## Bureau of Special Investigations Referral Form

Record <u>all</u> pertinent information related to the Referral in the space below. Anonymous informants who do not wish to be contacted must be asked to provide as much information as possible to ensure allegations can be investigated.

Please phone 1-877-282-6657 OR fax (518) 402-1637 OR email: foodfraud@health.ny.gov OR

bsiwicvendors@health.ny.gov OR mail the completed Referral to BSI, PO Box 2061, Albany, NY 12220-2061.

| Individual Taking Referral   |        |   |     |       |          |     |
|------------------------------|--------|---|-----|-------|----------|-----|
| Name                         |        | LA/VMA Name                                     |     |       |          |     |
| Email                        |        | Phone #   | ( ) |       |          |     |
| Informant/Caller Information |        |   |     |       |          |     |
| Name                         |        | Does Informant/Caller wish to remain anonymous? |     |       | ′es 🗆 No |     |
| Address                      | Street | City/Town                                       |     | State |          | Zip |
| Email                        |        | Phone #   | ( ) |       |          |     |

| Referral Information<br>Complete Relevant Information Based on the Subject of the Referral |                           |                     |  |  |  |  |
|--|---------------------------|---------------------|--|--|--|--|
| Subject of the Referral  | Vendor/Store/Store Employ | /66                 | WIC Local Agency/WIC Vendor<br>Management Agency/WIC Staff |  |  |  |
| (Who/What is the referral about)   | WIC Participant           | □ Other             |  |  |  |  |
| Date Referral Received   |                           | Date(s) of Incident |  |  |  |  |

| Complete this Section if the Referral is about a WIC Vendor/Store/Store Employee |        |      |                     |  |     |  |
|--|--------|------|---------------------|--|-----|--|
| Store Name   |        |      |                     |  |     |  |
| Store Address  | Street | City | City/Town State Zip |  | Zip |  |
| Phone #  | ( )    | Ve   | ndor ID #           |  |     |  |
| Store Owner's Name   |        |      |                     |  |     |  |
| Store Employee Name  |        |      |                     |  |     |  |

| Complete this Section if the Referral is about a WIC Participant |        |         |     |           |     |       |     |
|--|--------|---------|-----|-----------|-----|-------|-----|
| Participant<br>Name  |        |         |     |           |     |       |     |
| Participant<br>Address   | Street |         |     | City/Town |     | State | Zip |
| ID #   |        | Phone # | ( ) |           | DOB |       |     |

| WIC Local Agency/WIC Vendor Management Agency/WIC Staff |  |  |  |  |
|---|--|--|--|--|
| LA/VMA Name   |  |  |  |  |
| Staff Name  |  |  |  |  |

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| Description of Incident and/or Information Regarding the Referral (attach additional sheets if needed).<br>Ask open-ended questions using the "who/what/when/where/why/how" format.<br>To correct electronic formatting errors click out of description box. |  |  |  |  |
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| Resolution Information     |  |  |  |                 |  |
|----------------------------|--|--|--|-----------------|--|
| Description of Resolution: |  |  |  |                 |  |
|                            |  |  |  |                 |  |
|                            |  |  |  |                 |  |
|                            |  |  |  |                 |  |
|                            |  |  |  |                 |  |
| Completed By:              |  |  |  | Date Completed: |  |