

<div>PROGRAM INTEGRITY UNIT REFERRAL (CONFIDENTIAL REFERRALS AND TIPS ONLY)</div>		BFPP FILE NO. 2 - - -	
		TYPE CODE: 23	
SECTION I: REFERRAL INFORMATION - Completed by screener, manager, or administrator			
1. INDIVIDUAL'S NAME (First Name, Middle Initial, Last Name)		2. REFERRED BY (First Name, Middle Initial, Last Name)	
3. COUNTY/RECORD NUMBER		4. INDIVIDUAL NUMBER	
5. LANGUAGE PREFERENCE - ENTER LANGUAGE NAME (DO NOT ENTER CODE.)			
6. ASSISTANCE PROGRAMS/SERVICES APPLIED FOR OR RECEIVING			
<div><div><input type="checkbox"/> TANF <input type="checkbox"/> SNAP <input type="checkbox"/> SA <input type="checkbox"/> MATP</div><div><input type="checkbox"/> LTC <input type="checkbox"/> LIHEAP <input type="checkbox"/> CHILD CARE <input type="checkbox"/> EMPLOYMENT &amp; TRAINING <input type="checkbox"/> OTHER _____</div><div><input type="checkbox"/> SSI related MA CAT: _____ <input type="checkbox"/> TANF related MA CAT: _____ <input type="checkbox"/> GA related MA CAT: _____ <input type="checkbox"/> MG related MA <input type="checkbox"/> PCO related MA</div></div>			
7. REFERRAL CODE			
PROGRAM INTEGRITY USE ONLY FROM THIS POINT FORWARD:			
8. IMCW, MANAGER, OR ADMINISTRATOR NAME (First Name, Middle Initial, Last Name)			
9. DOES INDIVIDUAL CLAIM DOMESTIC VIOLENCE (DV)? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, AND THE CLIENT IS RECEIVING TANF, WAS THE REFERRAL REVIEWED AND APPROVED BY BOP? <input type="checkbox"/> YES <input type="checkbox"/> NO			
REFERRAL REVIEWED BY:			
COMMENTS:			
SECTION II: REASON(S) FOR REFERRAL TO OSIG (Explain) - Completed by IMCW, manager, or administrator.			
<div></div>			
SIGNATURE		DATE	

SECTION III: FINDINGS - Completed by OSIG Investigator		BFPP FILE NO. 2 - - -	
		TYPE CODE: 23	
1. DATE RECEIVED	2. INVESTIGATOR NAME (First Name, Middle Initial, Last Name)	3. DATE RETURNED	
4. INVESTIGATIVE FINDINGS (Use continuation page, if necessary.)			
INVESTIGATOR SIGNATURE		DATE	
SECTION IV: RESULT OF INVESTIGATION - Completed by IMCW, manager, or administrator. NOTE: Please return this completed and signed form to the OSIG (if applicable) within 30 days.			
ACTION TAKEN (Check box that applies.)		*AUTHORIZED WITH REDUCED BENEFITS	
<div><input type="checkbox"/> 61. NO REDUCTION IN BENEFITS</div> <div><input type="checkbox"/> 62. DENIED/CASE CLOSED</div> <div><input type="checkbox"/> 63. VOLUNTARY WITHDRAWAL</div> <div><input type="checkbox"/> 64. REDUCED BENEFITS *</div> <div><input type="checkbox"/> 65. REJECTED - CAO ACTION</div>		GRANT BENEFIT REDUCED	
		FROM TO	
		Cash:	\$ to \$
		Child Care:	\$ to \$
		SNAP:	\$ to \$
		LTC:	\$ to \$
		Special Allowance:	\$ to \$
LIHEAP:	\$ to \$		
MATP:	\$ to \$		
MA:	persons to persons		
COMMENTS			
SIGNATURE		DATE	

## **REFERRAL REASON CODES**

- 1 INCOME - ZERO INCOME
- 2 INCOME - MONTHLY EXPENSES EXCEED REPORTED INCOME
- 3 INCOME - FAMILY OR FRIENDS PROVIDING VOLUNTARY SUPPORT/LOANS
- 4 INCOME - CONTRADICTORY OR INCONSISTENT INCOME STATEMENTS
- 5 INCOME - SELF EMPLOYMENT
- 6 RESIDENCY - NEW TO PENNSYLVANIA
- 7 RESIDENCY - NO FIXED MAILING ADDRESS OR LISTING A PO BOX WITHOUT A PERMANENT ADDRESS
- 8 HOUSEHOLD COMPOSITION - LEGALLY RESPONSIBLE RELATIVE IS UNKNOWN
- 9 HOUSEHOLD COMPOSITION - QUESTIONABLE ABSENT PARENT/SEPARATION