IOWA DEPARTMENT OF JUSTICE

Iowa Attorney General's Crime Victim Assistance Division (CVAD)

Sexual Assault Examination Program

Reimbursement Form

STATE FISCAL YEAR	AGREEMENT NUMBER	VENDOR NUMBER
2016	*16-001*	*1*

VENDOR NAME AND ADDRESS	VENDOR CONTACT EMAIL ADDRESS / VENDOR CONTACT PHONE NUMBER
SA Victim Services Provider *100 Main Street* *Des Moines, IA 50320*	director@victimservices.org **VENDOR CONTACT PHONE NUMBER** *515-234-5478*

Invoice #	DATE OF RECEIPT	DESCRIPTION/LIST OF MEDICATION	DATE OF SA EXAM.	COUNTY OF SA SERVICE	CLIENT NUMBER	VICTIM GENDER AND AGE	RECEIPT/ INVOICE AMOUNT
1	12/1/2015	Levongesetrel	1/15/2016	Polk	23456	F - 25	$20
						Total Amount Reimbursed:	$20.00

CLAIMANT'S CERTIFICATION		DEPARTMENT'S CERTIFICATION (CVAD)	
I certify that the items for which payment/reimbursement is claimed were furnished for business as allowed under this Program/Agency and Agreement and that charges were reasonable, proper, and correct, and no part of the claim amount has been reimbursed or paid through another agency or source of funding then what is listed in this form.		I certify that the above expenses are incurred and the amounts are correct and should be paid from the funds designated.	
TITLE Program Accountant	DATE 1/20/2016	CVAD AUTHORIZED SIGNATURE	DATE
CLAIMANT'S SIGNATURE		ORIGINAL DOC #: AGKH	
		ORIGINAL DATE PAID:	