REIMBURSEMENT REQUEST FORM

Ohio Attorney General Sexual Assault Forensic Examination (SAFE) Program

PLEASE ANSWER ALL QUESTIONS

1. Medical Facility _____

   Address _____

   City _____

2. SAFE Account (Vendor ID No.)

3. Name of Healthcare Professional(s) conducting the examination:

4. If it is a pediatric patient, is the primary examiner an expert in child sexual abuse? (see instructions)

☐Yes ☐No

5. Patient Name (First, MI, Last. See instructions for "Jane Doe" kits):

6. Patient Gender:

☐ Male
☐ Female
☐ Transgender

7. Patient D.O.B (dd/mm/yyyy)

☐☐☐☐☐☐☐☐

8. Patient Hospital Identification Number:

9. Date/Time of the Assault/Abuse: dd/mm/yyyy Time (24 hour):

10. Date/Time of When Treatment Started: _____ _____

☐☐☐☐☐☐☐☐ ☐☐☐☐

11. Indicators/history of sexual assault/abuse:

12. If known, what is the age of the perpetrator?

13. Was drug/alcohol facilitated sexual assault (DFSA) suspected? ☐Yes ☐No

If not detailed in #11, describe indicators:

14. Was a DFSA kit collected per the ***2011 Ohio Sexual Assault Protocol for Sexual Assault Forensic and Medical Examinations*** (see instructions) ☐Yes ☐No

If a specimen was collected, where was it sent for analysis (if known)?

15. Check all services that were provided:

- ☐ Evidence collection kit
  - ☐ Ohio Department of Health kit
  - ☐ Other (Name of Kit): _____
- ☐ Genital Exam
- ☐ Colposcope or similar technology
- ☐ Medical History
- ☐ Photodocumentation
- ☐ Remote technology consultation

16. If an evidence collection kit was mandated by the ***2011 Ohio Sexual Assault Protocol for Sexual Assault Forensic and Medical Examinations*** and no evidence collection kit was used, explain why (see instructions):

17. If an evidence collection kit was collected, did law enforcement retrieve the kit?

☐ Yes ☐ No **If no, explain:**

18. To which law enforcement agency or public children services agency was a report given by the medical provider?

19. At the time of assault, was the patient confined in a county, city, or federal jail or prison, or in any other institution maintained and operated by the Dept. of Rehabilitation and Corrections or Youth Services?

☐ Yes ☐ No **If yes, where?**

20. **My signature certifies that the information above is accurate and the *2011 Ohio Sexual Assault Protocol for Sexual Assault Forensic and Medical Examinations* was followed.**

_____ _____

Signature* & Title (Signature of Facility Coordinator) Print Name

21. Along with the submission of the Reimbursement Request Form, attach an itemized statement of all services provided (see instructions).

22. Submit To:	Ohio Attorney General SAFE Program Attn: SAFE Account Clerk 150 E. Gay St., 25th Floor Columbus, Ohio 43215	For Questions about Billing, Please Call: (614) 995-5415 Or (614) 466-3552 or (800) 582-2877 www.ohioattorneygeneral.gov