COMMONWEALTH OF MASSACHUSETTS
DISABLED PERSONS PROTECTION COMMISSION
DEATH REPORTING FORM

Please call 1-800-426-9009 to file an oral report.
This form should be returned within 48 hours of the oral report.
Mail to: DPPC, 300 Granite Street, Suite 404, Braintree, MA 02184
Fax to: (857) 403-0296 Attn: Hotline
Or email to: DPPChotline@massmail.state.ma.us

For Department Use Only:

Case #: _____
Referral Agency: _____
Screening Decision: _____
Oversight Officer: _____
Date Received: _____

REPORTER INFORMATION:

Name: Click here to enter text. **Occupation:** Click here to enter text.
Agency: Click here to enter text. **Address:** Click here to enter text.
Telephone #: Click here to enter text.
Alternate Telephone #: Click here to enter text.

INFORMATION ON THE DECEDENT:

Name: Click here to enter text.
Address: Click here to enter text.
DOB or approximate age if DOB not known: Click here to enter text. **Gender:** ☐ **M** ☐ **F**
Social Security Number: XXX-XX-Click here to enter text.
Disability: Click here to enter text. **Known medical conditions:** Click here to enter text.
►**Was the Decedent receiving any care or supervision at the time of death? Explain:** Click here to enter text.
►**Agency providing services at the time of death:** Choose an item.

DETAILS REGARDING THE DEATH:

►**Summary of the details surrounding the death. (Include names, dates, times, and specific facts and any information regarding health or other issues leading up to the death):** Click here to enter text.

DETAILS REGARDING THE DEATH(continued):

►**Date and time of death:** Click here to enter text.
►**Cause of death:** Click here to enter text.
►**Location of death:**
Address: Click here to enter text.
Program or facility name: Click here to enter text.
Type of program/facility: Click here to enter text.
►**Is there any reason to believe that the death was the result of abuse or neglect? If yes, please explain:** Click here to enter text.

►**Were there any unusual or suspicious circumstances surrounding the death? If yes, please explain:** Click here to enter text.

►**Were local police notified?** ☐ **Yes** ☐ **No**
Name of Police Department: Click here to enter text.

►**Was the Medical Examiner notified?** ☐ **Yes** ☐ **No**

►**Was an autopsy conducted?** ☐ **Yes** ☐ **No**

COLLATERALS:

►**Persons involved that may have more information about the death:**
Name: Click here to enter text.
Relationship: Click here to enter text. **Agency:** Click here to enter text.
Telephone #: Click here to enter text.

Name: Click here to enter text.
Relationship: Click here to enter text. **Agency:** Click here to enter text.
Telephone #: Click here to enter text.

Was an oral report filed: ☐ **Yes** ☐ **No**
If not, please call (800)426-9009 to file an oral report.
If so, indicate date and time filed. Date: Click here to enter a date. **Time:** Click here to enter text.
****PLEASE ATTACH ADDITIONAL INFORMATION IF NECESSARY.**

Click here to enter text. Click here to enter a date. Click here to enter text.
Signature of Reporter **Date** **Time**