

APPLICATION FOR PAYMENT OF SEXUAL ASSAULT 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 21 O.S. §§ 142.19 & 142.20, this application is made for payment toward the forensic sexual assault examination of the victim named below. Payments up to the statutory maximum may be made directly to the service provider(s) for expenses incurred in the forensic examination and to provide to the victim medications as directed by the medical authority conducting the examination. Medications may only be provided to said victim on a one-time basis for the immediate trauma and medical examination.

VICTIM VERIFICATION

I hereby authorize the following medical facility, _____, to conduct a forensic sexual assault examination of my body in order to obtain physical evidence for the purpose of aiding in the apprehension and prosecution of my assailant. I understand that I will be personally responsible for the examination cost unless payment from the Sexual Assault Examination Fund is approved by the District Attorney's Office. 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.

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

Date of Birth

Male Female

County of Incident

Date of Exam

DISTRICT ATTORNEY VERIFICATION

I hereby certify that at the time this sexual assault forensic examination was performed, there existed reason to believe the above named individual was the victim of a sexual assault in this jurisdiction. I recommend payment be made from the Sexual Assault Examination fund for the above-mentioned forensic examination.

Signature of DA or Authorized ADA

Date Authorized

PLEASE COMPLETE REVERSE SIDE OF APPLICATION

SAEF Examiner Use Only
Amount Paid:

EXAMINING PHYSICIAN OR SANE NURSE VERIFICATION

I hereby certify that I have conducted a forensic Sexual Assault Examination on the above-named victim. The evidence has been collected and preserved and will be sent to the _____ Law Enforcement Forensic Laboratory.

Name & Title (Please Print)

Phone Number

Signature

Address

Social Security or Tax ID Number

City

State

Zip

MEDICAL FACILITY INFORMATION

Name of Facility

Address

Facility's Tax ID Number

City

State

Zip

INSTRUCTIONS FOR PROCESSING APPLICATION

After a victim has received an examination, the following steps must be taken to fill out the Application for Payment of Sexual Assault Examination.

- ♦ The hospital emergency room should have the victim or victim's parent/guardian complete **ALL** of the **Victim Verification** section.
- ♦ The attending nurse or qualified registered nurse should complete the **Examining Physician or SANE Nurse Verification** section.
- ♦ The hospital should complete the **Medical Facility Information** section.
- ♦ 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 Attorney of the county where the crime took place. Send to the attention of the Victim Witness Coordinator.
- ♦ The D.A. will then fill out the **District Attorney Verification** section.
- ♦ The D.A.'s office will then forward the application to the Oklahoma Crime Victims Compensation Program.
 - **Do not** mail application in Red Envelope.
 - **Do not** place application in completed rape kits.
 - **Do not** send application with patient.