Revision Date:
October 1, 2019

Background:
This section provides policies and procedures for reviewing cases for potential fraud in CAPI.

Purpose:
This section is revised for the sunset review. No Program rules have changed.

Policy:
Fraud prevention and detection is a primary goal of HHSA. Customers who change their statements regarding their current situation must clarify the information to establish eligibility. It is the worker's responsibility to ensure that all information in the case file is consistent. Lack of clarification is cause for case denial or suspension. If conflicting information exists, it must be corrected or clarified by the customer or a referral must be made to Public Assistance Fraud Division (PAFD).

1. Definitions:
The table below shows the definition of some terms used in this section.

Note: The person mentioned does not need to be the customer or anyone related to, or acting on behalf of, the customer.

Term	Definition
Fraud	Exists when any person knowingly, willfully and with intent to defraud: • Made or caused to be made a false statement to obtain benefits, obtain a continuance or increase of benefits, or avoid a reduction of benefits • Failed to disclose or misrepresented a fact, which could have resulted in a denial, suspension, or reduction of benefits.
Similar Fault	Exists when any person: • Knowingly failed to disclose a fact which, if disclosed, could have resulted in a denial, suspension, or reduction of benefits • Made statements that he/she knew to be untrue or incomplete during the process of obtaining benefits for continuing to obtain benefits. Intent to defraud is not required.

2. Worker's Role in Fraud Prevention/Detection/Referral:
Workers are responsible for issuing CAPI assistance to customers who meet all eligibility requirements. There are times when the documentation is questionable, or the customer's information is not consistent. In these situations, inconsistencies must be clarified prior to issuing benefits.

Make every effort to ensure that the customer understands his/her responsibilities to provide accurate and truthful information and to report within 10 days any changes that may affect his/her eligibility and/or grant amount. The customer must understand the penalties for failing to report truthfully and promptly. Review these responsibilities with the customer at each application and redetermination. Document in the case record to show if the customer appeared to understand these responsibilities.

Obtain all verifications mandated by the program and review these verifications to determine if they are questionable, inconsistent, or appear to have been altered. Attempt to resolve any conflicting, inconsistent, or incomplete information with the customer to the fullest extent possible. Fully document all contacts, responses from the customer, and any additional information received, as a result of contacts in the case record. If the inconsistent or questionable information still cannot be resolved, then initiate a fraud referral.

Information indicating that HHSA employees may have assisted customers to commit fraud or have committed fraud themselves must be elevated immediately to the Agency's Internal Investigations section. All staff is expected to cooperate with Internal Investigations. While the investigation is in progress, take no action on the application in question or make any changes to an active case in question without consultation with the Internal Investigations Manager.

If a questionable customer situation exists and the worker is uncertain if a referral should be made, consult with the supervisor and/or Public Assistance Investigator.

The table below shows some guidelines in clarifying inconsistent information.

Process	Action
Ask the Right Questions	Workers have the right to ask questions regarding the customer's situation which pertain to eligibility for assistance. If the information is not consistent with the previous case record information, ask the customer why the information is not consistent. If the customer refuses to clarify inconsistent information, aid must not be issued or continued.
Gather Accurate Information	It is the worker's responsibility to gather accurate information. If the customer cannot provide accurate information, assist the customer. Third party verification may be necessary in situations where the customer cannot provide accurate information. Verify information before issuing assistance or before allowing assistance to continue.
Review Documentation Carefully	All case documentation must be reviewed carefully for content and consistency. Each form, narrative entry, and piece of case documentation must build the history of the customer's situation. All forms and NOAs must be dated and allow the reader of a case file to understand the customer's situation.
Share Information Across Programs	In situations where companion cases exist, compare case information. New information, such as IEVS reports, must be shared with a worker who has the other active case. If information is not imaged for the companion case, enter a case comment.
Sworn Statements	In situations of abuse, obtain a sworn statement form the victim or victim's representative when the victim is not competent. This sworn statement may be used as verification of abuse if it is determined that the person is credible and documents this in the case record.

3. Allegation of Fraud:

Processing Guide 99-113.2A shows the actions based on the type of allegation and how it is received.

Procedure:
Follow the actions in the policies above and Processing Guide 99-113.2A for fraud prevention and detection in CAPI.

Program Impact/s:
None.

References:
MPP 20-000 and 20-200

Sunset Date:
This policy will be reviewed for continuance on or by 10/31/2022

Approval for Release:

9-25-19

Rick Wanne, Director
Eligibility Operations