ATTORNEY GENERAL OF TEXAS
GREG ABBOTT

Medicaid Fraud Control Unit
Resident Death Reporting Form

Date of Report: _____

Agency/Facility Information

Facility Name: _____

Vendor/Provider #: _____

Address: _____

City, County, ZIP Code: _____

Telephone Number: _____

Facility Director/Administrator's Name: _____

Type of Facility (NF, SNF, ICF/MR, etc.): _____ Capacity: _____

Corporation Name: _____

Address: _____

City, County, ZIP Code: _____

Telephone Number: _____

Identity of Deceased

Full Name of deceased: _____ SSN: _____

Race/Ethnic Group: 1.___ African-American 2. ___ Native American 3. ___ Anglo 4. ___ Asian
5. ___ Hispanic 6. ___ Middle East 7. ___Other (Specify) _____

Gender: _____ DOB: _____ Age: _____

Original date of admission: _____

Original diagnoses at time of admission: _____

_____

_____

Name of next of kin: _____

Address/Telephone Number: _____

Circumstances of Death

Date of Death: _____ Time of Death: _____ a.m./p.m.

Was death attended? ___ Yes ___ No If no, date discovered: _____ Time: _____a.m./p.m.

Full name of witness to death/discovery: _____ Date of Birth: _____

Address/Telephone Number: _____

Relationship to deceased: _____

License Type/Number: _____

If death was attended, name of attending physician: _____

Address: _____

City, State, ZIP Code: _____

Telephone Number: _____

Did death occur in the reporting facility? ___Yes ___No If no, list specific location of death, as well as date/time and method of transfer from the reporting facility:

_____

_____

All known diagnoses of deceased at time of death: _____

_____

Medical cause of death determined? ___Yes ___No If yes, list cause: _____

_____

Suspected manner of death (natural, accidental, suicide, etc.): _____

Summary of events involved in death (DO NOT WRITE “SEE ATTACHED REPORT”):

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Attach additional sheets if necessary)

Notifications

Was the Texas Department of Human Services contacted? ____ Yes ____ No

Date: _____ Time: _____ a.m./p.m.

Was local law enforcement contacted? ___ Yes ___ No If yes, name of agency, name of responding officer and case number:

_____

_____

List other regulatory or licensure agencies contacted and list their case numbers: _____

_____

_____

Disposition of Deceased

List the disposition of the deceased (i.e., coroner's office, mortuary, etc.) List complete name of entity, address, and phone number:

_____

_____

_____

Supplementary Information

Are there any other reports, photographs, witness statements, or documentation pertaining to this death, not previously disclosed? If so, list the type of report with applicable case number if known as well as the entity having custody. If your facility is in possession of any of these reports, please attach a copy.

_____

_____

_____

Additional Comments

_____

_____

_____

_____

_____

Report prepared by: _____ Title: _____

Signature of Agency/Facility Administrator: _____Date: _____