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|  | The Community Partnership for the Prevention of Homelessness Fatality Report Form |

The Community Partnership for the Prevention of Homelessness (TCP) requires all of it subcontractors to report a fatality within the program to TCP within 24 hours from the occurrence of the Fatality or within 24 hours of becoming aware of the Fatality. Please complete this form in its entirety and submit a PDF Copy of the report to the link noted below. Please ensure that the below report is completed in its entirety and includes all of the required signatures before submission. If you have any questions regarding the completion or submission of this report, please contact Ashley Burrell, Senior Compliance Specialist at [aburrell@community-partnership.org](mailto:aburrell@community-partnership.org).

[[**https://app.smartsheet.com/b/form/1777fd74f18a4665b8bd90e9556932b6**](https://app.smartsheet.com/b/form/1777fd74f18a4665b8bd90e9556932b6)](https://app.smartsheet.com/b/form/1777fd74f18a4665b8bd90e9556932b6)

### Provider Information

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| --- | --- | --- | --- | --- |
| Name: |  |  | Date of Report: |  |
| Title: |  |  | Phone Number: |  |
| Email: |  |  | Program Name: |  |

### Client Information

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| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Name of Deceased: |  | | |  | Age of Deceased: | |  | | Date & Time of Death: |  | | |  | Cause of Death: | |  | | Location of Death: |  | | |  | Source of Report | |  | | **Hypothermia Related:** | | Yes  No | **Medical Examiner Notified**  **If checked, when?** | | |  | | |
| Provider Observations **Please provide the date in which the client of interest was last seen by program staff prior to the client’s death:** \_\_\_\_\_\_\_\_\_\_\_\_\_  How did the client appear on this day? Were there any visible physical concerns? Did the client appear to be in distress?   |  | | --- | |  | |

### Incident Description

**Use the space below to provide a descriptive narrative regarding the incident. If additional space is needed, please use an additional sheet of paper and attach to this report.**

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### Provider Follow-Up

**Has program staff contacted the client’s noted emergency contacts to inform them about the client’s death? Yes No**

**Has the client’s HMIS profile (including case notes) been updated to reflect the client’s death? Yes No**

**Has the client been exited from the program in HMIS? Yes No**

***(Please note that following confirmation of a client’s death, the provider must exit the client out of the program in HMIS. This can be done by accessing the client’s HMIS profile, clicking the Entry/Exit Tab, select the pencil next to the exit date to edit, update the exit date to reflect the date of the client’s death, include the reason for leaving to indicate, “death” and click “save and continue”).***

### Acknowledgment

**By signing this form, you affirm that the information on this report is true the best of your knowledge.**

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| **Preparer Signature** | **Date** |
|  |  |
| **Program Manager Signature** | **Date** |