REIMBURSEMENT REQUEST FORM

Ohio Attorney General Sexual Assault Forensic Examination (SAFE) Program

PLEASE ANSWER ALL QUESTIONS

1. Medical Facility
This information will populate upon entering login and password

Address

City

2. SAFE Account (Vendor ID No.)

This information will populate upon entering login and password

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 (mm/dd/yyyy)

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8. Patient Medical Record Number:

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

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

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11. Indicators/history of sexual assault/abuse:

12. Was an Evidence Kit Collected? ☐ Yes ☐ No

If a kit was collected a drop down box will appear with the question:

Which Law Enforcement Agency received the kit, if applicable? Drop down box will appear with all law enforcement agencies listed. If the kit has not been collected yet note the agency called to take custody of the kit.

If a kit is not collected the following questions will populate:

Why was no evidence kit collected?

Were Other Services Provided? ☐ Yes ☐ No

Which services were provided?

☐ Genital Exam
☐ Medical History
☐ Remote Technology consultation

Which Law Enforcement Agency received the report, if applicable?

13. Was patient under the age of 18? ☐ Yes ☐ No

If answer is Yes, a drop down box will populate with the question:

Which Child Protective Agency received the report, if applicable?

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

Where is the DFSA kit now?

☐ At Hospital ☐ Sent directly to DFSA forensic testing lab (not hospital lab)

☐ Retrieved by law enforcement

15. Was Human Trafficking Suspected? ☐ Yes ☐ No

If YES a box will populate with the question:

Why was human trafficking suspected?

16. 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 was the confinement?**

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

By sending this electronic transmission, I solemnly affirm that I am duly authorized to make this submission on behalf of the above noted medical facility, and that all information included herein is true and accurate to the best of my knowledge and belief.

18. Submit To: https://safepublic.ohioattorneygeneral.gov/Forms/Logon.aspx?ReturnUrl=%2f	For Questions about Billing, Please Call: (614) 466-4797