Application for Crime Victim Compensation

STATE OF RHODE ISLAND
OFFICE OF GENERAL TREASURER JAMES A. DIOSSA

(*Please print clearly and complete all FOUR sections)** **Official Use Only**

Claim #_____

Sexual Assault Exam Claim Form

SECTION ONE: VICTIM INFORMATION (TO BE COMPLETED BY VICTIM or HEALTH CARE PROVIDER)

Date of crime_____/_____/_____ Location of Crime _____ _____
City State

Victim's Name_____ Rhode Island Resident? Yes____ No____
First Name Middle Initial Last Name

Victim's Address _____
Street City State Zip Code

Home Phone (____) _____ Cell Phone (____)_____E-mail _____@_____

Date of Birth _____/_____/_____ Gender:_____ Race_____ Ethnicity_____

SECTION TWO: CRIME INFORMATION (TO BE COMPLETED BY HEALTH CARE PROVIDER as reported by patient)

Type of Crime: Sexual Assault_____ (Domestic) Sexual Assault_____ Child Sexual Assault_____

Offender: Family member _____ Non-family member _____

Was the crime reported to law enforcement? Yes ____ No ____ Police Department: _____

SECTION THREE: MEDICAL PROVIDER INFORMATION (TO BE COMPLETED BY HEALTH CARE PROVIDER)

Date of Sexual Assault Exam: _____/_____/_____

Patient has Health Insurance: Yes___ No ___ Unknown___
Patient asked to be billed as self-pay: Yes___ No___

Name of Medical Facility or Hospital _____

Address _____Phone Number (_____) _____

Health Care Provider Name _____ License Type _____
Please Print Name MD, RN, PA

Health Care Provider Signature _____ Date _____ /_____/_____

By signing this form, the health care provider acknowledges that the patient reported to be a victim of a crime, but the provider does not confirm that a crime actually occurred.

* Please forward billing invoice directly to Crime Victim Compensation Program.

SECTION FOUR: VICTIM REPAYMENT AGREEMENT (TO BE COMPLETED BY VICTIM/ GUARDIAN)

REPAYMENT AGREEMENT

I understand the Victim Compensation Fund is a FUND OF LAST RESORT. I understand that Rhode Island law requires me to contact and repay the Crime Victim Compensation Program if I receive payments from the offender, a civil law suit, and insurance program, Government of private agency, or any other source after I receive payment from the Crime Victim Compensation Program. I agree to notify the Crime Victim Compensation Program if I hire an attorney to represent me in any action related to this crime.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize any hospital, medical facility, doctor, mental health provider, employer, insurance company, person or agency to give needed information to the Crime Victims Compensation Program. I understand that the information will only be used to determine compensation benefits. I understand that any records are protected under the federal confidentiality regulations and under the general laws of the state of Rhode Island and cannot be disclosed without my written consent except as otherwise provided by law. Any information released or received as a result of this consent shall not be further relayed in any way to any other person, organization, entity or other, without an additional written consent by me. I may withdraw this consent by giving written notification to the above party at any time prior to the disclosure or the release of the information. I authorize that a Photostat copy of the original of this authorization be accepted with the same authority as the original.

I certify that the information and supporting documentation contained in this application is true and accurate to the best of my knowledge.

BCI DISCLAIMER

Pursuant to Rhode Island General Laws 12-25-19(d), the Criminal Injuries Act of 1999, this office may deny an award for compensation if the victim committed violent felonious criminal conduct within the past five years or subsequent to his or her injury.

I, _____, my date of birth is ___/____/_____ hereby direct and authorize the Bureau of Criminal Identification of the RI Department of Attorney General to make available to the Crime Victim Compensation Program any criminal record that the Bureau of Criminal Identification has on file in reference to me.

I hereby waive and release any and all manner of actions, causes of actions and demands of every kind, nature and description, arising from any release of criminal records and requests there from, whatsoever against the State of Rhode Island, Bureau of Criminal Identification, the Attorney General and employees of the Attorney General's Office and the Office of the General Treasurer in both law and equity which I may now have or in the future may have.

Signature **Date**

Claim Forms and Invoices should be faxed or mailed to:

CRIME VICTIM COMPENSATION PROGRAM
Office of the General Treasurer
50 Service Avenue, 2nd Floor
Warwick, RI 02886
Phone 401-462-7655 Fax 401-462-7694
www.treasury.ri.gov

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