pennsylvania
COMMISSION ON CRIME AND DELINQUENCY

FOR OFFICIAL USE ONLY Claim #

Sexual Assault Counseling Claim Form

Please complete form and mail, email or fax to:
Victims Compensation Assistance Program (VCAP)
P.O. Box 1167
Harrisburg PA 17108-1167

(800) 233-2339 or (717) 783-5153
FAX (717) 787-4306
Email: ra-davesupport@pa.gov

SECTION 1 Victim Information

Victim Name _____ Date of Birth _____ Social Security # _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____

Do you have medical insurance? yes _____ no _____

Was your medical insurance applied to the counseling expenses? yes _____ no _____

Were monies applied for or received from other sources as a result of the sexual assault (i.e., civil settlement, restitution, etc)? yes _____ no _____

If the victim is currently under the age of 18, the victim's parent/guardian or the individual who assumes the financial obligation for the counseling expenses must complete the section below and sign on the second page as the claimant.

Claimant Name _____ Date of Birth _____ Social Security # _____

Street Address _____ City _____ State _____ Zip Code_____

Phone Number _____ Email _____ Relationship to Victim _____

SECTION 2 Crime Information

A victim of a sexual assault does not need to report the crime or talk to law enforcement authorities in order for the counseling expenses to be covered under the Sexual Assault Counseling Claim process. The following questions are asked to help determine which level of benefits you may be eligible for.

Approximate Date of Sexual Assault _____ (mm/dd/yyyy)

Location of Crime: County: _____ State: Pennsylvania

If you did report the crime to law enforcement you may be eligible for additional benefits. Was the crime reported to any authorities (law enforcement, district attorney, child protective services)? yes_____ no_____ Are you interested in learning more about these benefits? yes _____ no _____ If you marked yes, Program staff will contact you to further discuss eligibility for these benefits.

SECTION 3 Counseling Provider Information *For services provided on or after 11/26/2019.*

If you have copies of the itemized counseling bills and insurance benefit statements (if applicable and available) please submit them with the claim form. If you do not have copies, we will request them from the provider listed below.

Provider Name _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Fax Number _____

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The law specifically states that funds can only be paid for counseling expenses owed to the health care provider (i.e., mental health therapy provided by a psychiatrist, psychologist, licensed professional counselor, or licensed social worker). This applies to service dates on or after 11/26/2019 only.

SECTION 4 Statistical Information

The following information is used for statistical purposes only. The submission of information in this section is strictly voluntary.

Type of Offender: Clergy _____ Family _____ Stranger _____ Teacher _____ Coach _____ Group Leader _____
Medical Provider _____ Caregiver _____ Intimate Partner _____Other _____

Have you previously filed a claim with the Victim Compensation Assistance Program? Yes _____ No_____
If yes, please provide the claim number (if known): _____

SECTION 5 Signatures Required

Acknowledgment and Reimbursement Agreements

The Acknowledgement and Reimbursement Agreement must be signed before the claim review process will begin.

My signature below signifies I understand each of the following statements or points of law:
Any victim or claimant who knowingly or intentionally submits, or causes to be submitted, false or forged information related to a claim may be denied benefits and be subjected to appropriate criminal penalties under the laws of the Commonwealth.

I understand that the Crime Victims Compensation Fund is the payer of last resort. I specifically agree to inform the Program of and repay to the Commonwealth any funds that I may receive from any other source that has not already been considered, as a result of the crime and to the extent of the award. That is, I agree to repay any funds that I receive from the offender, any other person or source, which compensates me for the injury I suffered, including any award for pain and suffering. I further agree that if the claim is at any time determined to be in error, false or fraudulent, I will refund to the Program all sums of money paid by the Program.

X _____
Claimant's Signature Date

HIPAA Authorization & Release Agreement

This Authorization must be signed before the claim review process will begin.

I hereby authorize, in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 42 U.S.C. § 1320d, et seq.), any hospital, physician, health care provider or other person who attended, examined, or provided treatment to _____ (print name of victim) to furnish to the Office of Victims' Services, Victims Compensation Assistance Program any and all information in their possession with respect to the crime that is the basis for this claim. Copies of this authorization may be used in place of the original. **I understand that I may revoke this authorization at any time by providing the Office of Victims' Services, Victims Compensation Assistance Program, with a written, dated request to do so. Further, this authorization expires in 5 years from the date of my signature below or on the date that this claim is closed, whichever is sooner.

X _____
Claimant's Signature Date

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