Lifeline Connections
hope. help. Healing.

Compliance Report Form

If you believe you have a compliance concern, please fill out the contact information and complete either sections 1, 2, or 3 below. Please return the information to:

Compliance Officer
PO Box 1678 Vancouver, WA 98668
Phone: 360-397-8246
Fax: 360-397-8450
Email: compliance@lifelineconnections.org

Non-Retaliation Statement: The Agency, nor any of its officers, directors, or supervisors, shall intimidate or take retaliatory actions against any employee of the agency, who makes a report of the type defined below in good faith and without malice.

Directions:
Fill out the one section applicable to the type of Incident you are reporting:
- **Section 1: Breach of secured Protected Health Information**
- **Section 2: Non-Compliant Business Operations (staff member/ethical/WAC/providing services out of scope/violation of safety law/regulations)**
- **Section 3: Fraud, Waste, and Abuse Incident (Billing/Financial/Patient/Services)**

Contact information of person completing report:

Date Submitted to Compliance: ______________________

Check this box if reporting section 2 or 3 and wish to remain anonymous: ☐

Name: ______________________________

Department: ______________________________

Phone Number: ______________________________

Email address: ______________________________

Section 1: Breach of Secured Protected Health Information (PHI)

Date of Breach: ________________ Date of Discovery: ____________

How many patients were affected by the breach: _____________

Staff members involved: ____
(Including name & department if known)

____

Contact information for patient(s) affected: ____
(Including Name & Client ID# if known).
If you need additional space, attach an additional sheet.

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Detailed description of the breach (including the **location**, **a description of how the breach occurred, what information was released, person or entity the information was released to** and any additional information needed.)

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NOTICE: FOIA and HHS regulations may require that the information reported in this section be released publicly by the government. Breaches impacting more than 500 individuals may be posted on the HHS website. Further, the information contained in this report will be reported by OCR annually to Congress with every effort (permitted by law) to protect the information herein.

Section 2: Non-Compliant Business Operations

Date issue identified: __________ Date Reported to Director: _____________(if applicable)

Date submitted to Compliance Officer: ________________

Department impacted: ____

Contract impacted (if applicable): ____

Detailed description of the incident (including the **key issue(s), background issue, etc.)**

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Number of patients impacted: ________ Monetary impact (if known): __________

If patient impacted, provide a patient description including the patient name and patient ID:

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Number of clinicians/staff impacted: ________

Policy or procedure update needed?
If yes, indicate which document is in need of being updated: ____

Suggested resolution:

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Section 3: Fraud, Waste, and Abuse Incident

DEFINITIONS

Fraud is generally defined as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program. (18 U.S.C. § 1347)

Waste is overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Abuse is payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment.

Date of incident: _____________

What department did the incident occur? ____

Incident type:

☐ Claims/Encounters
☐ Administrative/Financial
☐ Patient Fraud
☐ Delivery of Services
☐ Other: __________________________________

Potential wrong-doing committed by:

☐ Provider(s)/Staff(s)
☐ Patient
☐ Other: __________________________________

If regarding an employee(s), provide the following information:

Employee(s)' name(s): ____

If regarding a patient(s)', provide the following information:

Patient(s)' name: ____

Patient(s)' ID number (if known)___________________________

For other, provide the following information:

Name(s): ____

Detailed description of the incident (include **<u>who</u>, <u>what</u>, <u>where</u>**, and **<u>when</u>**; provide description of systems or other unique elements of the department the incident occurred in).

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