Required____
Local______

ELMONT UNION FREE SCHOOL DISTRICT
Elmont, New York

MEDICAID COMPLIANCE PROGRAM *1348*

SPECIAL EDUCATION *COMMUNITY RELATIONS*

COMPLAINT OF ALLEGED MEDICAID FRAUD

This form is to be filed as part of the Formal Procedure in order to initiate a complaint of alleged fraud, waste, and/or abuse of the Medicaid program.

*Your name (optional):*____

*Address (optional):*____

*City (optional):*_________________________*State:*________ *Zip Code:* ________

Home Phone (optional) : (___) ________________________________

*Status: circle one - Instructional Staff - Non-Instructional Staff – Contractor – Volunteer - Supervisory Staff - Community Member - Other*_______________

Describe the Alleged Incident (s):

____

____

____

____

Have you also filed charges with a Federal, State, or Local Government agency?

Yes ____________

No ____________

Name(s) and office address of the individual(s) who perpetuated the abuse:

____

____

____

Identify all persons, if any, who may have also witnessed the incidents described above:

____

____

____

Optional:

I swear or affirm that I have read the above complaint and that it is true to the best of my knowledge, information and belief.

____
Complaint's Signature

Regulation
Adopted: 09/15/10 (Approved Board Meeting 09/14/10)
Amended: