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 ☐ RAPE ☐ INCEST
5. ADDRESS		**6.** DATE OF INCIDENT

PLEASE COMPLETE EITHER PART I OR PART II

PART I	
7. ☐ 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 ☐ DID ☐ DID NOT INCLUDE THE IDENTITY OF THE OFFENDER	

PART II
11. ☐ 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. _____ **13.** _____

SIGNATURE OF VICTIM DATE

ALL INFORMATION WILL BE KEPT CONFIDENTIAL!

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		1. RECIPIENT NO.
2. NAME OF VICTIM	**3.** BIRTHDATE	**4.** TYPE OF INCIDENT ☐ RAPE ☐ INCEST
5. ADDRESS		**6.** DATE OF INCIDENT

PLEASE COMPLETE EITHER PART I OR PART II

PART I	
7. ☐ I certify that I was the victim of the above-named incident and that I reported it to:	
8. NAME OF CHILD PROTECTION AGENCY:	**9.** DATE OF REPORT:
10. MY REPORT ☐ DID ☐ DID NOT INCLUDE THE IDENTITY OF THE OFFENDER	

PART II
11. ☐ I certify that I was the victim of the above-named incident and that I did not report the crime.

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