Kentucky Claims Commission - Crime Victims Compensation
Sexual Assault Exam Program
130 Brighton Park Blvd., Frankfort, KY 40601
Office 502-782-8249 Fax 502-573-4817

Full Amount: $538.00
Partial Amount: _____
_____
To be entered by CVC
CVC Case # _____

COMPREHENSIVE CHILD SEXUAL ASSAULT MEDICAL EXAM/ TREATMENT BILLING FORM

Patient Name: _____

Patient Account #: _____

Fax completed forms and itemized bills to (502)573-4817. For Information, call (502) 782-8255 / (800) 469-2120

CHILD ADVOCACY CENTER INFORMATION

CAC Name: _____ Federal ID #: _____

Address: _____ Phone #: _____

_____ Contact: _____
City State Zip Code

I certify that a CCSAME exam as defined in 907 KAR 3:160 was preformed, and that the sexual abuse was reported as required in KRS 620.030

_____ _____
CAC Director (Print) Signature

PATIENT INFORMATION

Name: _____ Female_____ Male _____
First Middle Last

Social Security or Govt ID #:_____ Date of Birth:_____ Age:_____
at time of crime

Address: _____
City State Zip Code

Telephone #: (Home) _____ (Work) _____ (Cell) _____

Parent/Guardian E-Mail: _____

Insurance: _____ Medicaid: _____ Date of Examination: _____ Time: _____ a.m./p.m.

FEDERAL GOVERNMENT INFORMATION (optional/for statistical use only)

Ethnic Group (Patient)
( ) Caucasian
( ) African American
( ) American Indian or Alaskan Native
( ) Hispanic / Latino
( ) Multiracial
( ) Asian
( ) Native Hawaiian / Other Pacific Islander
( ) Other

Are you (please check all that apply)
( ) U.S. Citizen ( ) Handicap ( ) Kentucky Resident

Is this a Federal Crime? ( ) Yes ( ) No

SEXUAL ASSAULT INFORMATION

Date of Assault: _____ Time: _____ a.m/p.m.

City:_____ County: _____ State: Kentucky

MEDICAL CERTIFICATION

Failure of the examiner to certify that a CCSAME, as set forth in 907 KAR 3:160, was preformed will result in the denial of your claim.

I hereby certify that a CCSAME, as set forth in 907 KAR 3:160, was performed by me upon the above named patient on: _____, 20____

_____ _____

Physician, SANE, Physician Assistant or Advanced Practice Registered Nurse whose training and/or scope of practice includes performance of genital examination (print name)

License Number

_____

Signature

Fax or mail completed form with itemized bill to:
Kentucky Claims Commission/SAFE Exam Program
130 Brighton Park Blvd.
Frankfort, KY 40601

Fax # 502-573-4817

KRS 346:200(9) No charge shall be made to the victim for sexual assault examinations by the hospital, the sexual assault examination facility, the physician, the pharmacist, health department, the sexual assault nurse examiner, the victim's insurance carrier or the Commonwealth.

I authorize the release of this information to the Kentucky Claims Commission/ Crime Victims Compensation for billing purposes.

_____ _____

Parent or Guardian's Signature **Date**