Reset Form

SAK Serial Number: IN _ _-_ _ _ _ _ _
ICJI Claim Number: S _ _-_ _ _ _ _ _
PIN: _ _ _ _

# Sexual Assault Compensation Information Sheet

Part of State Form 241 (R11 / 5-19)

The Indiana Criminal Justice Institute (ICJI), in accordance with Indiana Code 5-2-6.1-39, administers payment for certain costs associated with a forensic medical exam. These costs include, but may not be limited to, the cost of the forensic medical exam, mental health counseling, certain diagnostic testing, initial pregnancy and follow-up pregnancy testing, certain laboratory testing for STDs, alcohol, drugs, suturing and care of wounds, STD prophylaxis to include HIV prophylaxis, and other limited outpatient services. The approved costs will be paid by ICJI to the provider if the following conditions are met:

1. The patient must be the victim of a sex crime that occurred in Indiana.
2. The patient is treated by a provider that provides general medical, surgical and emergency services for sex crimes that occur in Indiana.
3. The patient must consent, in writing, to allow the release of their medical records to ICJI.
    a. The consent is authorized when the patient signs their name on the ICJI application while at the hospital.
    b. If the patient is under eighteen (18) years old, a parent or guardian must give consent in writing as the responsible party. In addition, law enforcement and/or the Indiana Department of Child Services must be notified.
4. The provider is responsible for applying to ICJI for payment of services. ICJI remits payment directly to the service provider on the patient's behalf.

Forensic medical exams must be provided free of charge to the patient.

ICJI may also provide payment for: One follow-up pregnancy test, sexually transmitted disease testing up to thirty (30) days following the initial treatment; one syphilis test up to ninety (90) days following the initial visit. ICJI will also provide payment for mental health treatment up to $3000. Services must be provided by a licensed mental health provider.

Additional information may be found at www.in.gov/cji/2333.htm or by calling 317-232-1233. You may also track the status of your sexual assault kit (SAK) by logging in to the Victim Compensation Claims System (VCCS) by visiting vcc.cji.in.gov/Public/Home.aspx selecting the SAK tracking module and entering your SAK serial number and assigned PIN.

**You may refuse to allow the service provider to apply to the fund on your behalf.**
This has no bearing on whether the case may be referred for prosecution. However, the hospital or sexual assault treatment center may bill you or your insurance provider for care received beyond the scope of the forensic medical exam.

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HIV medication(s) should be taken as prescribed and should be started within **seventy-two (72) hours** following the incident. Please present the prescription processing information below to the pharmacy of your choice. If you have any questions, please contact Member Services toll free at **(866)-921-4047**.

RXBIN: 020958
RX PCN: 07960000
RXGRP: TRUE5000
ID:
ID Key: DOB:
LASTNAME:
FIRSTNAME:

Pharmacy Help Desk: (844) 544-3228
Member Services: (866) 921-4047

**ICJI is not responsible for the distribution of HIV medication.**

**Receipt of the medication may take up to twenty-four (24) hours.**

# APPLICATION FOR BENEFITS
# SEX CRIME VICTIM SERVICES FUND

State Form 241 (R11 / 5-19)

encore

*INSTRUCTIONS:*
1. *Remove the information sheet and prescription identification card. Give both to the patient and ask them to read it prior to completing the application for benefits.*
2. *Attach a copy of the patient's complete Emergency Room record from the date of examination.*
3. *Attach an itemized bill to this application.*

SAK Serial Number

IN _ _-_ _ _ _ _ _

*If you have questions or concerns, please contact the Indiana Criminal Justice Institute at 317-232-1233.*

Send **ORIGINAL WHITE** copy to: Indiana Criminal Justice Institute, 101 W. Washington St. Suite 1170 - East Tower, Indianapolis, IN 46204.

## A. Consent (*To be completed by patient or guardian.*) *Initial by each item to indicate consent and understanding.*

_____ 1. I have read and understand the attached letter explaining the sex crime victim services fund.

_____ 2. I authorize this facility, its physicians, agents, and employees to examine me in relation to an alleged sexual assault, and to conduct tests for that purpose.

_____ 3. I authorize this hospital to release a completed copy of this application/report with any evidence of sexual assault , including, but not limited to, my clothing, laboratory specimens and medical records of this date to *(law enforcement agency)*:_____

_____4. I authorize the release of this application and medical records of this date to the sex crime victim services fund for the purpose of evaluation and payment.

_____5. If this case involves a minor, I authorize the appropriate Child Protective Services caseworker or law enforcement to release information regarding this investigation to the Indiana Criminal Justice Institute.

| Signature of patient or guardian | If patient is a minor, relationship to signee | Date *(mm/dd/yyyy)* |
|---|---|---|
| | | |

## B. Identifying Information (*To be completed by hospital personnel.*)

Is the patient a minor? If patient is seventeen (17) or under, you must report to law enforcement or Child Protective Services. *(check)* ☐ Yes ☐ No

| Name of patient | Name of parent or guardian (*if patient is a minor*) |
|---|---|
| | |

| Gender *(check)* | Race of Patient* | Marital Status | Date of birth *(mm/dd/yyyy)* | Date of assault / abuse *(mm/dd/yyyy)* |
|---|---|---|---|---|
| ☐ Male ☐ Female | | | / / | / / |

Address *(Street, City, State, ZIP Code)*

## C. Information about the assault (*To be completed by hospital personnel.*)

Is the patient reporting to law enforcement?** *(check)* ☐ Yes ☐ No

| If reported, date reported to law enforcement *(mm/dd/yyyy)* | Exact location of assault *(If known, address, city, state, county)* |
|---|---|
| / / | |

| Name of agency notified | | Name of officer / case worker reporting | |
|---|---|---|---|
| Case Number Assigned | Approximate time assault occurred : ☐ AM ☐ PM | Date arrived at hospital *(mm/dd/yyyy)* / / | Date evidence collected *(mm/dd/yyyy)* / / |

| Suspect's Name *(if known / applicable)* | Relationship to patient / victim *(if applicable)* |
|---|---|
| Does patient / victim know the suspect(s)? *(check)* ☐ Yes ☐ No | Race of Suspect *(if known)** |
| Type of sexual trauma *(check all that apply)*: ☐ Vaginal ☐ Child Molestation (*under sixteen (16)*) ☐ Oral ☐ Anal ☐ Unknown ☐ Other *(specify)*: | Type of evidence collected *(check all that apply)*: ☐ Sexual Assault (SA) Kit ☐ Clothing ☐ Medical Forensic Examination ☐ Patient History ☐ Other *(specify)*: |
| Was the collected evidence transferred to law enforcement? *(check)* ☐ Yes ☐ No | Date of evidence transfer to law enforcement *(mm/dd/yyyy)* / / |
| Name of transporting officer | Badge Identification number |
| Signature of transporting officer | |

## D. Service Provider information (*To be completed by hospital personnel.*)

| Patient Account Number | Was the patient admitted for inpatient care? *(check)* ☐ Yes ☐ No |
|---|---|
| Was the patient transferred from another facility? *(check)* ☐ Yes ☐ No | Name of transferring facility |
| Name of provider performing the exam | Telephone ( ) |
| Signature of provider | E-mail |

*Included for research purposes only. **Reporting is mandatory for all children ages seventeen (17) and younger.

**DISTRIBUTION:** Instruction Page – Patient; White – ICJI; Canary – Law Enforcement Agency; Pink - Hospital