

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, the Sexual Assault Examination Fund is established for the purpose of providing the victim of a sexual assault a forensic medical examination. Payments up to the statutory maximum may be made directly to the service provider(s) for the forensic medical examination, and to provide to the victim medications as directed by the health care professional.

VICTIM VERIFICATION

I hereby authorize the following medical facility, _____, to conduct a forensic 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.

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

MEDICAL FACILITY INFORMATION

Name of Facility

Address

Facility's Tax ID Number

City State Zip

SAEF Examiner Use Only
Amount Paid:

PLEASE COMPLETE REVERSE SIDE OF APPLICATION

EXAMINING PHYSICIAN OR SANE NURSE VERIFICATION

I hereby certify that I have conducted a forensic medical 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

INSTRUCTIONS FOR PROCESSING APPLICATION

After the victim of a sexual assault has received a forensic medical 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.
 - ♦ 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, Oklahoma City, OK 73103.

- **Do not** mail application in Red Envelope.
- **Do not** place application in completed rape kits.
- **Do not** send application with patient.