

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

RECIPIENT STATEMENT FORM

		1. RECIPIENT NO.
2. NAME OF VICTIM	3. BIRTHDATE	4. TYPE OF INCIDENT <input type="checkbox"/> RAPE <input type="checkbox"/> INCEST
5. ADDRESS		6. DATE OF INCIDENT

PLEASE COMPLETE EITHER PART I OR PART II

PART I	
7. <input type="checkbox"/> I certify that I was the victim of the above-named incident and that I reported it to:	
8. NAME OF AGENCY:	9. DATE OF REPORT:
10. MY REPORT <input type="checkbox"/> DID <input type="checkbox"/> DID NOT INCLUDE THE IDENTITY OF THE OFFENDER	
11. I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT KNOW THE IDENTITY OF THE OFFENDER	

PART II
12. <input type="checkbox"/> I certify that I was the victim of the above-named incident and that I did not report the crime.

I UNDERSTAND THAT ANY FALSE STATEMENTS MADE HEREIN ARE PUNISHABLE BY LAW AND THAT FALSE REPORTS TO LAW ENFORCEMENT AUTHORITIES ARE PUNISHABLE BY LAW.

13. _____
SIGNATURE OF VICTIM

14. _____
DATE

ALL INFORMATION WILL BE KEPT CONFIDENTIAL!