Adult Sexual Assault Forensic Examination Reimbursement Application

This application should be used by victims who did not or do not wish to disclose to law enforcement at this time and are primarily seeking reimbursement for only the cost of sexual assault forensic and medical examination This form is not applicable for minor victims.

Adult (18 years of age and older) Victim Information

Legal Name: ____________________ Social Security Number: ____________

Address: ____________________ City: __________ State: ______ Zip: ______

Date of Birth: __________ Gender: ☐ Female ☐ Male Phone #: (______) __________

Email Address: ________________________________

Legal Guardian Name: ______________ Relationship to adult victim: ____________

Legal Guardian Address: ______________ City: __________ State: ______ Zip: ______

Legal Guardian Email Address: ____________________ Phone # (______) __________

Authorization to Release Information

I authorize my insurance information, billing information and all medical records or reports relating to this examination to be released to the Idaho Crime Victims Compensation Program for payment consideration and to the prosecutor's office for the purposes of securing restitution.

______________________________ ______________

Signature of Victim or Legal Guardian Date

Crime and Examination Information

Crime Type: Adult Sexual Assault

Date of Crime: ____________ Location of Crime (City and State): ________________

Was the Crime reported to Law Enforcement? ☐ No ☐ Yes, Name of Agency ________________

Name of medical facility where examination was completed: ________________________

Address of medical facility: City ____________________ State: ____________

Date of Examination: __________ Sexual Assault Kit # ________________

Is a follow-up appointment required? ☐ No ☐ Yes, explain ________________________

Insurance Information

Please check all that apply:

☐ Private Insurance: Provider __________ Policy # ____________

☐ Medicaid: Medicaid Number __________ ☐ Medicare: Medicare Number ____________

☐ Indian Health Services ☐ Other

Completed Applications can be sent via:

Mail: Idaho Crime Victims Compensation Program P.O. Box 83720 Boise Idaho 83720-0041

Fax: 208-332-7559

Email: cvcp.admin@iic.idaho.gov