Filed in District Court
State of Minnesota
9/25/2026

State of Minnesota
County of Ramsey

District Court
2nd Judicial District

Prosecutor File No. 33.GM62.0262
Court File No. 62-CR-26-6900

State of Minnesota,
Plaintiff,

vs.

AWO AHMED MOHAMED DOB: 01/01/1990
2726 Huron Street
Roseville, MN 55113
Defendant.

COMPLAINT
Summons

The Complainant submits this complaint to the Court and states that there is probable cause to believe Defendant committed the following offense(s):

COUNT I

Charge: Theft by False Representation (over $35,000)
Minnesota Statute: 609.52.2(a)(3)(iii), with reference to: 609.52.3(1), 609.05.1
Maximum Sentence: Imprisonment of no more than 20 years or payment of a fine of no more than $100,000, or both.
Offense Level: Felony

Offense Date (on or about): 12/20/2022 to 06/06/2023

Control #(ICR#): 20230011

Charge Description: On or about warrant dates December 20, 2022, through June 6, 2023, in Ramsey County, State of Minnesota, Defendant Awo Mohamed (dob 1/1/1990) intentionally aided, abetted, advised, hired, counseled, or conspired with another to commit a crime, namely, to intentionally deceive a third person with a false representation which is known to be false, made with intent to defraud, and which does defraud the person to whom it is made, through the preparation or filing of a claim for reimbursement, a rate application, or a cost report used to establish a rate or claim for payment for medical care provided to a recipient of medical assistance under chapter 256B, which intentionally and falsely stated the costs of or actual services provided by a vendor of medical care, and the value of the property obtained was over $35,000, to wit: Defendant conspired with employees and recipients through Always on Time Health Services, Inc. to create false personal care assistant timesheets which were submitted as claims to the Minnesota Department of Human Services, who, in reliance on those claims, gave up possession of more than $35,000 in Medicaid funds.

COUNT II

Charge: Theft by False Representation (over $35,000)
Minnesota Statute: 609.52.2(a)(3)(iii), with reference to: 609.52.3(1), 609.05.1
Maximum Sentence: Imprisonment of no more than 20 years, or payment of a fine of no more than$100,000, or both.
Offense Level: Felony

Offense Date (on or about): 06/07/2022 to 12/06/2022

Control #(ICR#): 20230011

Charge Description: On or about warrant dates June 7, 2022, through December 6, 2022, in Ramsey County, State of Minnesota, Defendant Awo Mohamed (dob 1/1/1990) intentionally aided, abetted, advised, hired, counseled, or conspired with another to commit a crime, namely, to intentionally deceive a third person with a false representation which is known to be false, made with intent to defraud, and which does defraud the person to whom it is made, through the preparation or filing of a claim for reimbursement, a rate application, or a cost report used to establish a rate or claim for payment for medical care provided to a recipient of medical assistance under chapter 256B, which intentionally and falsely stated the costs of or actual services provided by a vendor of medical care, and the value of the property obtained was over $35,000, to wit: Defendant conspired with employees and recipients through Always on Time Health Services, Inc. to create false personal care assistant timesheets which were submitted as claims to the Minnesota Department of Human Services, who, in reliance on those claims, gave up possession of more than $35,000 in Medicaid funds.

COUNT III

Charge: Theft by False Representation (over $35,000)
Minnesota Statute: 609.52.2(a)(3)(iii), with reference to: 609.52.3(1), 609.05.1
Maximum Sentence: Imprisonment of no more than 20 years, or payment of a fine of no more than $100,000, or both.
Offense Level: Felony

Offense Date (on or about): 12/07/2021 to 05/24/2022

Control #(ICR#): 20230011

Charge Description: On or about warrant dates December 7, 2021, through May 24, 2022 in Ramsey County, State of Minnesota, Defendant Awo Mohamed (dob 1/1/1990) intentionally aided, abetted, advised, hired, counseled, or conspired with another to commit a crime, namely, to intentionally deceive a third person with a false representation which is known to be false, made with intent to defraud, and which does defraud the person to whom it is made, through the preparation or filing of a claim for reimbursement, a rate application, or a cost report used to establish a rate or claim for payment for medical care provided to a recipient of medical assistance under chapter 256B, which intentionally and falsely stated the costs of or actual services provided by a vendor of medical care, and the value of the property obtained was over $35,000, to wit: Defendant conspired with employees and recipients through Always on Time Health Services, Inc. to create false personal care assistant timesheets which were submitted as claims to the Minnesota Department of Human Services, who, in reliance on those claims, gave up possession of more than $35,000 in Medicaid funds.

COUNT IV

Charge: Theft by False Representation (over $35,000)
Minnesota Statute: 609.52.2(a)(3)(iii), with reference to: 609.52.3(1), 609.05.1
Maximum Sentence: Imprisonment of no more than 20 years, or payment of a fine of no more than $100,000, or both.
Offense Level: Felony

Offense Date (on or about): 05/25/2021 to 11/23/2021

Control #(ICR#): 20230011

Charge Description: On or about warrant dates May 25, 2021, through November 23, 2021, in Ramsey County, State of Minnesota, Defendant Awo Mohamed (dob 1/1/1990) intentionally aided, abetted, advised, hired, counseled, or conspired with another to commit a crime, namely, to intentionally deceive a

third person with a false representation which is known to be false, made with intent to defraud, and which does defraud the person to whom it is made, through the preparation or filing of a claim for reimbursement, a rate application, or a cost report used to establish a rate or claim for payment for medical care provided to a recipient of medical assistance under chapter 256B, which intentionally and falsely stated the costs of or actual services provided by a vendor of medical care, and the value of the property obtained was over $35,000, to wit: Defendant conspired with employees and recipients through Always on Time Health Services, Inc. to create false personal care assistant timesheets which were submitted as claims to the Minnesota Department of Human Services, who, in reliance on those claims, gave up possession of more than $35,000 in Medicaid funds.

COUNT V

Charge: Theft by False Representation (over $35,000)
Minnesota Statute: 609.52.2(a)(3)(iii), with reference to: 609.52.3(1), 609.05.1
Maximum Sentence: Imprisonment of no more than 20 years, or payment of a fine of no more than $100,000, or both.
Offense Level: Felony

Offense Date (on or about): 11/24/2020 to 05/11/2021

Control #(ICR#): 20230011

Charge Description: On or about warrant dates November 24, 2020, through May 11, 2021, in Ramsey County, State of Minnesota, Defendant Awo Mohamed (dob 1/1/1990) intentionally aided, abetted, advised, hired, counseled, or conspired with another to commit a crime, namely, to intentionally deceive a third person with a false representation which is known to be false, made with intent to defraud, and which does defraud the person to whom it is made, through the preparation or filing of a claim for reimbursement, a rate application, or a cost report used to establish a rate or claim for payment for medical care provided to a recipient of medical assistance under chapter 256B, which intentionally and falsely stated the costs of or actual services provided by a vendor of medical care, and the value of the property obtained was over $35,000, to wit: Defendant conspired with employees and recipients through Always on Time Health Services, Inc. to create false personal care assistant timesheets which were submitted as claims to the Minnesota Department of Human Services, who, in reliance on those claims, gave up possession of more than $35,000 in Medicaid funds.

COUNT VI

Charge: Theft by False Representation (over $5,000)
Minnesota Statute: 609.52.2(a)(3)(iii), with reference to: 609.52.3(2), 609.05.1
Maximum Sentence: Imprisonment of no more than 20 years, or payment of a fine of no more than $100,000, or both.
Offense Level: Felony

Offense Date (on or about): 09/29/2020 to 11/10/2020

Control #(ICR#): 20230011

Charge Description: On or about warrant dates September 29, 2020, through November 10, 2020, in Ramsey County, State of Minnesota, Defendant Awo Mohamed (dob 1/1/1990) intentionally aided, abetted, advised, hired, counseled, or conspired with another to commit a crime, namely, to intentionally deceive a third person with a false representation which is known to be false, made with intent to defraud, and which does defraud the person to whom it is made, through the preparation or filing of a claim for reimbursement, a rate application, or a cost report used to establish a rate or claim for payment for medical care provided to a recipient of medical assistance under chapter 256B, which intentionally and falsely stated the costs of or actual services provided by a vendor of medical care, and the value of the property obtained was over $5,000, to wit: Defendant conspired with employees and recipients through

Always on Time Health Services, Inc. to create false personal care assistant timesheets which were submitted as claims to the Minnesota Department of Human Services, who, in reliance on those claims, gave up possession of more than $5,000 in Medicaid funds.

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The Complainant states that the following facts establish probable cause:

Your affiant, Kara Vanderkooi, is an Investigator with the Medicaid Fraud Control Unit (MFCU) of the Minnesota Attorney General's Office. As a MFCU Investigator, I investigate allegations of fraud by health care providers enrolled in the Minnesota Medical Assistance (Medicaid) Program.

In this capacity, I, along with other MFCU investigators, and the Bureau of Criminal Apprehension (BCA), investigated Always on Time Health Services, Inc. (AOT), which is owned by Awo Mohamed (1/1/1990), the Defendant herein. Through AOT, Defendant conspired with others to defraud the Medicaid program out of more than $675,000.

Defendant, with others, cheated the Medicaid program by billing for services that were not provided at all, or not provided according to the recipient's needs and therefore not eligible for payment.

I. The Medicaid Program

The Medicaid program provides medical care and services to Minnesotans who meet certain income and other eligibility requirements (recipients). The Medicaid program, known in Minnesota as medical assistance, is administered by the Minnesota Department of Human Services (DHS). The DHS enrolls health care providers by entering into an agreement to furnish health care services and goods to Medicaid recipients.

Medicaid providers are informed of the laws and regulations governing their participation through the Minnesota Health Care Programs (MHCP) Provider Manual (Manual), which provides specific information for each provider type. For instance, providers must submit claims only after services are rendered and cannot submit claims that overstate either the level of care provided, or the amount of care provided. The Manual informs providers of criminal penalties for: (1) making a statement known to be false in an application for payment or for use in determining rights to such payment; (2) failing to disclose a fact affecting the vendor's initial or continuing right to receive payments with the intent to wrongfully obtain such payments; and (3) making a statement known to be false so that facility may qualify, or continue to qualify, as a home health agency. The Manual is available to providers electronically, and updates occur on a continuous basis. The DHS also issues bulletins to clarify existing laws and regulations and to summarize any changes.

The DHS further explains MHCP laws and regulations during a three-day training program called "Steps for Success." PCA services agency owners, managing employees, and qualified professionals must attend Steps for Success before enrolling in the MHCP. Finally, the DHS offers a "PCA Billing Lab" which teaches PCA services agencies how to properly bill claims to the DHS. As a condition of their enrollment in the MHCP, providers agree to comply with all rules relating to the delivery of Medicaid services to their recipients and to the submission of claims for such services, including those rules set forth in the Manual.

If a recipient is a minor or unable to direct his or her own care, a responsible party (RP) is appointed to direct and supervise the recipient's care and review and sign timesheets to verify that services have been provided. Minnesota law prohibits a recipient's PCA, Qualified Professional (QP), or home care agency or manager from serving as the RP.

As required by federal law, the MHCP prohibits providers from offering any kind of kickback, such

as cash, merchandise, or other goods or services to a recipient to induce him or her to receive health care services from the provider.

A. PCA Services

The Medicaid program covers PCA services for recipients who live in their own residence, but whose illness, injury, physical condition, or mental condition creates the need for assistance with certain activities of daily living. PCA services are provided in the recipient's home, and Minnesota law limits who can serve as a PCA for a recipient. For example, PCA services cannot be provided by the recipient's spouse, parents (if the recipient is a minor child), or responsible party. PCAs are limited to providing and being paid for up to 310 hours of PCA services per month.

PCAs must document the services they provide to recipients on a timesheet which must include the dates of service, the name and signature of the PCA and recipient, the arrival and departure time of the PCA (including a.m. and p.m. designations), the total number of hours worked daily, and a description of the services provided.

For the safety of recipients, before a PCA can begin to provide services, the agency must request a background study from the DHS and receive notice from the DHS that the PCA is not disqualified from providing PCA services. The agency must also train each PCA and ensure that he or she is competent to provide assistance to recipients.

B. Waivered Services

Home and Community-Based Services ("HCBS") are Medicaid-funded services that provide assistance and support for persons with disabilities who live independently in the community. These services are sometimes referred to as 245D services or "waivered services." Waivered services include a wide variety of services, each with a unique CPT code. The waivered services billed through Always on Time include:

- Homemaking (CPT S5130) is non-medical assistance to recipients including cooking, cleaning, and laundry. Homemaking services are to keep a recipient's home safe and sanitary and must occur in the recipient's home.

- Companion Care for adults (CPT S5135) assists with activities of daily living such as bathing, dressing, eating, errands, and social engagements. Companion care is used to enhance a recipient's quality of life. When it is billed with the modifier UA, it indicates that night supervision occurred. Night supervision includes overnight assistance and supervision provided by staff in the person's own home when that person is assessed to require overnight services. Overnight supervision is not covered if the provider resides in the home with the recipient, the recipient sleeps through the night, or for merely preventative support.

- Unskilled respite care (CPT S5150) provides relief for other caregivers. It is not intended to provide medical care, but instead is used when the primary caregiver needs a break. When a worker bills using S5150, that worker is indicating that the primary caregiver is on a break.

- Skills training (CPT H2014), also called Individualized Home Supports (IHS), includes services that provide support in community participation, health, safety and wellness, household management, and adaptive skills, helping the recipient to develop independence and improve a recipients' quality of life. IHS does not cover services that provide supervision or primarily deliver activities of daily living support.

An agency providing waivered services is responsible for coordination and evaluation of services and program management and oversight. The Agency must designate a specific staff person to provide supervision, support, and evaluation of the recipients' services. The designated person, among other things, develops and monitors the recipient's support plan for waivered services.

Per Minnesota Statutes 245D.081, all license holders must have an individual(s) assigned the position and responsibilities of Designated Coordinator and Designated Manager, and this must be submitted to DHS using the Designated Coordinator and Designated Manager Verification Form. The designated coordinator must provide supervision, support, and evaluation of activities, including instruction and assistance to direct support staff implementing the support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency. The designated manager is responsible for, in part, maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program, ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivisions 4, 4a, and 5.

A recipient's case manager, who is not an employee of the waivered agency, is responsible for assisting them in making informed decisions about their care including developing Coordinated Services and Support Plans ("CSSPs") that describe the recipient's choice of services and their individual preferences for the delivery of those services. Waivered agencies then must review the CSSP and complete an addendum and document how, when, and by whom the services will be provided.

Workers providing waivered services must document the services they provide on timesheets. Timesheets for waivered services also must include the time and type of services provided and must be signed by the worker and recipient verifying the service occurred. The completed timesheets are submitted to the waivered agency, who then submits claims to DHS or a MCO using the appropriate CPT code, based upon the service provided.

C. Services Agencies

A recipient who qualifies for PCA or Waiver services (or his or her RP) may hire a Services Agency (Agency/Agencies) to furnish the services. The Agency acts as an intermediary between the recipient and the DHS: the Agency hires or contracts with a PCA or care provider to provide the necessary services at the home of the recipient, and the Agency contracts with the DHS or a MCO to provide the services to the recipient.

An Agency is required by the DHS to ensure the accuracy of the timesheets submitted by the PCA or another worker. Using the data from PCA or waivered service timesheets, the agency submits claims for reimbursement to the DHS or the MCO. The DHS or MCO then reimburses the agency by issuing a warrant (payment), with the amount of the warrant determined by multiplying the number of units (one unit is 15 minutes) by a predetermined reimbursement rate.

Agencies are required to retain all health service and financial records relating to Medicaid claims for at least five years after the initial billing. These records include, but are not limited to, the following: appointment books, financial records, billing records, prior authorizations, care plans, and documentation of the services provided.

For the health and safety of recipients, a PCA services Agency must employ or contract with a Qualified Professional (QP) as a condition of enrollment in the Medicaid program. A QP is a professional, such as a nurse, who oversees the PCA work to ensure that recipients are receiving the care needed to be able to remain in their homes. A QP's role at an Agency is critical and an Agency cannot enroll in the Medicaid program or operate without a QP. A QP oversees the PCAs, ensuring that the recipient's needs

are met and the PCAs know how to properly provide services to the recipients. When a recipient enrolls with an agency, a QP conducts an initial visit within the first 14 days of providing services and works with the recipient to write a care plan detailing the specific needs of the recipient. A care plan is separate from the annual assessment of the recipient, which is completed by a Public Health Nurse for the county and state. After the initial visit, QP visits occur every 90 to 120 days, unless the PCA is 16 or 17 years old, then QP visits must occur every 60 days. After 180 days of services, QP visits may alternate between in-person, phone, and internet visits, if the care plan allows. When a QP visits, the QP must document the visit. An agency may submit a claim for the QP visit, including a modifier to indicate that the QP checked on the recipient and PCA. DHS will not pay claims if there is not a QP on staff properly supervising each PCA's care of his or her recipients.

I. Always On Time Health Services, Inc. (AOT)

DEFENDANT opened AOT in 2016, as a Personal Care Assistance service agency. AOT was located in St. Paul, Ramsey County, Minnesota. In April 2020, AOT was approved to provide Waivered services as well as PCA services. Defendant was sole owner of AOT through December 2022, when paperwork was filled out listing Ismail Abdulle as the owner of AOT. While on paper. DEFENDANT had transferred ownership of AOT, DEFENANT remained active in the operation and management of AOT. DEFENDANT was listed with the Minnesota Secretary of State as a Registered Agent for AOT, through its dissolution in 2024. DEFENDANT also remained on the bank accounts for AOT and received large sums of money from AOT accounts. Notably, Ismail Abdulle was not a signer on the AOT accounts.

During interviews, DEFENDANT was recognized as the owner of AOT. Numerous people interviewed stated that DEFENDANT was their contact at AOT. DEFENDANT also remained the contact with the State and other MCOs.

As explained above, a QP is essential to the operation of a PCA Service Agency. It is the responsibility of the QP to ensure that recipients are receiving proper care in order to safely live in their homes. Without QP supervision, PCA services are not eligible for Medicaid reimbursement because of the essential work QPs perform to ensure proper care for a recipient. When a QP joins an Agency, they sign a QP Acknowledgement form stating that by signing the form, they acknowledge and certify the following:

- Understand the qualifications of a QP
- Meet the qualifications
- Are aware of the duties and responsibilities of a QP for the Agency
- Assume the duties of a QP

Waivered services agencies also are required to have a Designated Coordinator and a Designated Manager. A Designated Coordinator oversees an agency's responsibility to support the recipient by providing supervision, support, and evaluation to ensure the recipient's outcomes are met, and that care is effective. A Designated Manager makes sure the coordinator's duties are completed and ensures staff competency through orientation and additional training. Proper supervision of Waivered services is required for the services to be eligible for Medicaid reimbursement.

DEFENDANT had QPs and Designated Coordinators and Managers on paper, but they did not perform the duties in the intervals required by laws, rules and regulations.

II. MFCU Investigation

My investigation included reviewing records from a DHS administrative investigation, obtaining additional information from DHS and others, executing numerous search warrants at AOT's office business location, obtaining voluminous financial records, conducting interviews with former AOT employees and recipients, and speaking with other witnesses. As detailed below, I found that DEFENDANT through AOT bilked the Medicaid program out of almost $700,000.

III. AOT's Fraud

Between September 2020 and June 2023, DEFENDANT through AOT, was paid Medicaid funds for fraudulent claims DEFENDANT conspired to submit for PCA and Waivered services that did not occur at all or did not occur in accordance with the law. MFCU investigators found that DEFENDANT submitted claims when recipients or workers were in-patient or incarcerated; when services were not provided; when services were not provided in accordance with the law, rules, or regulations, such that they were not eligible for Medicaid reimbursement. The investigation further substantiated that DEFENDANT knew these services were not rendered and were not eligible for payment.

A. DEFENDANT conspired with others to bill for services not rendered at all.

Throughout the investigation, many interviews were conducted of recipients and PCAs. Through these investigators learned that services that DEFENDANT submitted for Medicaid reimbursement were not provided. Some examples include:

1. Recipient F.Y.

MFCU investigators spoke with F.Y. F.Y. stated that they received PCA and night supervision, and that there had been homemaking services, but that was cut. F.Y. was shown many photos of people AOT reported had provided services to him. When F.Y. recognized someone who worked with him, F.Y. would mention what services, why they left, and whether the worker provided services well. F.Y. did not recognize at least eight of the workers, DEFENDANT reported as providing services for him. Between September 2020 and February 2023, DEFENDANT submitted or directed others to submit claims for over 4,000 hours of services that were not rendered by these 8 workers. For these falsely submitted claims, AOT received over $75,000 from Medicaid.

2. PCA Tondalaya Kirk-Gresham

MFCU investigators spoke with Tondalaya Kirk-Gresham (Kirk-Gresham), who worked as a PCA at AOT, and was also a RP for her children. Kirk-Gresham stated that her children started receiving services through AOT in 2019 or 2020 and continued to receive services from AOT until the business closed in 2023. During this time, Kirk-Gresham stated that DEFENDANT would tell her that a nurse would come out to visit with her and the children, but no nurse ever came. Kirk-Gresham stated she did not meet any nurse who worked for AOT.

Regarding services, Kirk-Gresham stated that she did not complete any training. Kirk-Gresham stated that she would turn in her time sheet when she picked up her check. Kirk-Gresham stated that while she had turned in time sheets, she was told by AOT staff that she had not turned in a time sheet, and that she should sign another time sheet. When Kirk-Gresham asked about completing the rest of the time sheet, the office staff told her that she did not need to complete the rest of the time sheet. Kirk-Gresham stated that DEFENDANT told her not to talk to anyone about AOT and that if she was asked, Kirk-Gresham could go to the DEFENDANT.

Kirk-Gresham stated she worked as a PCA for AOT, and the recipients she cared for were her father, L.K. and C.H. DEFENDANT submitted claims or directed that claims be submitted reporting that Kirk-Gresham provided more than 2,000 hours to other recipients. For these false claims, Medicaid reimbursed AOT over $39,000.

3. **Recipient L.M.**

L.M. was injured in an accident and began to receive PCA services. L.M. stated that he received services through AOT for about a year and a half. While at AOT he only received services from two PCAs. When shown photos of the people who provided services, L.M. stated that he had never seen two of the PCAs a day in his life and that he had never met the people in two of the photos. L.M. also stated that it was not his signature on timesheets that listed a PCA who did not provide services to him. For service dates between August and December 2022, DEFENDANT submitted claims or directed that claims be submitted listing PCAs provided around 1,400 hours of services to L.M. that were not provided to him. For these falsely submitted claims, Medicaid reimbursed AOT over $27,000.

4. **Recipient St.S.**

MFCU investigators interviewed St.S. St.S stated that she received services through AOT for a couple months in early 2023. St.S. stated that her daughter and daughter-in-law provided her services. St.S. stated that PCA Natasia Deadwyler came one day, but once with others, and did not say much. St.S. stated that M.G. did not help her. While M.G. and N.D. did not provide services to St.S, DEFENDANT submitted or directed claims to be submitted for over 150 hours of services they allegedly provided. For these falsely reported services, Medicaid reimbursed AOT, over $3,000.

5. PCA Jerry James

MFCU investigators spoke with Jerry James (James), who had worked for a short time, a couple weeks, at AOT as a PCA. While James stated he only worked for a week or two, DEFEENDANT submitted claims reporting he provided services to three recipients whom James had never met. For service dates between December 2022 and February 2023, DEFENDANT billed over 300 hours of services provided by James to recipients J.R., S.S. and J.J. For these false claims, Medicaid reimbursed h AOT, over $6,000.

6. **Recipient J.C.**

J.C. suffered a stroke and was cared for by his family. His wife, R.C., was his responsible party. R.C. stated that J.C. received homemaking services through AOT. In interviews, R.C. identified individuals who AOT billed for providing services to J.C but who never provided any services.

R.C. said that she had signed some blank time sheets. R.C. reviewed some time sheets and said it was not her signature because the name was spelled incorrectly. Other time sheets indicated that J.C. had signed it. R.C. said that one person came for a couple hours a couple times a week and would leave when the work was completed, even though some allotted hours may remain. R.C. only recognized one worker from AOT, Lul Abdi, who R.C. said was a good worker.

R.C. did not recognize any other people listed on AOT timesheets as providing any services to J.C. During the interview with MFCU investigators, R.C. commented that the work of caring for people in their homes is difficult, but the worker has to care about the person, and that it is horrific when people just make it about the money. Based upon these time sheets, claims were submitted and Medicaid reimbursed AOT over $3,000.

Between September 2020 and March 2023, DEFENDANT was the owner and operator of AOT. DEFENDANT submitted or caused to be submitted, over 3,300 claims reporting services were provided, when no services were provided. For these claims, DEFENDANT submitted claims or directed claims to be submitted for over 13,000 hours of services that were not provided. Medicaid reimbursed AOT over $250,000 for these false claims.

B. DEFENDANT conspired with others to bill for services while the recipient was in a location where services could not be provided, including in local jails and in hospitals.

If a recipient is hospitalized or in an inpatient treatment or care facility, Medicaid will not pay for PCA and certain waivered services. In hospitals and treatment or care centers, there are trained and paid staff to care for the recipients. Medicaid will also not pay for PCA or waivered services if the recipient is incarcerated as the workers would not have access to an inmate.

An agency cannot bill for services when the recipient is incarcerated. Jail staff assesses the needs of the inmates. Further, access is limited, so a worker would not have access to provide assistance for activities of daily living to a recipient who is in custody. Yet DEFENDANT submitted claims reporting services were provided while the recipient was in custody. For example, recipient D.J. (Derrick Johnson) was in custody from late January through mid-December 2021. D.J. was again in custody from February 16 through 23, 2023. During this time DEFENDANT put money into D.J.'s account at the jail, even personally bringing money to the jail. DEFENDNT knew D.J. was in jail and was not receiving services, yet she submitted claims reporting between 2.5 and 16 hours of services were provided to D.J. while he was incarcerated and could not receive services. For these false claims, Medicaid paid AOT, over $22,000.

While recipients were hospitalized, DEFENDANT through AOT billed for PCA and waivered services for recipients. For example, recipient S.J. was in a treatment facility for months in 2021 and then in a sober house. S.J. stated that she could not and did not receive any PCA services while she was in treatment or the sober house. Yet, DEFENDANT submitted claims reporting that S.J. received between three and five hours of PCA services almost daily between July and October 2021. For these falsely reported services, AOT received over $4,500. DEFENDANT and S.J. also texted, including on May 28, 2021, when DEFENDANT asked S.J. to pick up her money, and S.J. replied that she had already picked it up but it was short $30. On July 8, 2021, S.J. again texted DEFENDANT that she needed her money. In September, S.J. texted that she needed the log in and hours for her brother; DEFENDANT replied with the information, including the username and password for a PCA at AOT, then stated the hours typically reported for that PCA. S.J. entered the times he reported to work.

Recipient B.A. (Benjamin Adams) was incarcerated from August 11 through November 1, 2022. B.A. was also incarcerated on May 10, 2022; June 3, 2022, and November 10 and 11, 2022. During this time, DEFENDANT submitted claims reporting three PCAs provided between 3.5 and 6.25 hours of services a day, while the recipient was in custody. Services could not have been provided while B.A. was incarnated, yet DEFENDANT submitted claims for over 550 hours of services and Medicaid reimbursed AOT, almost $11,000 for these false claims.

DEFENDANT also submitted claims when C.A. (Chaka Adams), C.B. (Crystal Bass), and S.N. (Shirwa Nur) were in custody. DEFENDANT submitted claims reporting over 700 hours of PCA services were provided to the three recipients, when the services could not have been provided. For these false claims, Medicaid reimbursed AOT, over $13,500.

In total, DEFENDANT submitted claims for over 2,700 hours of services that did not occur. DEFENDANT profited when she received over $50,000 in Medicaid funds for services that were not provided while the recipients were in patient or in custody.

C. DEFENDANT conspired with others to bill for services that lacked documentation to support the services were actually rendered.

In addition to billing for services not rendered at all, DEFENDANT maximized billing by submitting claims without completed time sheets. MFCU investigators determined that the services billed and described below were not provided at all or were not eligible for reimbursement.

7. Recipient K.K.

Recipient K.K. signed time sheets that did not have times or dates completed. The timesheets state:

> After PCA has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive services from the PCA. Review the completed time sheet for accuracy before signing. It is a federal crime to provide false information on PCA billings for medical Assistance payment. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the PCA Care Plan.

There were also timesheets that neither K.K. nor a PCA signed or completed. For more than 250 claims, the timesheets were incomplete, lacking either signatures verifying that the work was completed, or had signatures but lacked any time or tasks. Yet, DEFENDANT submitted claims or directed claims to be submitted, without any support that the services had been provided. DEFENDANT submitted or caused to be submitted more than 500 hours of claims for services to K.K. that have no documentation that the services occurred. For these false claims, Medicaid paid AOT over $13,000.

8. **Recipient R.S.**

Recipient R.S received homemaking services from multiple workers. There are timesheets, but some while services were initialed and times entered, were not signed by the PCA. Others were not signed by R.S. Additionally, R.S.'s signature varied greatly, appearing that R.S. was not the one signing the timesheets much of the time. DEFENDANT submitted claims or directed others to submit claims for services without verification that the services were provided. For the more than 800 hours of services that DEFENDANT billed without complete timesheets, Medicaid reimbursed AOT, more than $15,000.

9. **Recipient A.J.**

A.J. was a recipient and also a RP for other recipients through AOT. A.J. signed timesheets before the PCA filled in the time in and out, or initialed by the services provided. A.J. could not have verified the services reported when she signed before any hours were listed. A.J. also signed timesheets that had a time, but no initials of what services were provided, or a PCA's signature. PCA, Fadumo Ali, stated that she never provided services to A.J. DEFENDANT submitted claims or directed claims to be submitted reporting that Fadumo Ali provided services to A.J., when they were not provided. DEFENDANT, through AOT, billed for over 600 hours of services that were not provided to A.J. For these false claims, Medicaid paid AOT over $15,000.

10. **Recipient W.S.**

Louvinia Byrd was the PCA for W.S. They routinely completed timesheets, but there were days when the timesheets were blank, indicating that services were not provided to W.S. On more than 25 days, DEFENDANT submitted or directed claims to be submitted when the timesheet was blank, or lacked verification, such that there was not a showing that services had been provided. For these falsely submitted services, Medicaid paid AOT over $1,700.

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11. **Recipient W.B.**

W.B. also received PCA services through AOT. At times, W.B. signed timesheets verifying services provided and the times the services were provided, showing that W.B. and the providers knew to complete and verify services on the timesheets. There were timesheets that did not have times or initials by the services provided, and other timesheets that had W.B. and a provider's name but were blank. Although the timesheets were not complete and there was no documentation that services were provided, DEFENDANT submitted or caused claims to be submitted for days without timesheet documentation, and Medicaid reimbursed over $6,000 to AOT, for these false claims.

There were more than 100 recipients that DEFENDANT submitted claims or directed that claims be submitted when the timesheet was blank except for typed in names of a recipient and provided and typed in dates, or in cases where the timesheet was signed but no times are services were designated. DEFENDANT had been trained through DHS when she attended the Steps for Success course where she was taught the operation of PCA Service agencies, and when she completed the billing lab training, teaching DEFENDANT the proper way to submit claims, which is that a claim should not to be submitted until after the work had been completed, and without documentation of that the service had been provided. There is nothing to show any services occurred on the days that blank or incomplete timesheets are what AOT received. Yet DEFENDANT billed or directed others at AOT to bill for services that were not reported or verified on timesheets. For these false claims, Medicaid reimbursed AOT over $275,000.

D. Worker not eligible to provide services

In order to provide services to a Medicaid recipient, a worker must pass a background study. During COVID, temporary background studies were completed, which allowed someone to work throughout the pandemic. Temporary background studies expired by December 31, 2022. A worker who wanted to continue providing services had to complete a full background study to be eligible to continue to provide services to Medicaid recipients.

Agencies coordinate the background studies for their employees. DEFENDANT did not have the employees of AOT, who had temporary background studies, submit full background studies, so they would remain eligible. While DEFENDANT did not submit full background studies, she continued to submit claims for these employees. DEFENDANT submitted claims for more than a dozen ineligible employees in January and February 2023. DEFENDANT submitted claims for more than 4,000 hours of services and Medicaid reimbursed AOT over $85,000.

IV. AOT Bank Account Payments.

DEFENDANT juggled money between AOT accounts, as well as to her personal accounts. DEFENDANT was paid $2,500 a pay period from AOT (between $1,800 and $1,840 after taxes). DEFENDANT additionally wrote checks from AOT's accounts to herself, including at times after the paperwork to transfer AOT to Ismail Abdulle was created. Some of the times DEFENDANT made checks out to herself, include:

- $10,000 on December 11, 2020
- Two checks totaling $10,000 on May 21, 2021
- $5,000 on June 2, 2021
- Two checks totaling $30,000 on June 17, 2021

- $10,000 on July 2, 2021
- $30,000 on August 17, 2021
- $50,000 on February 13, 2023
- $20,000 on May 22, 2023

Further, DEFENDANT withdrew large amounts from AOT's bank account, including $117,883.92 on December 20, 2022, just a few days after the date of the paperwork transferring AOT to Ismail Abdulle. There was another transfer, on February 6, 2023, for $139,841.00. Between March 2022 and July 2023, there was over $520,000 additionally withdrawn, in what appears to be cash and/or cashier's checks in amounts ranging from around $100 to as much as $50,000. This is in addition to over $125,000 in wire transfers between April 2022 and January 2023, including transfers to an overseas bank. There were no records in AOT's files indicating that this money was used for the benefit of AOT or its service providers.

DEFENDANT paid kickbacks to recipients and RPs. DEFENDANT would text a biller directing the biller to send money to recipients or RPs via Cash App. For example, on December 13, 2021, DEFENDANT texted "$Alexisls92 send 225" to Ayan Dirie, a biller for AOT. Ayan Dirie replied, "I sent it." DEFENDANT regularly instructed office staff to send money through Cash App to at least 20 recipients and RPs.

DEFENDANT made checks out to people who did not work for AOT. For example, there are five checks to Timothy Townsend totaling over $4,000. However, Timothy Townsend did not work at AOT. Two of the checks are signed over to another person.

V. CONCLUSION

From September 2020 through June 2023, DEFENDANT engaged in an extensive plan to defraud the Medicaid program. Through AOT, DEFENDANT submitted or directed the submission of claims for services that were not eligible for reimbursement because they were not provided at all or were not provided in accordance with Minnesota law. DEFENDANT used dozens of recipients, PCAs, and care givers to falsely report that PCA and Waivered services were being provided. Each line that MFCU investigators learned was a crime, is listed on an excel spreadsheet, the charging spreadsheet. The spreadsheet has notes of why each claim line on the spreadsheet was determined to be false. There are over 9,000 individual claims that comprise the overall totals of the complaint. The spreadsheet detailing each fraudulent claim shows that Medicaid paid more than $675,000 to AOT based upon the fraudulent claims DEFENDANT submitted. Aggregated into six-month charging periods by warrant date (the date the claim was paid), DEFENDANT aided and abetted in fraudulent schemes and caused the Medicaid program to overpay as follows:

- Count 1 - between December 20, 2022, and June 6, 2023, Medicaid paid out more than $35,000 in Medicaid funds based upon Defendant's fraudulent submissions for PCA and Waivered services.
- Count 2 - between June 7, 2022, and December 6, 2022, Medicaid paid out more than $35,000 in Medicaid funds based upon Defendant's fraudulent submissions for PCA and Waivered services.
- Count 3 - between December 7, 2021, and May 24, 2022, Medicaid paid out more than $35,000 in Medicaid funds based upon Defendant's fraudulent submissions for PCA and Waivered services.
- Count 4 - between May 25, 2021, and November 23, 2021, Medicaid paid out more than $35,000 in Medicaid funds based upon Defendant's fraudulent submissions for PCA and Waivered services.

- Count 5 - between November 24, 2020, and May 11, 2021, Medicaid paid out more than $35,000 in Medicaid funds based upon Defendant's fraudulent submissions for PCA and Waivered services.

- Count 6 - between September 29, 2020, and November 10, 2020, Medicaid paid out more than $5,000 in Medicaid funds based upon Defendant's fraudulent submissions for PCA and Waivered services.

SIGNATURES AND APPROVALS

Filed in District Court
State of Minnesota
9/25/2026

Complainant requests that Defendant, subject to bail or conditions of release, be:
(1) arrested or that other lawful steps be taken to obtain Defendant's appearance in court; or
(2) detained, if already in custody, pending further proceedings; and that said Defendant otherwise be dealt with according to law.

Complainant declares under penalty of perjury that everything stated in this document is true and correct. Minn. Stat. § 358.116; Minn. R. Crim. P. 2.01, subds. 1, 2.

Complainant

Kara Vanderkooi
Investigator
445 Minnesota Street
Suite 1400
St. Paul, MN 55101

Electronically Signed:
09/25/2026 11:44 AM
Ramsey County, Minnesota

Being authorized to prosecute the offenses charged, I approve this complaint.

Prosecuting Attorney

Kristi Nielsen
445 Minnesota Street
Suite 1400
St. Paul, MN 55101
(651) 296-3353

Electronically Signed:
09/25/2026 11:14 AM

Filed in District Court
State of Minnesota
9/25/2026

FINDING OF PROBABLE CAUSE

From the above sworn facts, and any supporting affidavits or supplemental sworn testimony, I, the Issuing Officer, have determined that probable cause exists to support, subject to bail or conditions of release where applicable, Defendant's arrest or other lawful steps be taken to obtain Defendant's appearance in court, or Defendant's detention, if already in custody, pending further proceedings. Defendant is therefore charged with the above-stated offense(s).

[X] SUMMONS

THEREFORE YOU, THE DEFENDANT, ARE SUMMONED to appear as directed in the Notice of Hearing before the above-named court to answer this complaint.

IF YOU FAIL TO APPEAR in response to this SUMMONS, a WARRANT FOR YOUR ARREST shall be issued.

[ ] WARRANT

To the Sheriff of the above-named county; or other person authorized to execute this warrant: I order, in the name of the State of Minnesota, that the Defendant be apprehended and arrested without delay and brought promptly before the court (if in session), and if not, before a Judge or Judicial Officer of such court without unnecessary delay, and in any event not later than 36 hours after the arrest or as soon as such Judge or Judicial Officer is available to be dealt with according to law.

[ ] ***Execute in MN Only*** [ ] ***Execute Nationwide*** [ ] ***Execute in Border States***

[ ] ORDER OF DETENTION

Since the Defendant is already in custody, I order, subject to bail or conditions of release, that the Defendant continue to be detained pending further proceedings.

Bail: $
Conditions of Release:

This complaint, duly subscribed and sworn to or signed under penalty of perjury, is issued by the undersigned Judicial Officer as of the following date: September 25, 2026.

Judicial Officer Timothy Mulrooney
Judge

Electronically Signed: 09/25/2026 12:01 PM

Sworn testimony has been given before the Judicial Officer by the following witnesses:

COUNTY OF RAMSEY
STATE OF MINNESOTA

State of Minnesota

Plaintiff

vs.

Awo Ahmed Mohamed

Defendant

LAW ENFORCEMENT OFFICER RETURN OF SERVICE
I hereby Certify and Return that I have served a copy of this Summons upon the Defendant herein named.

Signature of Authorized Service Agent:

DEFENDANT FACT SHEET

Filed in District Court
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9/25/2026

Name:	Awo Ahmed Mohamed
DOB:	01/01/1990
Address:	2726 Huron Street Roseville, MN 55113
Alias Names/DOB:	
SID:	MN24F49896
Height:	
Weight:	
Eye Color:	
Hair Color:	
Gender:	
Race:	
Fingerprints Required per Statute:	Yes
Fingerprint match to Criminal History Record:	Yes
Driver's License #:	
Case Scheduling Information:	The AGO is prosecuting this case. The state is not available for a First appearance on 11/6/2026,
Alcohol Concentration:	

STATUTE AND OFFENSE GRID

Cnt Nbr	Statute Type	Offense Date(s)	Statute Nbrs and Descriptions	Offense Level	MOC	GOC	Controlling Agencies	Case Numbers
1	Charge	12/20/2022	609.52.2(a)(3)(iii) Theft-Medical costs	Felony	U1059	X	MN062015A	20230011
	Penalty	12/20/2022	609.52.3(1) Theft - Firearm or property value over $35,000	Felony	U1059	X	MN062015A	20230011
	Modifier	12/20/2022	609.05.1 Liability for Crimes of Another-Intentional	No-Level	U1059	X	MN062015A	20230011
2	Charge	6/7/2022	609.52.2(a)(3)(iii) Theft-Medical costs	Felony	U1059	X	MN062015A	20230011
	Penalty	6/7/2022	609.52.3(1) Theft - Firearm or property value over $35,000	Felony	U1059	X	MN062015A	20230011
	Modifier	6/7/2022	609.05.1 Liability for Crimes of Another-Intentional	No-Level	U1059	X	MN062015A	20230011
3	Charge	12/7/2021	609.52.2(a)(3)(iii) Theft-Medical costs	Felony	U1059	X	MN062015A	20230011
	Penalty	12/7/2021	609.52.3(1) Theft - Firearm or property value over $35,000	Felony	U1059	X	MN062015A	20230011
	Modifier	12/7/2021	609.05.1 Liability for Crimes of Another-Intentional	No-Level	U1059	X	MN062015A	20230011
4	Charge	5/25/2021	609.52.2(a)(3)(iii) Theft-Medical costs	Felony	U1059	X	MN062015A	20230011
	Penalty	5/25/2021	609.52.3(1) Theft - Firearm or property value over $35,000	Felony	U1059	X	MN062015A	20230011
	Modifier	5/25/2021	609.05.1 Liability for Crimes of Another-Intentional	No-Level	U1059	X	MN062015A	20230011
5	Charge	11/24/2020	609.52.2(a)(3)(iii) Theft-Medical costs	Felony	U1059	X	MN062015A	20230011
	Penalty	11/24/2020	609.52.3(1) Theft - Firearm or property value over $35,000	Felony	U1059	X	MN062015A	20230011
	Modifier	11/24/2020	609.05.1 Liability for Crimes of Another-Intentional	No-Level	U1059	X	MN062015A	20230011
6	Charge	9/29/2020	609.52.2(a)(3)(iii) Theft-Medical costs	Felony	U1059	X	MN062015A	20230011
	Penalty	9/29/2020	609.52.3(2) Theft - Value over $5,000 or trade secret, explosive, Controlled Substance I or II	Felony	U1059	X	MN062015A	20230011
	Modifier	9/29/2020	609.05.1 Liability for Crimes of Another-Intentional	No-Level	U1059	X	MN062015A	20230011