Georgia Department of Human Services
OFFICE OF INSPECTOR GENERAL
REQUEST FOR CASE REVIEW
Two Peachtree Street, NW. Room 30.449
Atlanta, GA 30303-3142
OIGBRU5667referrals@dhs.ga.gov

1. COUNTY NAME/NUMBER:

2. HOTLINE REFERRAL NUMBER:

HEAD OF HOUSEHOLD INFORMATION

3. SOCIAL SECURITY # **4. DOB:** **5. SEX:** ☐ M ☐ F

6. GATEWAY CLIENT ID# **7. RACE** ☐ A ☐ B ☐ H ☐ O ☐ W

8. FIRST NAME: **9. INITIAL** **10. LAST NAME:**

11. ADDRESS 1: **12. ADDRESS 2:**

13. CITY: **14. STATE:** **15. ZIP:** **16. AREA/PHONE:**

SECONDARY HOUSEHOLD INFORMATION

17. SOCIAL SECURITY NO.	NAME	DOB	RELATIONSHIP	GATEWAY CLIENT ID NO.	REPEAT OFFENDER
					☐ Yes ☐ No
					☐ Yes ☐ No

SUSPECTED OVERPAYMENT

18.CATEGORY	19. STATUS			20. ESTIMATED OVERPAYMENT			21. GATEWAY AU ID
PROGRAM	ACTIVE	CLOSED	FALSE STMT	START DATE	END DATE	AMOUNT	
☐ EBT	← EBT Trafficking ONLY						
☐ FS	☐ Active	☐ Closed	☐ Yes ☐ No				
☐ TANF	☐ Active	☐ Closed	☐ Yes ☐ No				
☐ NON EBT							
☐ FS	☐ Active	☐ Closed	☐ Yes ☐ No				
☐ TANF	☐ Active	☐ Closed	☐ Yes ☐ No				

22. METHOD OF DISCOVERY: ☐ CLEARINGHOUSE ☐ CLIENT REPORT ☐ CHILD SUPPORT SERVICES ☐ HOTLINE
☐ QUALITY CONTROL ☐ NEW HIRE ALERT ☐ PRISONER ALERT ☐ UNEMPLOYMENT COMPENSATION BENEFITS ☐ OTHER

23. SOURCE OF REFERRAL:

24. OP RESULTED FROM:

☐ **A. UNREPORTED EARNED** (Wages, Self Employment, Etc.)	Employer: Employer Address: (Address Continued)
☐ **B. UNREPORTED UNEARNED** (SS, SSI, WC, UCB, VA, CS, Etc.)	Source: Date Income Began:
☐ **C. RESOURCES** (Insurance, Property, Bank Accounts, Etc.)	List resources, value, vendor name and location if applicable.
☐ **D. HOUSEHOLD COMPOSITION/RESIDENCY** (Child out of Home, Spouse in Home, Out of State, Etc.)	Name:
☐ **E. EBT TRAFFICKING** (Card #, Store Name & Address)	Name:
☐ **F. OTHER** (i.e. Dual Assistance)	Name:

25. REPEAT OFFENDER: ☐ Yes ☐ No **26. DATE OF DISCOVERY:**

27. Explain: (Describe Violation checked in # 24. Include Names, Addresses, and Telephone Numbers, if known. Include Names of Respondent(s) if other than #17 above. Attach additional sheet if needed.)

28. WORKER/ ORIGINATOR SIGNATURE **29. DATE:**

31. RECIPIENT PHYSICAL DISABILITY ☐ Yes ☐ No

32. INTERPRETIVE SERVICES ☐ Yes ☐ No

30. TELEPHONE NO.

33. RECIPIENT NON-PHYSICAL DISABILITY ☐ Yes ☐ No

34. TRANSLATION SERVICES ☐ Yes ☐ No