

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

RECIPIENT STATEMENT FORM

(FOR VICTIMS OF INCEST UNDER AGE 18)

		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 incest and that I reported it to:	
8. NAME OF CHILD PROTECTION AGENCY:	9. DATE OF REPORT:
10. MY REPORT <input type="checkbox"/> DID <input type="checkbox"/> DID NOT INCLUDE THE IDENTITY OF THE OFFENDER	

PART II
11. <input type="checkbox"/> I certify that I was the victim of incest 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.

12. _____
SIGNATURE OF VICTIM

13. _____
DATE

ALL INFORMATION WILL BE KEPT CONFIDENTIAL!