MARTHA COAKLEY
ATTORNEY GENERAL

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE ATTORNEY GENERAL
VICTIM COMPENSATION & ASSISTANCE DIVISION
ONE ASHBURTON PLACE
BOSTON, MASSACHUSETTS 02108

(617) 727-2200
(617) 742-6262 FAX
WWW.MASS.GOV/AGO

Massachusetts Forensic Sexual Assault Exam Expense Application

The Victim of Violent Crime Compensation Assistance fund is available to assist you by paying for medical expenses incurred as a result of a Forensic Sexual Assault Exam performed by a SANE nurse or other medical provider. If you do not wish to use your health insurance or portions of the exam are not covered by insurance, this fund can pay for expenses relating to the performance of the exam itself, and medications prescribed at the time of the exam**.**

Please complete this application and mail it to the address above, or send by fax to the Victim Compensation & Assistance Division of the Office of Attorney General Martha Coakley at (617) 742-6262. **Please be sure to attach a copy of the Treatment and Discharge form and copies of any bills and/or receipts.** Our staff is also available to assist you in understanding your rights as a crime victim and provide support and referrals to other appropriate services. For additional information, call the Victim Compensation & Assistance Division at (617) 727-2200.

Applicant Information

First name _____ Middle Initial _____ Last name _____

Parent/Guardian Name _____ Date of birth _____ Gender: **M**____ **F**____
(If applicant is under the age of 18) *(month/day/year)*

Current mailing address _____

City _____ State _____ Zip _____ Email _____

Home phone _____ Cell phone _____

Massachusetts Sexual Assault Evidence Collection Kit Number*: _____

The kit number is located on the Treatment and Discharge form that you received from the hospital or medical provider. Please attach a copy of that form to this application.

Date of incident _____ City/Town where incident occurred _____

Medical facility _____

Date of treatment _____

CERTIFICATION:

I give permission to any hospital, medical facility, doctor, person or agency, including state and federal agencies, to give information to the Victim Compensation and Assistance Division. I understand that the information will be used to determine my claim for victim compensation benefits. I do not authorize the use or release of this information to any person or entity for any other purpose whatsoever. A photocopy of this signed release is as valid as the original. This authorization shall expire upon final determination of all requirements under M.G.L. c. 258C and 940 CMR 14.00.

I certify, under the pains and penalties of perjury, that all information and supporting documentation contained in this application is true and accurate to the best of my knowledge and belief.

Signature	*PRINT your name*	*Date signed*