

PUBLIC ASSISTANCE FRAUD COMPLAINT FORM

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

1. Complaining Party

Do you wish to remain anonymous? No Yes (if yes skip to section 2)

Name: _____
Address: _____
City: _____
State: _____
Zip: _____
Phone: _____
Alt Phone: _____
Email: _____

2. Fraud Information

a. Type of Fraud

- Medicaid
- TANF Temporary
- Assistance 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?