

ANOKA COUNTY
Sexual Assault Victim Fund

Dear Applicant,

Please complete the attached application for funds in its entirety to the best of your ability. Incomplete applications may cause a delay in processing. All applications for financial assistance from the Sexual Assault Victim Fund are reviewed by the Anoka County Sexual Violence Services Professionals Committee. The review committee may confirm that you have reported your incident to a mandated reporter, and may also verify the existence and/or credentials of the person and/or program to which you are requesting payment.

The amount of money and the person or agency to which the cost should be remitted needs to be clearly identified. A maximum of \$1,000 can be paid out per incident per applicant. When the application and any supplemental documents have been received by the Anoka County Sexual Violence Services Professionals Committee, you will be contacted by email or telephone regarding notification of receipt of application. Any additional materials or documentation will be requested at that time if the application is incomplete. A formal letter stating approval and amount granted or disapproval will be mailed to you within seven (7) business days of receipt of application submission. The Sexual Assault Victim Fund treasurer will mail payment to the designated payee within 30 days in the case of an approval.

Before submitting your application, please verify that you meet all of the following **eligibility requirements**:

1. Applicant must be a current resident of Anoka County, OR the sexual assault must have occurred within Anoka County.
2. Requests for financial assistance must pertain to expenses incurred as a result of the sexual assault.
3. Applicant needs to demonstrate that all other means of reimbursement have been exhausted.
4. Applicant must have disclosed the sexual assault to a mandated reporter (law enforcement, social services, school personnel, victim services program staff, counselor or therapist, etc.).
5. Applicant must sign a release of information to any entities to which payment has been requested.

Completed application and applicable documentation should be submitted to:

Alexandra House, Inc.
Healthcare Coordinator
2150 – 3rd Avenue, Suite 100
Anoka, MN 55303
Fax: 763-576-8113
Phone: 763-795-5477
Email: HCAvocate@alexandrahouse.org

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Applicant must demonstrate that all other means of reimbursement have been exhausted prior to this application.

Please list all other financial sources accessed for assistance/repayment:	Was your request for assistance approved?	How much were you awarded?	What costs did the monetary award cover?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	

Please provide an itemized list of all requests for financial assistance/reimbursement for costs not covered by other sources. *(Items must pertain to expenses incurred as a result of the sexual assault):*

Please provide contact information for all parties to which payment is requested (healthcare facility, daycare, therapists, self, etc.)

*** Attach additional payee contact information if needed.**

Name: _____

Name: _____

Address: _____

Address: _____

Phone #: _____

Phone #: _____

Please complete ONLY if you are requesting financial assistance for medical bills related to the incident.

Do you have health insurance coverage?

Yes No

If yes, have you submitted these costs to the insurance company?

Yes No

If you answered "NO" to any of the above questions, please explain:

PLEASE INCLUDE A COPY OF THE PATIENT RESPONSIBILITY STATEMENT WITH THE VICTIM'S NAME AND SERVICES RENDERED.

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NOTE: *If you are requesting payment of outstanding bills, attach a copy of the bill with the account number. If you are requesting reimbursement of transportation costs, include number of miles and verification of visits to therapists, court, etc. If you are requesting reimbursement for lost wages, we cannot consider this expense if sick/vacation time was available. If not, include amount of wage and number of hours.*

4. Please describe in detail how your request for funds directly relates to the incident of sexual assault:

Attach additional pages if necessary.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I acknowledge and agree that all or any part of the payment awarded may be paid directly to the supplier of services/aforementioned parties to which payment is requested on my behalf, and authorize them to release any information that will verify the amount of services rendered and the cost of those services to the Anoka County Sexual Violence Services Professionals Committee.

Applicant Signature: _____ Date: _____

Please submit your application by mail to:
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Healthcare Coordinator
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Suite100
Anoka, MN 55303