

# Client Fraud Report

CLIENT PROVIDER ONE ID NUMBER  
(NINE NUMERICAL DIGIT) \*

**WA**

CLIENT ACES ID, IF AVAILABLE

\* Indicates Required Field.

**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
- My supervisor
- Law enforcement
- Residential Care Services
- Adult Protective Services
- Child Protective Services
- Other

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:

Email completed form to [ADSAFraud@dshs.wa.gov](mailto:ADSAFraud@dshs.wa.gov).