to explain where the person lived.
g. Complete information regarding the funding source.

Section III. Information Regarding Death

a. Complete the date of death (MM/DD/YYYY).
   Complete the time of death. Check whether it was AM or PM. Check estimated if the actual time of death is not known.
b. Select the apparent cause of death by checking the appropriate box for cause of death.
   Select whether the death was expected or unexpected.
   - An example of expected would be cancer, terminal heart failure, or end stage renal failure.
   - An example of unexpected would be a heart attack or sudden illness.
c. Complete the street address, city, zip code and county where the death occurred.
d. Complete the place of death by checking all the boxes that apply. If other, explain.
e. Complete whether death occurred in a setting where DDD services were provided.
   - If the death occurred in a setting where DDD services were provided, check to indicate the setting the death occurred.
f. Check whether the death occurred in a private residence with DDD contracted staff present.
   If DDD staff were present, please complete the additional information including the staff's action on the scene immediately prior to the death, the staff's action on the scene immediately following the death and the activities of the deceased in the 24-hour period prior to death. If no, skip to question g.
g. Check whether mental health issues contributed to the person's death. If yes, explain.
h. Check whether the Deceased Person was ill 72 hours prior to death. If yes, explain (such as in the hospital, vomiting or increased temperature).
i. Check whether the Deceased Person was receiving hospice care. If yes, enter the date that hospice began (MM/DD/YYYY).
j. Check whether 911 was called. If yes, list the name of the person who called the number and his or her title.
k. Check whether CPR was administered. If yes, provide a general description such as provider staff or paramedics not names.
l. Select information whether an autopsy was requested. If yes, list who requested it and provide a copy of the report.

m. Check whether law enforcement was notified. If yes, indicate the date (MM/DD/YYYY), and time of the call and the name and position of caller, the agency that was notified and whether law enforcement investigated the death. If there is a report available, please provide a copy of the report.
n. Indicate whether protection and safety were called. If yes, indicate the date (MM/DD/YYYY), and time of the call and the name and position of caller. Also indicate whether protection and safety indicated the report would be accepted. If there is a report available, provide a copy of the report.
o. List any concerns that were expressed by staff or family about the event.
p. Select whether a DDD provider internal investigation will be conducted. If yes, please provide a copy of the complete internal investigation documentation.

Section IV. Medical Information

a. Indicate whether the Deceased Person was treated by any doctors or health care providers in the last 30 days. If so, include the dates, doctor or type of provider and diagnosis and/or recommendations from these contacts.
b. List information regarding hospitalizations within the last 6 months of the date of death, include the dates of hospitalization, name of hospital and diagnosis and/or recommendations.
c. Select all the conditions that the person had prior to or at the time of death. Add comments as appropriate.
d. Select events that have occurred within 30 days prior to death. Check all that apply.

Section V. Medications

a. Indicate whether the person was prescribed medication(s). If yes, indicate whether the medication list is in Therap. If the person was prescribed medications, but they are not listed in Therap, attach a list of medications at the time of death.

If additional space is needed in any section, please use the open box at the end of the notification to continue your comments (and indicate from what section the text is a continuation).

After completing the form, send the form through Therap using Secure Communications (SComm) to: First name - DHHSDDQuality and Last name - Mailbox. Or fax to 402-471-5177. If further information is obtained after the initial information is sent, it should be sent through SComm or the fax number as well.