THE INSTITUTE FOR HUMAN SERVICES, INC.

CO Use Only

Date Rec. _____
ED _____
BD _____
Closed _____
Report # _____

Date:

Please note: Form may be submitted anonymously.

Name (Optional): _____

Contact Number (Optional):

Please Check (Optional): ☐ **Employee** ☐ **Volunteer** ☐ **Client**

Type of issue: _____

Date Issue occurred:

Detailed description of the issue:

Please email the completed form to Kelsie Acor—Medicaid Corporate Compliance Officer: Compliance@ihsnet.org

Or mail to The Institute for Human Services, Inc. 50 Liberty Street Bath, NY 14810

Attn: Medicaid Corporate Compliance Officer

Or place in the drop box at the Institute for Human Services, Inc. second floor