Anonymous & Confidential Reporting Form

for Potential Compliance Issues and/or Concerns

BHSN

TRANSFORMING CARE | ENRICHING LIFE

ANONYMOUS COMPLIANCE CONCERN REPORTING FORM

Organization: Behavioral Health Services North, Inc. (BHSN)

Program Area (if known):_____

Location where potential incident occurred:_____

Street Address:_____

City:_____ State:_____

Please Identify the Person(s) Thought to Be Involved:

	Name	Title or Relationship to BHSN
Person #1	_____	_____
Person #2	_____	_____
Person #3	_____	_____

Please note: BHSN provides agency staff and members of the community the opportunity to anonymously share suspected concerns regarding compliance matters. These matters may include, but are not limited to issues related to fraud, waste, and abuse. Persons reporting compliance issues shall be protected under BHSN's policy of non-intimidation and non-retaliation.

BHSN will ensure that the confidentiality of persons reporting compliance issues shall be maintained unless the matter is subject to a disciplinary proceeding, referral to or investigation by the New York State Medicaid Fraud Control Unit, Office of the Medicaid Inspector General, law enforcement, or disclosure is required during a legal proceeding.

Written anonymous reports can be made by mailing a completed copy of this form to BHSN Compliance Officer, 22 US Oval - Suite 218, Plattsburgh, NY 12903. Anonymous concerns can also be shared by phone by calling *67 (518)563-8206 x2500.

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Please describe the nature of the concern (more space is available on next page):

Please provide the specific or approximate date and time when the concern occurred:

How long do you think this issue has been going on?

How did you become aware of the concern?:

Please list any other individuals that you believe may have information about the concern:

	NAME	CONTACT INFORMATION IF KNOWN
Person #1	_____	_____
Person #2	_____	_____
Person #3	_____	_____

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Please provide any additional information that you would like to include:

FOR ADMINISTRATIVE USE ONLY

*Date Received*_____

*Staff Receiving*_____

On behalf of Behavioral Health Services North, we thank you for your assistance.