APPLICATION FOR PAYMENT OF ACUTE SEXUAL ASSAULT

FORENSIC MEDICAL EXAMINATION

OKLAHOMA CRIME VICTIMS COMPENSATION PROGRAM
421 NW 13TH St., Ste. 290 Oklahoma City, OK 73103
405-264-5006 OR 800-745-6098

DAC SAEF Claims Examiner Use Only

SAEF Claim No. _____

Reviewed by: _____ **Date:** _____

Approved by: _____ **Date:** _____

Nurse: $_____

Facility: $_____

Medications: $_____

Total: $_____

Pursuant to 21 § 142 A-3 (c) (4), the victim of the crime of rape or forcible sodomy has the right to a free forensic medical examination. 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 pursuant to 21 O.S. §142.19 & 142.20. The Crime Victims Compensation Board shall establish the procedures for disbursement of the Sexual Assault Examination Fund. Pursuant to statute, no more than Eight Hundred Dollars ($800.00) can be paid from the Sexual Assault Examination Fund for a sexual assault forensic medical examination; and no more than One Hundred Dollars ($100.00) 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 for medications shall be made only upon claims signed by a health care professional AND an adult victim or guardian if the victim is a minor.***

VICTIM VERIFICATION

I hereby authorize _____ to conduct an acute forensic sexual assault medical examination of my body. If I choose to file a claim with my insurance company for reimbursement of the acute 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. ID number: _____

_____
Victim's Name (please print)

_____
Victim's Signature

_____
Victim's Mailing Address

_____
Victim's City State Zip

Date of Birth: _____ ☐Male ☐Female

Age: _____

_____
Name of Parent/Guardian/Person requesting exam (please print)

_____
Parent/Guardian/Requestor Signature
(***required for medications if victim is under 18***)

_____
Parent/Guardian's Address (if different)

_____
Parent/Guardian's City State Zip

_____ _____
Date of Incident County of Incident

_____ _____ _____
Date of Exam Start time End time

Have you received information about Crime Victims Compensation? ☐ Yes ☐ No

If no, how would you like information to be provided? ☐ I do not wish to receive information

☐ Mailing address listed above ☐ Email: _____

*Attempt to reach parent or guardian via _____ was made ☐ with ☐ without success

Notes: _____

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

(FAILURE TO FULLY COMPLETE THIS PAGE WILL RESULT IN NON-PAYMENT)

With my signature below, I hereby certify:

1. I have conducted an acute forensic sexual assault examination on: _____
2. I have collected DNA samples and/or documented my examination according to accepted standards or protocols
3. During the course of this examination, I collected the following evidence: (check all that apply)

☐ Sexual Assault Evidence Kit ☐ Photo Documentation ☐ History of the Assault ☐ Exam or Summary Report

☐ **Standard parameters not followed; Not all boxes are marked from item 3. Detailed documentation must be provided with this application for consideration of payment for each box not marked.**

☐ Other items not included in kit (specify here) _____

4. I have submitted the evidence to the following law enforcement agency: _____

Name & Title (Please Print) _____ Address _____

Signature _____ City _____ State _____ Zip _____

Phone Number _____ Email _____

COMPLETION OF THIS SECTION IS REQUIRED FOR PAYMENT!

Is the examining Physician, Physician's Assistant, Nurse Practitioner, or SANE Nurse 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.

IMPORTANT! If a provider, such as a Physician, Physician's Assistant, Nurse Practitioner, SANE Nurse 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.

MEDICAL FACILITY INFORMATION

Name of Facility where exam was performed _____ Facility Payment Address (if different) _____

Physical Address where exam was performed _____ City _____ State _____ Zip _____

City _____ State _____ Zip _____ Phone _____

Verification by Physician or Facility Director

(This section must not be completed by the person performing the acute forensic sexual assault examination)

I hereby certify that the above-named examining physician, physician's assistant, nurse practitioner or SANE nurse has conducted an acute forensic medical examination as specified above.

Print Name _____ Print Title of Physician or Facility Director/Coordinator _____

Signature _____ Date _____ Phone _____ Email _____

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OFFICIAL CRIME VICTIMS COMPENSATION

ACUTE SEXUAL ASSAULT EXAMINATION INVOICE

Victim's Name (please print) _____ Date of Incident _____ Date of Exam _____

Medications	Cost
	Total $

ACUTE FORENSIC SEXUAL ASSAULT EXAMINER

Exam Fee: _____ Payable to: _____

Social Security or Tax ID: _____

FACILITY

Facility Fee: _____ Payable to: _____

Tax ID: _____

MEDICATIONS (Maximum $100.00)

Medications Fee: _____ Payable to: _____

Tax ID: _____

THE FOLLOWING STEPS MUST BE TAKEN TO REQUEST PAYMENT

1. The Victim or parent/guardian/requestor should complete ALL of the Victim Verification section.
2. Indicate what attempts were made to contact the victim's parent or guardian if the victim is a minor.
3. Complete **ALL** sections of the Acute Sexual Assault Application for Payment.
4. The medical professional conducting the exam should ensure the Verification by Physician or Facility Director section has been completed by someone other than the person performing the exam.
5. Each provider seeking payment must provide an Official Crime Victims Compensation Sexual Assault Examination invoice **(no other invoices will be accepted as of February 1, 2025)**. The invoice must include the tax ID or Social Security number for each provider seeking payment.
6. **If the exam is performed outside of the standard parameters without all boxes of item 3 marked on page 2, detailed documentation must be provided for each box not marked for consideration of payment.**
7. New sexual assault nurses and providers seeking payment not previously registered as a state Supplier must register at the Oklahoma Supplier and Payee Registration Portal online at: supplier.registration@omes.ok.gov with the Office of Management and Enterprise Services (OMES). Once approved, provide their Supplier ID, payment information and a copy of their SANE Training Certification to the District Attorneys Council SANE claims Examiner.
8. Submit completed applications to:

District Attorneys Council
Attn: Victims Services Division
421 NW 13th St., Ste. 290
Oklahoma City, OK 73103

- Do not place application in completed rape kits.
- Do not send the application with the patient.

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