Claim Form

Criminal Injuries Compensation Fund
Easing the Burden for Crime Victims

Before you fill out this application, please read the information below.

You may qualify to receive payment if:

The victim

- suffered physical injury or was killed as a result of a criminal act
- suffered emotional injury as the result of a felony
- cooperated with law-enforcement agencies and the courts
- was not involved in any illegal activity at the time of the crime
- did not provoke or willingly take part in the incident

The crime

- was committed in Virginia, or a country where Virginia residents are not eligible for compensation
- was the result of a terrorist act
- was reported to a law-enforcement agency within 120 hours (5 days), unless there is a good reason for the delay

You

- paid or a responsible for paying the victim's funeral bill
- are a surviving family member who suffered emotional injury due to the murder of a parent, spouse, sibling, child or grandchild

This claim

- is being filed within one year from the date of the crime, unless there is a good reason for the delay
- is filed only after you have exhausted all other financial resources (except income from your salary)

You cannot be paid for:

- pain, suffering, or property loss
- injuries resulting from vehicular accidents (unless the driver was under the influence of alcohol)
- attorney fees
- missed doctor's appointments

Legal considerations:

- you are required to cooperate with all law-enforcement agencies including prosecuting attorneys
- while your claim is pending, healthcare providers are prohibited by law from initiating collections action against you

Before you complete this application:

If the victim is a minor or is mentally incompetent

- provide proof you are the adult responsible for the victim's welfare (either parent, guardian or legal custodian)

If the victim is covered by any insurance program

- make sure you have first filed a claim with the health insurance provider; Medicare; private health plan; homeowners' or renter's insurance agency; employer's or union group's insurance plan; or automobile insurance company

If the victim was treated at a hospital but not covered by insurance

- make sure to contact the hospital's patient accounting office to apply for charity care assistance. CICF will need to be provided with a copy of the decision made on your charity care application.

How to complete this application:

If you need help filling out this application:

- call 1-800-552-4007 (toll-free)
- e-mail cicfmail@vwc.state.va.us
- contact your local Victim Witness program

Attach all itemized statements for services rendered; receipts; and insurance or benefit statements to this application.

* If you receive additional bills and/or benefits statements for continuing treatment, you may mail them to CICF at a later date.

Mail this completed application form, along with all attachments, to:

Criminal Injuries Compensation Fund
P.O. Box 26927
Richmond, Virginia 23261

1. Claim Summary

Check all desired compensation.

☐ **Medical expenses**
payment or reimbursement for crime-related expenses with a hospital, physician, dentist, or other medical provider

☐ **Mental health expenses**
mental health counseling for the victim of the crime

☐ **Mental health expenses (up to $2,500)**
grief counseling for dependents and survivors of homicide victims

☐ **Funeral or burial expenses (up to $5,000)**
payment or reimbursement for the victim's burial, cremation and/or headstone and/or plot

☐ **Loss of wages**
compensation for the victim who lost wages due to the crime, as verified by a medical provider

☐ **Loss of financial support**
compensation for dependents of homicide victims, and for victims of domestic violence or child sexual assault when the offender is removed from the home

☐ **Crime scene clean-up**
cleaning of items damaged as a result of the crime

☐ **Moving expenses (up to $1,000)**
reimbursement for the cost of professional movers, moving equipment rental, temporary storage, first month's rent, and loss of a security deposit

☐ **Mileage**
reimbursement of mileage to and from doctors' appointments; mileage to and from court appearances, if the victim is a minor

☐ **Prescriptions**
reimbursement for medication that was prescribed as a result of the crime

☐ **Home security**
reimbursement for replacement of doors, locks, windows, and installation of home security system

☐ **Other**
reimbursement for replacement of eyeglasses, hearing aids, dentures or other medically necessary aids

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A. If known: What is the status of criminal case?_____

What court was/will the criminal case be heard? ☐ Juvenile & Domestic ☐ General District ☐ Circuit

B. Will there be a civil lawsuit filed against the person or place responsible for the injury? ☐ Yes ☐ No

Name of attorney_____Phone number of attorney_____

Address _____

C. Who referred you to the Criminal Injuries Compensation Fund?

☐ Police/Sheriff's Office ☐ Victim Witness Program ☐ Attorney's Office
☐ Commonwealth's Attorney Office ☐ Hospital ☐ Medical Doctor
☐ Other Name of contact, if known_____

(Optional)

Victim's ethnic group
☐ African-American/Black ☐ Asian or Pacific Islander ☐ Caucasian/White
☐ American Indian/Alaskan native ☐ Bi-racial ☐ Hispanic

Description of the victim <u>at the time of the crime</u>
☐ Married ☐ Divorced ☐ Male
☐ Single Age _____ ☐ Female

Handicapped prior to crime? ☐Yes ☐No **How?** _____

2. Claim Information

A. Victim's name_____
First Middle Last

Social security number_____Date of birth_____

Street address_____County_____

City_____State_____Zip_____

Home phone number_____Work phone number_____

B. Complete only if you are applying on behalf of the victim

Applicant's name_____
First Middle Last

Social security number_____Date of birth_____

Street address_____County_____

City_____State_____Zip_____

Home phone number_____Work phone number_____

Relationship to victim Spouse ☐ Parent ☐ Sibling ☐ Child ☐ Other_____

3. Crime summary

A. Check type of crime

☐ Assault ☐ Driving under the influence ☐ Homicide ☐ Robbery

☐ Child sexual assault ☐ Sexual assault on adult ☐ Kidnapping ☐ Child abuse

☐ Other crime – describe:_____

Is the victim related to the offender? ☐ Yes ☐ No Relationship to victim _____

Did the crime occur at the victim's place of employment? ☐ Yes ☐ No

B. Date of the crime_____Date crime was reported_____

Law enforcement agency reported to_____

Incident report number_____Name of officer_____

C. Name of offender(s) Social security number of offender(s), if known

_____

_____

D. Location of the crime_____
Street Address City/County

4. Medical Expenses

A. If the victim was insured, or has Medicare:

- **Fill in the information below, and**
- **Attach a copy of the insurance card**

Name of insurance/Medicare carrier_____

Address_____

City_____State_____Zip_____

Group number _____ Policy number_____

B. Check any applications filed.

☐ Social Security ☐ Social Services ☐ Medicaid

☐ Workers' Compensation ☐ Hospital Charity Care ☐ Other:_____

C. Complete if the crime involved motor vehicles.

Victim's auto insurance company name_____

Address_____

Suspect's auto insurance company name_____

Address_____

D. List all medical facilities, doctors, dentists, licensed counselors, and other medical providers who treated the victim for injuries resulting from the crime. Attach a separate sheet of paper listing additional providers, if necessary.

Name_____Specialty_____

Street address_____City, state, zip_____

Name_____Specialty_____

Street address_____City, state, zip_____

Name_____Specialty_____

Street address_____City, state, zip_____

Name_____Specialty_____

Street address_____City, state, zip_____

5. Loss of wages

If filing for lost wages, complete the information below:

Employer's name _____Phone #:_____

Mailing address_____

City_____State _____ Zip _____

6. Homicide Claim

A. Date of Death _____/_____/_____ (Attach copy of signed funeral contract and copy of death certificate.)

B. List the victim's dependent(s). Attach another sheet of paper, if necessary.

Name	Relationship	Date of birth	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____

C. If the victim was contributing financial support to any dependents at the time of death, what was that monthly amount? $_____

D. Check any fund that will pay dependent(s) and specify the amount.

☐ Social Security $_____ ☐ Workers' Compensation Fund $_____

☐ Auto Insurance $_____ ☐ Victim's estate $_____

☐ Name other fund_____

Name of licensed mental health counselor _____

E. Did the victim have life or burial insurance? ☐ Yes ☐ No

If yes,

Name of Insurer	Address	Coverage Amount	Beneficiary
_____	_____	_____	_____

F. What is the funeral cost? $_____ Have funeral expenses been paid? ☐ Yes ☐ No

If yes, by whom?

Name_____Phone # _____

Street address_____

City_____State_____Zip _____

7. Notarized Agreement

These terms are set forth fully in Virginia Code 19.2-368. Your application will not be processed unless this form is signed on the signature line and witnessed by a Notary Public.

Collections

I agree that the Criminal Injuries Compensation Fund (CICF) may pay any award for my benefit directly to the person or entity, to who I owe a payment as a result of the crime. I understand CICF will attempt to collect my award from the person responsible for the crime. I further agree that if I later recover money from any other source as a result of the crime, receive restitution or sue the person responsible for this crime and recover damages, I will immediately repay the CICF award. In the event I fail to repay a CICF award, I agree to be responsible for all collections costs allowed by law.

Oath

I affirm that I have reviewed this application and understand its contents. I swear it is true and complete to the best of my knowledge. I understand that if any information I submit is false, or if I have not fully cooperated with all law-enforcement agencies, including the criminal prosecution, the claim may be denied or revoked and collected upon.

Authorization:

I authorize any hospital, physician, counselor, funeral director, or other person who attended or examined _____ (*the name of the victim*) and any municipal authority, employer or union, insurance company, social service bureau, Social Security office, or any other person, firm, agency or organization to furnish to the Criminal Injuries Compensation Fund, or its representative, any information requested, including tax data and prior police records, needed to complete the claimant's or victim's claim for benefits. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization is for the collection of information related only to this claim.

I HAVE READ, UNDERSTOOD AND AGREE TO THE INFORMAITON IN SECTION 7. I swear or affirm that I am the Claimant; I have reviewed and understand all of the requirements of the Fund. The information submitted is true and complete to the best of my knowledge and belief. I understand that submitting false information is a felony under 19.2-368.16 of the Code of Virginia.

_____ _____

Print Claimant's Name Claimant's Signature

City/County of _____, Commonwealth/State of_____

Subscribed and sworn before me this _____ day of _____, _____

_____

Signature of Notary Public

My commission expires the _____ day of _____, _____

Notary Public Number:_____

Please note that the Criminal Injuries Compensation Fund is a division of the Workers' Compensation Commission, which is exempt from HIPAA, and for HIPAA purposes, the Fund is a "payer" to which disclosures may be made without prior authorization.