

**Geer Nursing and Rehabilitation Center
Notice
Pursuant to Deficit Reduction Act of 2005**

Geer Nursing and Rehabilitation Center strives to comply with all state and federal laws and regulations prohibiting the submission of false claims to the state or federal government to obtain payment for healthcare services. To assist in that effort, Geer Nursing and Rehabilitation Center requires that its employees, contractors, and agents also comply with those laws. Contractors and agents include those who (a) furnish or authorize the furnishing of Medicaid healthcare items or services on behalf of Geer Nursing and Rehabilitation Center, (b) perform billing or coding functions on behalf of Geer Nursing and Rehabilitation Center, or (c) are involved in monitoring the healthcare provided by Geer Nursing and Rehabilitation Center.

The Geer Nursing and Rehabilitation Center's Compliance Program mandates compliance with federal and state laws including: (a) the False Claims Act, 31 U.S.C. §§ 3729-3733, (b) the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812, (c) the Anti-Kickback Statute, 42 U.S.C. 1320a-7b (b), (d) Stark Laws, 42 U.S.C. § 1395 et al. (e) the Connecticut False Claims Act and related laws. Geer Nursing and Rehabilitation Center has also established a policy for compliance with the provisions of Section 6032 of the Deficit Reduction Act. Geer Nursing and Rehabilitation Center expects that employees, contractors and agents will comply with all state and federal laws, regulations and guidance in performing their duties, including the Federal and State False Claims Acts and that all employees will recognize that they are subject to criminal and civil penalties and disciplinary action for the failure to comply with the Compliance Program and with federal and state laws.

Geer Nursing and Rehabilitation Center will not take retaliatory action against any individual who in good faith reports conduct which violates federal or state laws. Protections afforded those employees and contractors who provide assistance to the government by investigating and reporting fraud, waste, or abuse are addressed in the Compliance Program, the DRA Compliance Policy.

Geer Nursing and Rehabilitation Center requires that its employees, contractors, and agents familiarize themselves with the Compliance Program, the DRA Section 6032 Policy, and the Employee policies as applicable, and follow those policies to facilitate compliance with the above laws, principles, and standards. The Compliance Program and the DRA Section 6032 Policy are available to employees, contractors, and agents on Geer Nursing and Rehabilitation Center's website at www.geercares.org. If for any reason you cannot access the Compliance Program or the DRA Section 6032 Policy through the website, you may contact the Compliance Officer at complianceofficer@geercares.org to obtain a copy.

Employees, contractors, and agents who suspect noncompliance with any of the above laws shall contact the Compliance Officer by calling 860-824-3836, or emailing complianceofficer@geercares.org.

**Geer Nursing and Rehabilitation Center
Canaan, Connecticut**

Department: Compliance	
Subject: Deficit Reduction Act of 2005	
Date Issued: 10/4/18	Date Revised:
Supersedes	
Approvals	

- I. **SCOPE:** The Compliance Officer and/or the designee are responsible for implementing this Policy. The Policy applies to all employees, contractors and agents of Geer Nursing and Rehabilitation Center (hereinafter collectively “Covered Entity”).

- II. **PURPOSE:** The purpose of this Policy is to inform and educate the Covered Entity’s employees, contractors and agents about the Covered Entity’s commitment to its Compliance Program, and the Federal and State False Claims Acts, including applicable administrative, civil and criminal penalties and protections provided under the laws for those who report suspected fraud, waste and abuse.

- III. **POLICY:** Covered Entity is committed to conducting its operations in compliance with applicable Federal and State laws, and regulatory guidance. This commitment requires that we ensure that the health care services provided to eligible members are done so by providers entitled to participate in federal programs, are medically necessary, meet certain quality requirements, are provided in a cost-effective manner, are billed appropriately and paid according to contract terms and Covered Entity policies. Covered Entity, in the course of its operations, works to prevent fraud, waste and abuse (FWA), and to detect and correct any instances of FWA, whether through an employee, contractor, or agent. To that end, all employees, contractors, and agents must understand how the Covered Entity’s Compliance Program and its requirements and obligations of the Federal and State False Claims Acts prevent and detect fraud, waste and abuse in federal and state healthcare programs.

IV. Procedure

- A. Covered Entity's employees, contractors, and agents will comply with the State and Federal False Claims Acts and the Compliance Program to prevent and detect fraud, waste and abuse in federal healthcare programs, or any program in which the government pays any portion of the healthcare provided. Information regarding protections and rights for reporting actual or suspected fraud, waste or abuse is contained in the Covered Entity's Whistleblower Policy. Additionally, the Compliance Program and this Policy may be obtained by contacting the Compliance Officer. All employees, contractors, and agents of the Covered Entity have a responsibility to report to Geer's Compliance Officer any incident of actual or suspected fraud, waste and abuse, or any misconduct which potentially violates Federal or State laws.
- B. Any employees, contractors, or agents who knowingly and intentionally submit a false claim to the State or Federal government will be reported to the necessary authority.
- C. Employees, contractors, or agents shall contact the Compliance Officer in person, at 860-824-3836, via email to complianceofficer@geercares.org to report any concerns related to compliance with the Federal and State False Claims Acts. Concerns may also be reported to Administration, a Director, or a Compliance Committee Member of Geer Nursing and Rehabilitation Center.
- D. The Geer Nursing and Rehabilitation Center will make this Policy and its Compliance Program available to all employees, contractors, providers and agents. Information regarding individual protections and rights are included within this Policy and included in the Employee Policies provided in the whistleblower policy. Information about the Geer Nursing and Rehabilitation Center's Compliance Program and this Policy may also be obtained by contacting the Compliance Officer, or by accessing them on the Geer Nursing and Rehabilitation Center's website.

V. Guidelines: Examples of different types of false claims include:

- A. Billing for Items or Services Not Actually Rendered: Employees and agents shall not submit a claim for reimbursement without adequate information to indicate that the service billed for was actually rendered or the item billed for was actually provided to the patient. Such information should include: the date and time the service was rendered, or item was provided; the identity of the patient; a description of the services rendered or item provided; and the identity of the person providing the service or item for which reimbursement is sought.
- B. Providing Medically Unnecessary Services: Claims should not be submitted to a patient or his or her payor that seek reimbursement for a service that is not warranted by the patient's current or documented medical condition.
- C. Upcoding: The assignment of E&M codes should not be used that provide for a higher payment rate than the billing code that actually reflects the service furnished to the patient.

- D. Duplicate Billing: Duplicate billings should be avoided. This occurs when more than one claim is submitted to more than one primary payor at the same time.
- E. Refund of Credit Balances: Credit balances should be fully refunded on a timely basis.
- F. Falsely Billing Physician/Provider Services: Claims for physician/provider services should not be presented if the person providing the service is not a physician.
- G. Unbundling: Bills should not be submitted piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost.
- H. Transactions with Physicians and Others: Any transaction potentially involving fraud and abuse laws shall only be entered into after consultation with legal counsel and/or the Compliance Officer.
- I. Intentional misuse of a provider number issued by a federal health care program: Services provided must be billed under the provider who actually performed the services unless exceptions to this are allowed as defined by federal or state laws.

VI. ADDITIONAL INFORMATION

- A. FEDERAL FALSE CLAIMS ACT (FCA): The FCA imposes civil liability on persons or corporations who, among other things “(1) knowingly present or cause to be presented a false or fraudulent claim for payment to the government; (2) knowingly use a false record or statement to obtain payment on a false or fraudulent claim paid by the government; or (3) engage in a conspiracy to defraud the government to obtain allowance for, or payment of, a false or fraudulent claim. The FCA defines “knowing” or “knowingly” as having actual knowledge of the information; acting in deliberate ignorance of the truth or falsity of the information; or acting in reckless disregard of the truth or falsity of the information; and requires no proof or specific intent to defraud. Violations of the FCA are subject to civil, monetary penalties of not less than \$5,500 and no more than \$11,000, plus three times the amount of damages which the government sustains because of the act of that person. In healthcare, the amount of damages sustained is the amount paid for each false claim that is filed. Examples of the type of activities prohibited by the FCA include billing a federally funded program, such as Medicare or Medicaid, for services that were not provided and/or upcoding, i.e., billing for a highly reimbursed service in lieu of service actually provided. Another example is retaining improper overpayments received from a federally funded program. The FCA applies to billing and claims sent from a medical provider to any government payor program, including Medicare and Medicaid, other Federal healthcare programs, and other State healthcare programs funded, in whole or in part, by the Federal government.
- B. FEDERAL ANTI-KICKBACK LAW: A violation of the Anti-Kickback statute is also a false claim. The Anti-Kickback statute forbids the knowing or willful offer, payment, solicitation, or receipt of any type of remuneration to induce or in return for referrals of items or services paid for by Medicare or Medicaid. An example of a “kick-back”

in violation of this law would be a physician accepting compensation from a pharmaceutical company in response to the physician writing prescriptions to his/her patients for medications manufactured by the pharmaceutical company. The compensation or other benefits received by a physician in this example could be construed as a payment for that physician's referral of his/her patients to use a specific drug/pharmaceutical that is paid for by the government. The law is also violated in the event inappropriate inducements are made to patients, such as waiving co-insurance or deductibles without regard to financial need. Violations of Anti-Kickback law can result in significant civil and criminal liability for physicians, non-physicians and organizations, and the penalties can include significant fines, imprisonment, or both.

- C. **STARK LAW:** A violation of the Stark Laws may, under some circumstances, also create a violation of the False Claims Act. Stark Law prohibits physicians from referring Medicare and Medicaid patients for certain "designated health services" reimbursable by the Medicare and Medicaid programs to entities with which the physicians (or their immediate family members) have a financial relationship. A financial relationship may be an ownership interest or a compensation arrangement, and may be direct or indirect. In addition to prohibiting the referral for services, the Stark Law bans billing and collecting for services rendered pursuant to a prohibited referral.

Billing in violation of the Stark Law subjects the parties, both the referring physician and the billing entity, to monetary penalties equal to \$15,000 per claim, two times the amount claimed, and potential exclusion from the Medicare and Medicaid programs. Other civil monetary penalties apply for failing to report information and for circumvention schemes, which can be substantial. There are exceptions to Stark Law, but they require a proper legal analysis before entering into any such relationship.

- D. **CIVIL ACTIONS UNDER THE FCA:** Enforcement of the FCA is the responsibility of the U.S. Attorney General, but the FCA also includes a qui tam or whistleblower provision. Qui tam actions are brought by private individuals on behalf of the government. More specifically, a "qui tam action" is defined as a claim brought by a relator or informer under a statute that establishes a penalty for the commission or omission of a certain act. If a wrongdoing is found, part of the penalty paid by the wrongdoer is paid to the relator or informer, with the remainder going to the government.

A qui tam action is initiated by a relator filing his or her lawsuit in the Federal District Court on behalf of the government for false or fraudulent claims submitted by an individual or entity doing business with or being reimbursed by the United States government. The lawsuit is filed and shall remain under seal for a period of sixty (60) days in order for the government to investigate and decide whether it will pursue the action. At the end of the 60-day period, the complaint is unsealed and the Department of Justice or the U.S. Attorney General's office begins prosecuting the claim. If the government decides not to pursue the case, the relator has the right to continue with the case on his or her own. The government may join the action at a later date, if it can demonstrate good cause for doing so. If the government proceeds with the lawsuit and is successful, the person who filed the action will receive between 15% and 25% of any proceeds of the action, plus attorney's fees and costs. The amount of the award depends on contributions of the individual to the success of the case. If the government declines to pursue the case, the qui tam plaintiff will be entitled to between 25% and 30% of the proceeds of the successful case, plus

reasonable expenses and attorney's fees and costs awarded against the defendant. On the other hand, if the qui tam plaintiff is unsuccessful and the court finds that the lawsuit was clearly frivolous, clearly vexatious, or primarily for the purpose of harassment, it may reward the defendant in the action reasonable expenses and attorney's fees. Whether or not the government proceeds with the lawsuit, if the court finds that the qui tam plaintiff planned and initiated the violation upon which the lawsuit was brought, the court may reduce the share of the proceeds which the person would have otherwise received. If the qui tam plaintiff is convicted of criminal conduct arising from his or her role in the violation, the person will be dismissed from the civil lawsuit and shall not be paid any part of the proceeds.

- E. ANTI-RETALIATION PROTECTIONS FOR WHISTLEBLOWERS UNDER THE FCA: Any individual associated with an organization who observes activities or behavior that may violate the law in some manner and who reports their observations either to management or to the governmental agencies is provided protections under the law. Whistleblowers initiating a qui tam action may not be discriminated or retaliated against in any manner by their employer. Any employee, who is discharged, demoted, suspended, threatened, harassed, or confronts discrimination in furtherance of a qui tam action, or as a consequence of whistleblowing, are entitled to all relief necessary to make the employee whole.
- F. SOCIAL SECURITY ACT: The Social Security Act authorizes the Secretary of Health and Human Services to seek civil monetary penalties and assessments for many types of conduct. The Secretary of Health and Human Services has delegated many of these civil monetary penalties to the Office of Inspector General (OIG). In most of the cases for which the OIG may seek civil monetary penalties, the OIG may also seek exclusion from participation in all federal healthcare programs.
- G. CONNECTICUT FALSE CLAIMS LAWS AND RELATED LAWS:

- a. Connecticut False Claims Act**

Under the Connecticut False Claims Act (Connecticut General Statutes § 17b-301a et. seq.) (the "CFCA"), a person is civilly liable to the state if such person:

Knowingly submits a false or fraudulent claim, record or statement for payment or approval under a medical assistance programs administered by the Department of Social Services ("DSS").

Conspires to defraud the state government by getting a false or fraudulent claim allowed or paid;

Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay to the state under a medical assistance program administered by DSS; and commits other fraudulent acts enumerated in Connecticut General Statutes § 17b-301(b).

Connecticut False Claims Act - Key Terms:

The term "**knowing**" and "**knowingly**" means that a person, with respect to information: (A) has actual knowledge of the information;(B) acts in deliberate ignorance of the truth or falsity of the information; or (C) acts in reckless disregard of the truth or falsity of the information, without regard to whether the person intends to defraud;

The term "**claim**" means any request or demand, whether under a contract or otherwise, for money or property that is made to a contractor, grantee or other recipient if the state provides any portion of the money or property that is requested or demanded, or if the state will reimburse such contractor, grantee or other recipient for any portion of the money or property that is requested or demanded;

Connecticut False Claims Act - Penalties

Any person who violates the CFCA will be liable to the State of Connecticut for a **civil penalty** of not less than \$5,500 or more than \$11,000, an additional fine of three times the amount of damages that the state sustains because of the act of that person, plus the costs of investigation and prosecution of such violation.

Connecticut False Claims Act - Actions by Attorney General and Private Persons

The **Connecticut Attorney General** (the "Attorney General") is required to diligently investigate violations of the CFCA and may bring a civil action against any person found to have violated the CFCA. Before filing suit, the Attorney General may issue a subpoena requiring production of documents, written answers and oral testimony.

The CFCA also provides for **Actions by Private Persons** (*qui tam* lawsuits) who can bring a civil action on behalf of the person and the State for a violation of the Act. Generally, the action may not be initiated more than six years after the violation, but in no event more than ten years after the date on which the violation is committed, whichever occurs last. When the action is filed it remains under seal for at least sixty days. The State may choose to intervene in the lawsuit and assume primary responsibility for prosecuting, dismissing or settling the action. If the State chooses not to intervene, the private party who initiated the lawsuit (the "*qui tam* plaintiff") has the right to conduct the action.

In the event the State proceeds with the lawsuit, the *quit am* plaintiff may receive fifteen to twenty-five percent of the proceeds from the action or settlement. If the *qui tam* plaintiff proceeds with the action without the State, the plaintiff may receive twenty-five to thirty per cent of the recovery. In either case, the *qui tam* plaintiff may also receive an amount for reasonable expenses plus reasonable attorney's fees and costs.

If the civil action is frivolous, clearly vexatious, or brought primarily for harassment and the defendant prevails in the action, the *quit am* plaintiff may have to pay the defendant its fees and costs. If the *qui tam* plaintiff planned or initiated the violation, the share of the proceeds may be reduced and, if found guilty of a crime associated with the violation, no share will be awarded to the *quit am* plaintiff.

i. Connecticut False Claims Act - Whistleblower Protection

The CFCA also protects employees from retaliation. An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in the terms and conditions of employment because of lawful acts conducted in furtherance of an action under the CFCA may bring an action in the appropriate State superior court seeking reinstatement, two times the amount of back pay plus interest, and other enumerated costs, damages and fees.

b. Criminal & Fraud Statutes and Regulations Related to False Claims

In addition to the Connecticut False Claims law, there are several state laws designed to prevent and detect fraud and abuse. Employees and contractors of Geer are expected to act in accordance with these laws, which are summarized below. Violations of these laws carry the possibility of criminal and/or monetary penalties as well as exclusion from participation in the Medicaid program.

i. Vendor Fraud - Conn. Gen. Stat. §53a-290 et seq.

Geer, its employees or contractors will be considered to have committed vendor fraud when, with intent to defraud, Geer or the individual:

- Presents for payment any claim for goods or services that is false;
- Accepts payment for goods or services in excess of the amount actually due or the amount allowed by law for the goods or services;
- Attempts to provide services or sell goods to resident knowing the resident does not need the goods or services;
- Sells goods to or performs services for a resident without prior authorization from the Department of Social Services when a prior authorization is required; or
- Accepts from any person or source, other than the state, additional compensation in excess of the amount allowed under the law.

ii. Health Insurance Fraud - Conn. Gen. Stat. §53-440 et seq.

A person is guilty of health insurance fraud when, with the intent to defraud, he/she:

- Makes any written or oral statement as part of (or in support of) an application for health insurance or claim for payment knowing the statement is false, incomplete, deceptive or misleading or omitting material information whether for himself, a family member or third party;
- Assists, solicits or conspires with another to prepare or present any written or oral statement to any insurer or agent in connection with an application or claim for health care benefits knowing that the statement contains false, deceptive or misleading information.
- Misleading information includes falsely representing that goods or services were medically necessary or that they met professionally recognized standards.

The term "insurer" includes any private or governmental agency that provides medical benefits to Medicare or Medicaid recipients. Health insurance fraud is punishable by imprisonment and/or fines. In addition to the imprisonment and/or the assessment of fines, any person found to have committed health care fraud must make restitution payments to the aggrieved insurer, including attorney's fees and investigative costs.

iii. Larceny. Defrauding the Government - Conn. Gen. Stat. §53a-118 et seq.

A person is guilty of larceny against the government when he/she: Authorizes, certifies, attests

or files a claim for benefits or reimbursement from a local, state, or federal agency knowing it is false; or knowingly accepts the benefits from a claim he knows is false.

**iv. Tampering with or Fabricating Physical Evidence: Class D Felony
- Conn. Gen. Stat. §53a-155**

A person is guilty of tampering with or fabricating physical evidence if, believing an official proceeding is pending or about to be instituted, he alters, destroys, conceals or removes any record or document or makes, presents or uses any record or document knowing it is false for the purpose of misleading a public servant.

v. False Statement in the Second Degree - Conn. Gen. Stat. §53a-157b

A person is guilty of making a false statement in the second degree when he intentionally makes a false written statement under oath, or on a form which states that false statements made therein are punishable, knowing them to be untrue and with the intent to mislead a public servant.

vi. Toll Free Vendor Fraud Telephone Line - Conn. Gen. Stat. §17b-25a

This statute requires the Commissioner of Social Services to provide toll-free telephone access for a person to report vendor fraud. Vendor fraud can be reported by mail, fax or phone at the following address or phone numbers:

State of Connecticut Department of Social Services Medical Audits Division
25 Sigourney Street
Hartford, Connecticut 06106-5033
Phone: 1-800-842-2155
Fax: (860) 424-5900

vii. Vendor Fraud - Conn. Gen. Stat. §17b-99

This statute sets forth penalties for vendor fraud and provides for the issuance of regulations and audits as follows:

- Any vendor found guilty of vendor fraud under §53a-290 *ets eq.* shall be subject to forfeiture or suspension of any license or franchise from the state after a hearing and shall have such license or franchise revoked.
- No vendor is eligible for reimbursement for any goods provided or services performed by a person convicted of a crime involving fraud in federal or state programs and such vendor shall be terminated from the respective federal and state programs.
- Vendors must notify the Department within 30 days after the date of employment or conviction of the identify and extent of services performed by any person convicted of a crime involving fraud in Medicare, Medicaid or other federal health care program.
- Prior to acceptance of a provider agreement or at any time upon request of the Department, a vendor must furnish the Department with the identity of any person

convicted of crime involving fraud in programs who has an ownership or control interest in the vendor or who is an agent or managing employee.

- The Department shall distribute to all vendors a copy of rules, regulations, standards and laws governing the program.
- The Department shall conduct any audit in accordance with the statute.

viii. Financial Incentive for Reporting Vendor Fraud - Conn. Gen. Stat. §17b-102; Regs. Conn. State Agencies 17b-102-01 et seq.

Under these statutes and regulations, the Department of Social Service may offer up to 15% of any amounts recovered by the state as a result of a person's report of vendor fraud.

ix. Administrative Sanctions - Reg. Conn. State Agencies §17-83k-1 et seq.

These regulations set forth administrative sanctions against vendors who violate state or federal laws, rules or regulations governing the programs in which they participate. Sanctions include suspension, limitation and termination from participation in state programs. Examples of violations that may lead to such sanctions include:

- Failure to comply with any provision of a contract or agreement in effect between the vendor and the Department of Social Services;
- Furnishing or ordering services in excess of a recipient's needs or that fail to meet professionally recognized standards;
- Making a false statement or misrepresentation of fact for purpose of claiming or determining payment;
- Accepting compensation in excess of the amount authorized by law for goods provided or services performed;

WHISTLEBLOWER PROTECTIONS

Geer encourages persons who believe that a violation of law or facility policy has occurred to communicate their concerns to facility management. Employees and contractors who become aware of any violation of these laws are required as part of their job responsibilities to bring such violations to the attention of facility management. Violations of the type described in this policy can be reported to Geer's Corporate Compliance Officer. The contact information of Geer's Corporate Compliance Officer is as follows:

Corporate Compliance Officer
Kathy Pollard
Direct Line: **1-860-824-3836**
Confidential Hotline: **1-860-362-1030**
Email: **complianceofficer@geercares.org**

It is the right of all persons under Connecticut law to be protected against retaliation for reporting violations of these laws. Geer will not discriminate or retaliate in any manner against employees or contractors who disclose information about suspected violations. The following laws prohibit discrimination and/or retaliation:

Conn. Gen. Stat. §31-51m. Protection of Employee Who Discloses Employer's Activities or Unethical Practices. No employer may discharge, discipline or otherwise penalize any employee because that person reports a violation or suspected violation of any state or federal law or regulation or because the employee is requested by the public body to participate in an investigation, hearing or inquiry.

Conn. Gen. Stat. §4-61dd. Whistleblowing. Large State Contractors. No employee or officer of a large state contractor may take or threaten to take any personnel action against an employee in retaliation for disclosing information of any matter involving corruption or violation of state or federal laws or regulations.

Conn. Gen. Stat. §31-51 g. Liability of Employer for Discipline or Discharge of Employee on Account of Employees' Exercise of Certain Constitutional Rights. Any employer who disciplines or discharges an employee for exercising his/her constitutional rights shall be liable to the employee for damages, including punitive damages, and for reasonable attorney fees as part of the costs of any action for damages. If the action for damages is brought without substantial justification, the court may award costs and attorney's fees to the employer.

Regs. Conn. State Agencies §4-61dd-1 et seq. Rules of Practice for Contested Case Proceedings under the Whistleblower Protection Act. These regulations set forth the rules of practice for conducting case proceedings under the Whistleblower Protection Act.

REPORTING PROCEDURES

All persons associated with Geer must be committed to and responsible for complying with Geer's Code of Conduct, including this policy on Preventing Fraud and Abuse, and for promptly reporting any potential violations or legal concerns to a supervisor, or Geer's Corporate Compliance Officer. If any such person has a concern regarding a violation of this policy on Fraud and Abuse, such person must immediately report the violation. If any employee knows or suspects a violation and fails to report it, the employee could be considered a party to the violation. Just because an employee is not involved in illegal or unethical behavior or behavior that constitutes a violation under this policy, does not mean that he/she is not responsible for reporting known violations.

Reporting Suspected Compliance Concerns:

1. Inform your manager, supervisor, compliance liaison (facility administrator), or another member of senior management if you suspect a violation or you just need clarification of an existing policy or procedure.
2. Compliance Officer: Contact Geer's Compliance Officer directly by calling the 24-Hour Access Line at **1-860-824-3836**
3. Hotline: Call Geer's Confidential Hotline Voice Mailbox **1-860-362-1030**
4. Email: **complianceofficer@geercares.org**
5. Regular Mail: Send a written report to Geer's Corporate Office at:

99 South Canaan Road
Canaan, CT 06018
Attn: Corporate Compliance Officer

Mark envelopes "Personal & Confidential"