PUBLIC ASSISTANCE FRAUD COMPLAINT FORM

Please complete this form with as much information and in as detailed a manner as possible.

Please remember that all complaints are kept strictly confidential

1. Complaining Party

Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Alt Phone: _____

Email: _____

2. Fraud Information

a. Type of Fraud

- ☐ Medicaid
- ☐ TANF - TemporaryAssistance to Needy Families
- ☐ Safety Net
- ☐ Food Stamps
- ☐ Day Care
- ☐ HEAP – Home Energy Assistance Program
- ☐ Other: _____

b. Complaint Against Recipient of Benefits

Name: _____

DOB or Age: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

c. Provider of Services

Provider's Name: _____

Provider's ID Number: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Location of Fraudulent Activity: (if different from Provider's address) _____

Insurance Claim Number: _____

3. Description of the suspected fraudulent or abusive activities

Give a statement that clearly describes the persons involved, dates, locations and nature of the incident or issues that you are reporting. The more specific the information you provide us, the better we will be able to follow-up on your complaint.

_____

_____

_____

_____

***Have you contacted your local law enforcement agency with regard to this Complaint?**

- ☐ Yes
- ☐ No

If yes, what is the name of the agency and when did you contact that agency?

_____

_____

***Have you contacted any other local or state agency with regard to this Complaint?**

- ☐ Yes
- ☐ No

If yes, what is the name of the agency and when did you contact that agency?

_____

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