## WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES FRAUD REFERRAL FORM IFM-1

Case Name:	Case Number:		County Number:			
Date of Birth:	:: Soc. Sec. Number:		Date of Last Application Review:			
Programs Overpaid:	Cash Assistance	Food Stamps	Medicaid O	her:		
Estimated Fraud Perio	od: FROM:	(MI	M/YY) TO:		(MM/YY)	
UNREPORTED INFO	RMATION: (Fill in known	details in Summar	ry section)			
☐ Income ☐ Assets ☐ Residence	d Composition (Someone (Someone with unreported e (Someone with unreported E (Someone living out of State (Someone ELIGIBILITY FAC	earned / unearned Bank Accounts? ( ate? Who? Whe	CDs? Autos? Wh	o has it? Where is it'	?	
SOURCE OF INFORI	MATION: (Person making	the original comp	laint / informing Dh	HHR)		
Name:	Telep	hone:	Address:			
* Is this person w	villing to be known and go to or validated the complaint?	court if necessary				
Worker Signature:			Date:			
	Ec	OR IFM USE O	NI V			
AG Error Yes No						
Suspect Over Ag			No -Issuance Less Th	an \$1,000 ☐ Yes	∏No	
Agency Error	☐ Yes ☐ No		Lack of False Statement in Record Yes No			
Vehicle Case	☐ Yes ☐ No		or R & R Incomplete		□ No	
Terminally III or Dead ☐ Yes ☐ No Fraud Ended More Than Two Years Ago ☐ Yes ☐ No						

IFM-1 (Revised 03/04)