APPLICATION FOR PAYMENT OF SEXUAL ASSAULT FORENSIC MEDICAL EXAMINATION

OKLAHOMA CRIME VICTIMS COMPENSATION PROGRAM
421 NW 13TH ST, SUITE 290 ◆ OKLAHOMA CITY, OKLAHOMA 73103
(405)264-5006 ◆ (800)745-6098

SAEF Claim No._____

Pursuant to 22 O.S. § 40.1, the victim of the crime of rape or forcible sodomy has the right to a free forensic medical examination. Pursuant to 21 O.S. §142.19 & 142.20, the Sexual Assault Examination Fund is established for the purpose of providing the victim of a rape, rape by instrumentation, or forcible sodomy a forensic medical examination. The Crime Victims Compensation Board has established the procedures for disbursement of the Sexual Assault Examination Fund. Pursuant to statute, no more than Four Hundred Fifty Dollars ($450.00) can be paid from the Sexual Assault Examination Fund for a sexual assault forensic medical examination; and no more than Fifty Dollars ($50.00) can be paid for medications which are related to the sexual assault, and directed and deemed necessary by the health care professional. Such payments may not exceed the amounts specified by law, regardless of the amount of any individual bills comprising the claim. Payments up to the statutory maximum may be made directly to the service provider(s) for the sexual assault forensic medical examination.

VICTIM VERIFICATION

I hereby authorize the following medical facility, _____, to conduct a forensic sexual assault medical examination of my body. If I choose to file a claim with my insurance company for reimbursement of the sexual assault examination, any monies received shall be returned to the Sexual Assault Examination Fund of the Oklahoma Crime Victims Compensation Program. I am currently covered by Medicaid or another federally-funded program ☐. If box is checked, please list your ID number _____.

_____
Victim's Name (please print)

_____
Name of Parent/Guardian – if victim is under 18 years of age (please print)

_____
Victim's Signature

_____
Parent/Guardian's Signature

_____
Victim's Address

_____
Parent/Guardian's Address (if different)

_____
Victim's City State Zip

_____
Parent/Guardian's City State Zip

_____ ☐ Male ☐ Female
Date of Birth

_____
County of Incident **Date of Exam**

MEDICAL FACILITY INFORMATION

_____
Name of Facility

_____
Address

_____
Facility's Tax ID Number

_____
City State Zip

PLEASE COMPLETE REVERSE SIDE OF APPLICATION

SAEF Examiner Use Only
Amount Paid:

EXAMINING PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER OR SANE NURSE VERIFICATION

With my signature below, I hereby certify:

1) I have conducted a forensic sexual assault or child sexual abuse medical examination on: _____; and
2) I have collected samples and/or documented my examination according to accepted standards or protocols; and
3) I collected the following evidence during the course of this examination (*check all that apply*):
   ☐ Sexual Assault Evidence Kit ☐ Photo Documentation ☐ History of the Assault ☐ Exam or Summary Report
   ☐ Other (items not included in kit; specify here) _____; and
4) I have submitted the evidence to the following agency: _____,

_____	_____
Name & Title (Please Print)	Phone Number
_____	_____
Signature	Address
_____	_____
Social Security or Tax ID Number	City State Zip

Is the examining Physician, SANE Nurse, Nurse Practitioner, or Physicians Assistant contracted to receive payment through Medicaid and other federally-funded programs, such as Medicare? ☐Yes ☐No. If yes, and the victim is currently covered by a federally-funded program, you must file with that program and submit a denial with this application to receive payment from the Sexual Assault Examination Fund, pursuant to 185:15-1-6 of the Sexual Assault Examination Fund Rules and Regulations. **Failure to fully complete this section will result in non-payment. IMPORTANT! If a provider, such as a Nurse Examiner or SANE program, is not contracted to receive payment through Medicaid or other federally-funded programs, there is no need to request the Medicaid number under the victim verification section of this application.**

INSTRUCTIONS FOR PROCESSING APPLICATION

After the victim of a sexual assault has received a forensic medial examination, the following steps must be taken to request payment for the exam:

- The hospital emergency room should have the victim or victim's parent/guardian complete **ALL** of the **Victim Verification** section.
- The hospital should complete the **Medical Facility Information** section.
- The medical professional conducting the exam should complete the **Examining Physician or SANE Nurse Verification** section completely.
- Attach an itemized statement for each provider seeking payment to the back of the application. Tax ID and Social Security Numbers must be listed for anyone receiving a payment.
- Forward the application and attached itemized statements to the District Attorneys Council, Victims Services Division, 421 N.W. 13th Street, Suite 290, Oklahoma City, OK 73103.
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  - **Do not** mail application in Red Envelope.
  - **Do not** place application in completed rape kits.
  - **Do not** send application with patient.