# 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