CHILD ADVOCACY/RAPE CRISIS/SEXUAL ASSAULT CENTER APPLICATION AND INSTRUCTIONS

FORENSIC MEDICAL EXAMINATION PROGRAM

INSTRUCTIONS

To expedite the processing of your application, please submit a complete Forensic Medical Examination Application Packet, which includes items 1 and 2 below.

1

Fill out and sign the attached application.

2

Collect the required documents and attach to your application.

3

Mail the complete application packet to
Criminal Justice Coordinating Council,
Forensic Medical Examination Program
104 Marietta Street NW, Suite 440
Atlanta, GA 30303

The victim or their parent/legal guardian may apply to the CVCP to be considered for other benefits (i.e. medical, counseling, or lost/wages/loss of support). You can visit our website to get additional information about the CVCP and download the CVCP application.

If you would like help completing your application, or if you have any questions, please call us. We are available to assist you.

Office: (404) 657-2222
Toll Free: (800) 547-0060
TTY: (404) 463-7650
Fax: (404) 463-7652
crimevictimscomp.ga.gov

GEORGIA CRIME VICTIMS COMPENSATION PROGRAM
CRIMINAL JUSTICE COORDINATING COUNCIL

The Georgia Crime Victims Compensation Program will pay for the cost of a forensic medical examination up to $1,000 per victim, per victimization for a sexual assault that occurred in Georgia on or after July 1, 2011; otherwise, the appropriate law enforcement agency must be billed. Please note that the request for payment for the reasonable costs of a forensic medical exam complies with the following provisions:

PLEASE NOTE

- A physician, physician assistant, registered nurse, SANE-A (adult adolescent) or SANE-P (pediatric) must have performed the forensic medical examination.
- All applicable sections of the Application for Payment must be completed. Incomplete applications will not be processed and will be returned to the person that submitted the application, noting the reason the application is incomplete. The acknowledgement section of the application must be signed by the medical professional that conducted the forensic medical examination. Please Note: We must have an eligible application with the original signature of the medical examiner AND the Agency Executive Director or their designee on file before we can remit payment.
- All charges/services associated with the forensic medical examination that was performed must be itemized and submitted with the application, and only those expenses for the actual examination will be considered for payment. The bill must be submitted one time, within 30 days of the examination.
- The Forensic Medical Examination Fee Schedule reflects the maximum allowable cost for each service and/or procedure related to a forensic medical examination for sexual assault victims.
- Payment made by the Georgia Crime Victims Compensation Program for a forensic medical examination, as defined in O.C.G.A. § 17-15-2 (6) (A-E), must be considered as payment in full. The victim cannot be billed directly or indirectly for a forensic examination. All other services can be billed to the victim or their respective insurance.
- The Georgia Crime Victims Compensation Program is not bound by any billing or contractual agreements made between agencies and/or service providers. Please Note: The facility fee may not be paid to an individual examiner, unless they are the owner of the facility where the exam was conducted.
- The provider and/or facility should bill the Georgia Crime Victims Compensation Program the usual and customary charges for the forensic examination on a HCFA-1500, UB04, UB92, or itemized statement. To be considered for reimbursement, the bill for service must include the associated CPT Code or Revenue Code and an itemization of the services provided.
- The cost of only two forensic medical examinations per year, per sexual assault victim, will be considered a reasonable cost. If more than two requests are submitted per year, per victim, the third claim will be submitted to the Georgia Crime Victims Compensation Board for consideration.
- Any provider and/or facility submitting their Applications for Payment are subject to a site visit by the Criminal Justice Coordinating Council and must cooperate with the site visit process as a condition of receiving future payments for forensic medical examinations. Please Note: Please refer to our website for our FME Fee Schedule, Policy and Procedures, and FME forms.

FORENSIC MEDICAL EXAMINATION

CHILD ADVOCACY/RAPE CRISIS/
SEXUAL ASSAULT CENTER
APPLICATION

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Atlanta, GA 30303

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www.crimevictimscomp.ga.gov

O.C.G.A. § 17-5-72 provides that a victim shall have the right to a forensic medical examination, regardless of whether the victim participates in the criminal justice system or cooperates with law enforcement by pursuing prosecution of the crime. A victim must not be billed, directly or indirectly, for the cost of a forensic medical examination.

SECTION 1. VICTIM INFORMATION

In this section, please provide information about the victim.

Victim Name (First, Middle, Last)	Gender ☐ Male ☐ Female	Date of Birth (MM/DD/YY) / /
Social Security Number (or TIN)	Phone Number	

Demographic Data (For Statistical Use Only)

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian and Other Pacific Islander
☐ White/Non-Latino/Caucasian ☐ Hispanic/Latino ☐ Other Race _____

If 17 or older, is the victim a veteran? ☐ Yes ☐ No Is the victim disabled? ☐ Yes ☐ No If yes, is the disability as a result of the crime? ☐ Yes ☐ No

SECTION 2. VICTIM'S PARENT/LEGAL GUARDIAN INFORMATION

In this section, if the victim is a minor or has a caregiver, please provide information about the Victim's Parent/Legal Guardian.

Victim's Parent/Legal Guardian Name (First, Middle, Last)	Best Contact Phone Number	Relationship to Victim

Street Address (including apartment #)	City	State	Zip Code

Demographic Data (For Statistical Use Only)

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian and Other Pacific Islander
☐ White/Non-Latino/Caucasian ☐ Hispanic/Latino ☐ Other Race _____

Is the victim's parent/legal guardian a veteran? ☐ Yes ☐ No Is the victim's parent/legal guardian disabled? ☐ Yes ☐ No

SECTION 3. CRIME INFORMATION

In this section, please provide information about the crime that occurred.

Location of Crime (City and State)

Please Select the Type of Crime Reported:

☐ Rape
☐ Statutory Rape
☐ Child Molestation
☐ Aggravated Child Molestation
☐ Sodomy
☐ Aggravated Sodomy
☐ Incest
☐ Sexual Battery
☐ Aggravated Sexual Battery
☐ Human Trafficking
☐ Other _____

Date of Crime (MM/DD/YY) / /	Was the crime reported to law enforcement? ☐ Yes ☐ No	Date Crime Reported (MM/DD/YY) / /

Agency Crime Reported To	Law Enforcement Agency Case Number (if known)	Officer/Investigator Name

Did the alleged offense occur while the victim was incarcerated or in state custody (e.g. state mental facility)? ☐ Yes ☐ No

SECTION 4. MEDICATION

In this section, please provide information about medications prescribed for this victim, for this examination.

Please check ALL applicable boxes:

☐ No medication was prescribed/dispensed to the victim.
☐ An nPep starter pack was dispensed to the victim.
☐ An nPep starter pack was only prescribed (i.e., no medications dispensed) for the victim.
☐ An nPep full regimen was dispensed to the victim.
☐ An nPep full regimen was only prescribed (i.e., no medications dispensed) for the victim.
☐ Non HIV Medication(s) were dispensed to the victim.
☐ Non HIV Medication(s) were only prescribed (i.e., no medications dispensed) for the victim.

SECTION 5. FACILITY INFORMATION

In this section, please provide information on the facility where the forensic examination services were provided.

Name of Facility	Date of Forensic Examination(MM/DD/YY) / /	FEI Number
Street Address (City, State, Zip Code)		Facility Phone Number
Was a Rape Kit completed? ☐ Yes ☐ No	Was the facility space donated? ☐ Yes ☐ No	

SECTION 6. REMIT TO

In this section, please indicate who should receive payment and claim updates for the forensic medical examination rendered.

Name of Facility or Individual		FEI Number or Social Security Number
Street Address (City, State, Zip Code)		
Communication Preference for Claim Updates? ☐ Email ☐ Mail	Phone Number	Email Address

SECTION 7. CRIME VICTIMS COMPENSATION PROGRAM

In this section, please indicate which one applies.

☐ Our agency helped the victim with completing and/or submitting the required Victims Compensation application and documents.
☐ Our agency only told the victim about the Program or shared materials about the program with the victim.

The victim may apply for benefits offered through the Crime Victims Compensation Program for other expenses incurred as a result of the victimization to include the following:

- Medical Expenses: up to $15,000
- Counseling Expenses: up to $3,000
- Crime Scene Sanitization Expenses: up to $1,500
- Funeral Expenses: up to $6,000
- Economic Support Expenses: up to $10,000

SECTION 8. MEDICAL EXAMINER ACKNOWLEDGEMENT

This section must be read and signed by the medical examiner who conducted the forensic medical examination.

With my signature, I declare and affirm under penalty of perjury, pursuant to O.C.G.A. § 17-15-11, that the information provided above in Sections 1, 4, and 5; as well as the statements listed below on this Application for Payment are true and correct:

1. I confirm that the forensic medical examination on which this application is based was performed at this facility for the sole purpose of collecting forensic evidence on the above named victim.
2. If a colposcopy service/anogenital examination was conducted, I confirm that an approved medical device or equipment was utilized to conduct this service.
3. If brand name medications were prescribed, I confirm that they were medically necessary.

Name of Examiner (Printed) _____

Examiner's Title _____

X_____ Date (MM/DD/YY) _____/_____/_____

Examiner's Signature

SECTION 9. AGENCY ACKNOWLEDGEMENT

This section must be signed by the CAC/RCC/SAC Agency Executive Director or their designee.

With my signature, I declare and affirm under penalty of perjury, pursuant to O.C.G.A. § 17-15-11, that the information provided above in Sections 1-8; as well as the statements listed below on this Application for Payment are true and correct:

1. I confirm that none of the items/services listed on the itemized bill were donated.
2. I confirm that the items/services billed were related to conducting the forensic medical examination on which this application is based for the sole purpose of collecting forensic evidence on the victim listed in Section 1.
3. I confirm the itemized bill reflects the usual and customary fees for the services rendered.

Name of Executive Director or designee _____

X_____ Date (MM/DD/YY) _____/_____/_____

Signature of Executive Director or designee

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