Spokane County Counseling and Recovery Services (CAReS) Division

Compliance, Fraud, and Abuse Report Form

Date: _________________ Date(s) the suspected violation occurred/is occurring: ___________________________

Date of Discovery: _________________ How was this discovered? ___________________________________________________________________________

Name of Individual/group suspected of committing a violation: _____________________________

What kind of fraud are you reporting?

- [ ] false documentation
- [ ] potential criminal acts
- [ ] fraudulent billing practices
- [ ] conflicts of interest
- [ ] kickbacks/bribes
- [ ] unethical behaviors
- [ ] confidentiality violations
- [ ] other _____________________________
- [ ] inappropriate and unprofessional behavior related to practice guidelines.

Please describe the reason you believe a violation has occurred (who, what, where, when, how)

Please list any supporting evidence and where it can be obtained

Has this been reported to any other authorities? Please list if yes.

The information you share will be investigated and addressed in a timely manner. Every effort will be made to keep your identity confidential. The compliance team that investigates a complaint may include the Healthcare Compliance Analyst, compliance officer, senior management and Spokane County attorneys. We are required to investigate reports and take appropriate corrective action. In addition, we are required to report some illegal issues directly to federal and state authorities.

You may prefer to report anonymously. However, we will be unable to follow up or get additional necessary information if you do not provide your name and contact information. Your name will be kept confidential to the extent possible under the law. By law, your employer may not retaliate against you for making good faith reports of potential violations.

_______________________________________________________________________________________________

Optional Information:

Person Reporting – Name ____________________________ Title _____________________________

Phone ____________________________ Email: ____________________________

Please mail this form to: Kate Kennedy, Health Care Compliance Analyst
Spokane County CSD
1116 W. Broadway Avenue
Spokane, Washington 99260