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| Text  Description automatically generated | **Client Fraud Report**  \* Indicates Required Field. | | | CLIENT PROVIDERONE ID NUMBER (NINE NUMERICAL DIGIT) \*  **WA** | |
| CLIENT ACES ID, IF AVAILABLE | |
| TYPE OF FRAUD SUSPECTED \*  Client has unreported income  Client owns unreported assets (vehicles, boats, motor homes, etc.)  Client is living at a different address, out of state, or out of country  Client is receiving benefits under false or multiple names  Client claims coverage for treatments or supplies not received (signs timesheets for hours not provided; submits receipts for items not used for client)  Other | | | | | |
| ALLEGATION SUMMARY \*  Describe the nature of suspected fraud. Attach any available supporting documents (timesheets, bills, etc.). | | | | | |
| DATES \*  Provide date, dates, or date span of suspected fraudulent activity. | | | | | |
| OTHER CONTACTS  Provide names and contact information of others who may have information about this allegation. | | | | | |
| MONETARY IMPACT  Enter the approximate amount of money involved in the fraudulent activity (if known). | | | | | |
| OVERPAYMENT \*  Has an overpayment been initiated?  Yes  No If yes, please attach a copy of the overpayment paperwork. | | | | | |
| OTHER REPORTS  Have you reported this to anyone else? Check all that apply.  No one  Residential Care Services  Other  My supervisor  Adult Protective Services  Law enforcement  Child Protective Services | | | | | |
| REPORTER’S NAME \* | | DATE FORM COMPLETED \* | REPORTER’S EMAIL ADDRESS \* | | REPORTER’S PHONE NUMBER \* |
| REPORTER’S POSITION \*  Case Manager / Social Worker  Supervisor  Manager / Administrator  Support Staff  Other | | | | | |
| AGENCY \*  Choose the agency you (the reporter) work for.  AAA  HCS  DDA | | | | | |
| REGION / AAA \*  Region where client is served.  1N  1S  2N  2S  3N  3S  HQ  AAA; name: | | | | | |