CRIME VICTIMS COMPENSATION

GENERAL INFORMATION AND INSTRUCTIONS ON FILING A CLAIM

Following the instructions below will speed the processing of your claim:

- Read the application thoroughly and provide all requested documentation.
- Print legibly using blue ink or type information.
- Attach a copy of the police.
- Mail this completed form, along with all required documentation, to the address above.

ADDITIONAL INFORMATION

- The victim must be an innocent victim of a crime or some conduct that could be charged as a crime (a conviction is not required).
- The claimant filing on behalf of a victim can be a third party who is required to pay for the victim’s crime-related bills; a legal guardian; a victim’s attorney or power of attorney; the parent of a minor child; a surviving spouse, parent, or child of a victim of criminally injurious conduct who died as a direct result of such conduct who has paid or owes expenses related to the crime.
- Incident must be reported to law enforcement within 48 hours; or, if not reported within the required time, a justifiable reason must be provided.
- Victim/claimant must cooperate with law enforcement and the prosecution (i.e. testify and/or provide whatever truthful information is required to prosecute the alleged offender).
- The deadline for filing is five years from the time of the crime, unless good cause can be provided for the delay.
- CVCB does not pay for any property loss, except corrective lenses and dentures destroyed or lost as a result of the crime.
- The amounts the CVCB can pay are capped at $5,000 for funeral/burial expenses and $25,000 total for all expenses resulting from the crime.
**SECTION I  Victim Information (to be filled out by victim or claimant)**

**Victim's Name:** ___________  **Social Security No.:** ___________

**Date of Birth:**
- **Month:** ___________
- **Day:** ___________
- **Year:** ___________

**Age:** ___________  **At time of Crime:**

**Address:** ___________

**City:** ___________  **State:** ___________  **ZIP Code:** ___________

**Telephone (home):** ___________  **(work):** ___________  **(cell):** ___________

**E-mail:** ___________

**SECTION II  Claimant Information (to be filled out by person filing on behalf of a victim)**

**Claimant's Name:** ___________

**Date of Birth:**
- **Month:** ___________
- **Day:** ___________
- **Year:** ___________

**Social Security No.:** ___________

**Address:** ___________

**City:** ___________  **State:** ___________  **ZIP Code:** ___________

**Telephone (home):** ___________  **(work):** ___________  **(cell):** ___________

**E-mail:** ___________

**SECTION III  Crime Information (YOU MUST ATTACH A COPY OF THE POLICE REPORT)**

<table>
<thead>
<tr>
<th>Type of Crime (Check One)</th>
<th>Location of Crime: <strong>Address</strong></th>
<th><strong>City</strong></th>
<th><strong>County</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Assault</td>
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<tr>
<td>■ Homicide (murder)</td>
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<tr>
<td>■ Sexual Assault Adult</td>
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<td>■ Sexual Assault Child</td>
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<td>■ Child Physical Abuse</td>
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<tr>
<td>■ Domestic Assault</td>
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<td>■ DUI</td>
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<tr>
<td>■ Other</td>
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</tbody>
</table>

**Date of Crime:**
- **Month:** ___________
- **Day:** ___________
- **Year:** ___________

**Date Reported:**
- **Month:** ___________
- **Day:** ___________
- **Year:** ___________

**Crime Reported To:** ____________  **Law Enforcement Agency**

**Was the crime reported within 48 hours of its discovery?**
- **Yes**  - **No**

**If no, please explain why:** ___________

**Name of Offender:** ___________

**Has Offender been charged with a crime?**
- **Yes**  - **No**

**If yes, what charge?** ___________

**What Court?**  **District:** ___________  **Case Number:**__

**Circuit:** ___________  **Case Number:** ___________

**Juvenile:** ___________  **Case Number:** ___________
SECTION IV. Describe what happened. *(If you know the reason for the crime, please explain)*


SECTION V. Describe the injuries.


SECTION VI. Medical Expenses
Each bill must be listed below in order to be considered. Each must be a direct result of the crime, and each must have attached itemized documentation including date and type of service. Notices from collection agencies will not be accepted. If you need additional space, please attach a separate sheet of paper.

<table>
<thead>
<tr>
<th>Name of hospital, doctor, counselor and all other related medical bills</th>
<th>Charge</th>
<th>Insurance Paid</th>
<th>Claimant / Victim Paid</th>
<th>Current Balance</th>
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</tbody>
</table>

SECTION VII. Other sources of payment *(You MUST attach documentation)*

Please check everything that applies regarding coverage to victim or claimant at the time of the crime, or as a result of the crime:

- [ ] Medicaid
- [ ] Medicare
- [ ] Workers Comp
- [ ] Health Insurance
- [ ] Veterans Benefits
- [ ] Homeowner’s Insurance
- [ ] Auto Insurance
- [ ] Other

SECTION VIII. Lost Wages

What was the claimant / victim’s employment status at the time of the crime? □ Employed □ Unemployed
If employed, did the claimant / victim lose time from work as a result of the injury? □ Yes □ No
If yes, is the claimant applying for lost wages? □ Yes □ No
If yes, attach the Employment Verification Form, which MUST be filled out by the EMPLOYER and NOTARIZED.
If yes, attach the Physician Statement and/or the Mental Health Counselor Report, which MUST be filled out and signed by the DOCTOR and/or the THERAPIST.
If the claimant / victim was self-employed, attach a copy of both state and federal tax returns that cover period of crime.
SECTION IX. Financial Information (This information is about the person who is filing for assistance). Exclude expenses requested in this claim.

Total monthly income prior to incident ___________________________ Paid out per month ___________________________
Total current monthly income ___________________________ Pay out per month ___________________________
List ALL sources of income: (include every source of income including spouse’s income, food stamps, welfare, child support, Social Security, pensions, Workers Compensation benefits, veterans’ benefits, AFDC, or any other income.
List monthly amounts below:

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

SECTION X. Funeral / Burial Expenses (This section is to be filled out only if the victim is deceased)

REIMBURSEMENT OR PAYMENT FOR FUNERAL/BURIAL EXPENSES CANNOT EXCEED $5,000

THE FUNERAL CONTRACT SHOWING THE LEGALLY RESPONSIBLE PARTY MUST BE ATTACHED

Date of Death: ___________________________ Month ___________________________ Day ___________________________ Year ___________________________
List benefits available from any of the following sources: (List any and all amounts received or to be received by the victim or claimant). This includes any money received from contributions or donations.

Life Insurance: $ ___________________________ Workers Comp: $ ___________________________ Burial Insurance: $ ___________________________
Social Security: $ ____________________ Estate: $ ____________________ Other: $ ____________________

Name of Funeral Home: ___________________________
Address: ___________________________ Telephone No. ___________________________

Street ___________________________ City ___________________________ State ___________________________ Zip ___________________________

Amount of Funeral Expenses: $ ____________________ Have they been paid? ( ) Yes ( ) No

If yes, by whom: ___________________________ Relationship to victim: ___________________________
Address: ___________________________ Telephone No. ___________________________

Street ___________________________ City ___________________________ State ___________________________ Zip ___________________________

SECTION XI. Loss of Support (Fill out this section if you are financially dependent on the victim or filing for someone who is financially dependent on the victim).

The victim’s employment status at time of crime: ☐ Employed ☐ Unemployed

If employed, the attached Employment Verification Form MUST be filled out and signed by the EMPLOYER and NOTARIZED.

List income you now receive as a result of the victim’s death. (You must list all amounts being received and attach all documentation showing amounts and sources).

Social Security: $ ____________________ Workers Comp: $ ____________________ Welfare: $ ____________________
AFDC: $ ____________________ Other: $ ____________________

(Source and Amount Received)
SECTION XII. Federal Government Information (Optional / for Statistical Use Only)

Ethnic Group (Victim)  □ U.S. Citizen  □ Federal Crime
  □ White  □ Handicap  □ Kentucky Resident
  □ Black
  □ American Indian or Alaskan Native  □ Law Enforcement  □ Hospital
  □ Hispanic (Mexican, Puerto Rican,  □ Victim Advocate  □ Prosecutor
    Cuban or other Spanish culture)  □ Judge  □ Other
  □ Multiracial

Who referred you to the compensation program?

SECTION XII. Restitution and Civil Lawsuit (Enter information regarding any payments the court has ordered to be paid to you by the offender or any settlement you have received or will receive as the result of a lawsuit)

The victim and/or claimant filed or plans to file a civil lawsuit against anyone relating to the injury received as a result of the crime.  □ Yes  □ No

If yes, name of attorney: ___________________________________________

Address: ___________________________________________________________
  Street  City  State  ZIP Code  Telephone: _______________________

The offender was ordered by the court to pay restitution.  □ Yes  □ No  If yes, amount: $ _______________________

How is it to be paid?

SECTION XIV. Authorization and Subrogation

VERIFICATION OF APPLICATION: I hereby certify, subject to penalty, fine or imprisonment that the information contained in this application for Crime Victims Compensation is true and correct to the best of my knowledge.

SUBROGATION: In consideration of the payment received from the Crime Victims Compensation Board, in the event I recover damages or compensation from the offender or from any other public or private source as a result of the injuries or death which was the basis of my claim for compensation from the fund, I agree to repay such amount up to the full amount I received from the fund. I understand that compensation from any other public or private source includes, but is not limited to, receipt of insurance, Medicare, Medicaid, Workers Compensation, disability pay, etc. I further agree and understand that no part of recovery due the Crime Victims Compensation Board may be diminished by any collection fees or for any other reason whatsoever.

Should I choose to recover damages or compensation for the injury or death from any sources, I agree to promptly notify the Crime Victims Compensation Board by sending copies of any pleadings, settlement proposals and any other documents relative thereto. I further agree to fully cooperate with the Crime Victims Compensation Board should the Board decide to institute an action against any person or entity for the recovery of all or any part of the compensation received from the fund.

MEDICAL / PSYCHIATRIC / EMPLOYMENT RELEASE: I hereby authorize any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility, or any other person or firm to release any and all information requested. I understand and acknowledge that my mental health records may contain confidential remarks made by me, information regarding drug or alcohol abuse, HIV status, or other personal data. I further agree and hold blameless any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility or any staff person of any and all liability for the release of these records.

SIGNATURE: ___________________________ DATE: __________

You are not required to have an attorney assist in submitting your application; however, if an attorney does assist you, the attorney must sign this application.

Attorney’s Name: ___________________________ Social Security # or Fed ID: ___________________________

Address: ___________________________ Telephone: ___________________________

Attorney’s Signature: ___________________________ Date: __________
EMPLOYMENT VERIFICATION
To be completed and signed by employer only
Must be NOTARIZED

Employee’s Name: ____________________________    Social Security #: ____________________________

Date of Crime: ____________________________    Victim was employed at the time of crime:    ☐ Yes ☐ No

If yes, complete the following:

Employer’s Name: ____________________________    Telephone: ____________________________

Address: ______________________________________    Address ______ City ______ State ______ ZIP Code ______

Victim missed time from work because of injuries related to the crime:    ☐ Yes ☐ No

If yes, from ____________________________ to ____________________________.

The items listed below are to be WEEKLY AMOUNTS:

Gross Earnings: $ ____________________________    Net Take Home Earning Per Week: $ ____________________________


Other Deductions (Itemized): $ ____________________________    Typical days worked per week: M T W TH F Sat Sun
(please circle)

Victim has returned to work:    ☐ Yes ☐ No    Victim’s wage continued while off work:    ☐ Yes ☐ No

If the victim’s wage continued while off work, complete the following:

<table>
<thead>
<tr>
<th>Deduction</th>
<th>Amount Per Week</th>
<th>From Date</th>
<th>To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private or Health</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacation</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sick</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employers Group</td>
<td>$</td>
<td></td>
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</tr>
<tr>
<td>Disability</td>
<td>$</td>
<td></td>
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<tr>
<td>Union</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, Specify</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employer’s Signature and Title

SUBSCRIBED AND SWORN TO BEFORE ME BY ____________________________

THIS ____________________________ DAY OF ____________________________, 20___

MY COMMISSION EXPIRES: ____________________________

NOTARY PUBLIC: ____________________________

Signature
PHYSICIAN STATEMENT
To be completed and signed by DOCTOR only

Victim / Patient Name: ________________________________

Type of Injury: ________________________________

Date of Injury: __________ Date(s) victim unable to work: from _______ to _______.

Victim suffered permanent disability: □ Yes □ No

If yes, please state the victim’s percentage of permanent disability to the body as a whole in accordance with the AMA Guidelines:

________________________________________

COMMENTS:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Name of Attending Physician: ________________________________

Address:________________________________________ Address: ________________________________

City: ________________________________ State: ________ ZIP Code: __________

Telephone: ________________________________ Federal ID Number: ________________________________

________________________________________ ________________________________
Signature Date
MENTAL HEALTH COUNSELOR'S REPORT
To be completed by COUNSELOR only. Must include an attached Treatment Plan.

Person receiving services: ____________________________________________

Social Security Number: __________________________ Crime date: ____________

Date(s) victim unable to work: from ___________ to ___________

The trauma and treatment is a direct result of this crime: ☐ Yes ☐ No

Presenting Complaint: _____________________________________________

Diagnosis of Record: ______________________________________________

Description of injury and/or psychological trauma resulting from crime:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

HEALTH INSURANCE CARRIER:

Company Name ____________________________________________ Telephone Number / Extension______________________

_______________________________________________________________

Address __________________________ City __________ State ZIP __________

**PLEASE ATTACH A SEPARATE TREATMENT PLAN**

Authorized Signature of Treating Therapist / Counselor __________ Telephone Number __________

License specialty Type ___________________________________________

Mailing Address __________________________ City __________ State ZIP __________

Professional License No. / Federal ID ________________________________