Claim Form

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

This claim form should be submitted within one year of the crime.
*Please include a letter explaining the delay, if more than one year has passed.*

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

You may qualify for payment if:

**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

**THE VICTIM**
- 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 crime

Who can apply?
- victims who suffered physical injury as a result of a criminal act
- victims who suffered emotional injury as the result of a felony
- ANYONE who paid or is responsible for paying the victim’s funeral bill
- a surviving family member who suffered emotional injury due to the murder of a parent, spouse, sibling, child, or grandchild

You cannot be paid for:
- pain, suffering, or property loss
- injuries resulting from vehicular accidents except in certain circumstances
- attorney fees
- missed doctor’s appointments

In order to receive payment you must:
- cooperate with all law-enforcement agencies including Commonwealth Attorneys
- bill any relevant insurances, including:
  - medical insurance(s)
  - Medicaid/Medicare
  - renter’s/homeowner’s insurance
  - life/burial insurance
  - automobile insurances
- if you are uninsured and went to a hospital, you MUST APPLY to the hospital’s financial assistance program before you can receive payment
- provide any requested documentation

**If the victim is a minor or is mentally incompetent**
- provide proof that you are the adult responsible for the victim’s welfare (either parent, legal guardian or legal custodian)

Fax or mail this completed application to:

Virginia Victims Fund
P.O. Box 26927
Richmond, VA 23261
Fax: 804-823-6905

If you need assistance:
- e-mail cicfrequests@cicf.virginia.gov
- call 1-800-552-4007 (toll-free)
- contact your local Victim/Witness Assistance Program

While your claim is pending, healthcare providers are prohibited by law from taking collection action against you.
SECTION A – VICTIM INFORMATION
(Provide all requested information related to the injured person.)

Victim's Name: ____________________________________________
(First Name) __________________________ (Middle Name) _______ (Last Name) __________________________ (Suffix – Jr, Sr, I, II, III, etc.)

Social Security #: __________ - _______ - ______________ ☐ None
Gender: ☐ Male ☐ Female ☐ Unknown
*Check "None" ONLY if you do not have a SSN.

Date of Birth: _____ / _____ / __________ Date of Death: _____ / _____ / __________
*If claim is related to a homicide.

Marital Status: ☐ Divorced ☐ Married ☐ Separated ☐ Unknown ☐ Unmarried ☐ Widowed

Ethnic Group:
☐ Hispanic or Latino ☐ American Indian/Alaska Native
☐ African American/Black ☐ Native Hawaiian and Other Pacific Islander
☐ White /Caucasian ☐ Other
☐ Asian ☐ Unknown
☐ Multiple Races
☐ Other
☐ Unknown

Address: __________________________________________________
(Complete Mailing)

__________________________________________        __________________________________________
(City)        (State)  (Zip Code)
__________________________________________        (Country if not United States)

Home/Cell Phone: ___________________________ Work Phone: ________________________________

Was the victim disabled prior to the crime? ☐ Yes ☐ No

How is the victim related to the offender?
☐ Spouse ☐ Other
☐ Parent ☐ Grandparent
☐ Sibling ☐ Acquaintance
☐ Child ☐ Not related
☐ Boyfriend/Girlfriend

Who referred you to the Criminal Injuries Compensation Fund?
☐ Victim Witness ☐ Funeral Home ☐ Other Government Agency
☐ Police Department ☐ Friend ☐ SAFE Coordinator
☐ Commonwealth Attorney ☐ Media ☐ Other
☐ Medical Provider ☐ Internet
SECTION B – CLAIMANT INFORMATION
(Provide all requested information about the person filing the claim, if different from the victim.)

Claimant’s Name: ____________________________________________________________
(First Name) (Middle Name) (Last Name) (Suffix – Jr., Sr., I, II, III, etc.)

Social Security #: __________ - ________ - ______________ ☐ None
Gender:  ☐ Male  ☐ Female  ☐ Unknown
*Check “None” ONLY if you do not have a SSN.

Date of Birth: _______ / _______ / __________

Marital Status:  ☐ Divorced  ☐ Married  ☐ Separated  ☐ Unknown  ☐ Unmarried  ☐ Widowed

Ethnic Group:
☐ Hispanic or Latino
☐ African American/Black
☐ White /Caucasian
☐ Asian
☐ Multiple Races
☐ American Indian/Alaska Native
☐ Native Hawaiian and Other Pacific Islander
☐ Other
☐ Unknown

Address: ________________________________________________________________
(Complete Mailing)

__________________________________________________________________________
(City) (State) (Zip Code)
__________________________________________________________________________
(County) (Country if not United States)

Home/Cell Phone: ____________________________  Work Phone: ____________________________

How are you related to the victim?
☐ Spouse  ☐ Child  ☐ Grandparent
☐ Parent  ☐ Boyfriend/Girlfriend  ☐ Acquaintance
☐ Sibling  ☐ Other  ☐ Not related

SECTION C – CRIME INFORMATION
(You can obtain this information from the responding law enforcement agency.)

Crime Date: _____ / _____ / ________

City/County where the crime occurred: _______________________________________

Street address where the crime occurred: _____________________________________
SECTION D – REPORTING INFORMATION

Was the crime reported to law enforcement within five (5) days/120 hours?   ☐ Yes   ☐ No

Date the crime was reported to Law Enforcement: ______ / _____ / ____________

Name of the Law Enforcement Agency investigating: ________________________________________

Was a motor vehicle involved in this crime?   ☐ Yes   ☐ No

Police Report Number, if Known: ______________________________________

If warrants were obtained against the defendant, please attach a copy of those warrants.

SECTION E-OFFENDER INFORMATION (Enter all known information)

Offender's Name: ________________________________________________________________

 First Name)  (Middle Name)  (Last Name) (Suffix – Jr, Sr., I, II, III, etc.)

Social Security #: _______ - ______ - ______________ Date of Birth: ______ / ______ / ____________

Offender's Name: ________________________________________________________________

 (First Name)  (Middle Name)  (Last Name) (Suffix – Jr, Sr., I, II, III, etc.)

Social Security #: _______ - ______ - ______________ Date of Birth: ______ / ______ / ____________

 Please list any additional offenders on a separate sheet and submit with this application.
Court case is being heard in:
☐ Juvenile & Domestic Relations  ☐ General District  ☐ Circuit

Has the court ordered the offender(s) to pay any restitution to you for this crime?
☐ Yes  ☐ No  Amount, if known: __________________________

CIVIL CASE

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

If yes, please provide the following about your attorney:

Name of Attorney: ______________________________________________________

Address: ______________________________________________________________

(Complete Mailing)

________________________________________  (City/County)  (State)  (Zip Code)

Telephone: ____________________________  Fax: ____________________________

SECTION F – EMPLOYER INFORMATION (Complete this section if you are requesting lost wages.)

Are you self-employed?  ☐ Yes  ☐ No

If yes, send a copy of your most recent Federal Income Tax Return with W2 Wage Statements, 1099s, etc.

If no, please provide the following about your employer.

Name of Employer: ______________________________________________________

Address: ______________________________________________________________

________________________________________  (City/County)  (State)  (Zip Code)

Telephone: ____________________________

Please list any additional employers on a separate sheet and submit with this application.

Did the crime occur at your place of employment?  ☐ Yes  ☐ No

If yes, have you filed with the Virginia Workers’ Compensation Commission?  ☐ Yes  ☐ No

To apply with the Virginia Workers’ Compensation Commission, please call 1-877-664-2566 (toll-free).

Updated 02/12/2016
SECTION G – INSURANCE/COLLATERAL RESOURCES

Were you covered by health insurance at the time of the crime? ☐ Yes  ☐ No

IF YES:  Policy Number: _____________________  Group Number: _____________________

Name of Private Health Insurance Carrier: _________________________________________________________________

Address: __________________________________________________________________________________________

_______________________________________________________________________________________
(City/County) (State) (Zip Code)

Please list any additional insurance on a separate sheet and submit with this application.

IF NO:

If you do not have health insurance and sought treatment from a hospital, you must contact their financial services department and apply for charity care assistance. VVF must be provided with a copy of the decision made on your charity care application before payment can be made.

IF YOU ARE APPLYING FOR REIMBURSEMENT OF CRIME SCENE CLEAN-UP EXPENSES:

Do you have homeowners or renters insurance? ☐ Yes  ☐ No

If yes, please provide the following about your insurance carrier:

Name: ______________________________________ Policy Number: ______________

Address: __________________________________________________________________________________________

_____________________________________________________________________________________________
(City/County) (State) (Zip Code)

IF AN AUTOMOBILE WAS INVOLVED IN THE CRIME:

Please provide the following insurance coverage information.

Claimant’s Auto Insurance: ___________________________  Policy Number: ______________

Address: __________________________________________________________________________________________

_____________________________________________________________________________________________
(City/County) (State) (Zip Code)

Offender’s Auto Insurance: ___________________________  Policy Number: ______________

Address: __________________________________________________________________________________________

_____________________________________________________________________________________________
(City/County) (State) (Zip Code)
IF YOU ARE APPLYING FOR REIMBURSMENT OF FUNERAL RELATED EXPENSES:

Was the victim covered under any life and/or burial insurance?  ☐ Yes  ☐ No

If yes, please provide the following:

Name of Beneficiary: ____________________________________________

Name of Life/Burial Insurance Carrier: ____________________________________________

Address: __________________________________________________________________________

(City/County)  (State)  (Zip Code)

Please note that if the funeral bill has been paid or is paid anytime during the processing of your VVF application, detailed receipts or copies of cancelled checks will be required in order to consider reimbursement to anyone other than the funeral home.

SECTION H – EXPENSES

Please check all expenses that you are requesting reimbursement for:

☐ 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

☐ Grief counseling (up to $3,500)
grief counseling for family 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
replacement of lost wages for the victim who could not work because of crime-related injury, as verified by a medical provider

☐ Domestic loss of support
compensation for victims of domestic violence or child sexual assault for loss of the offender's wages when the offender is removed from the home

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

☐ Temporary Housing
housing necessary when a previous dwelling is rendered unsafe by the crime

☐ Homicide Loss of Support
financial support for the care of legal dependents of a homicide victim

☐ Prosthesis
reimbursement for replacement of eyeglasses, hearing aids, dentures, false limbs, or other medically necessary aids

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

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

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

☐ Moving expenses (up to $2,000)
reimbursement for the cost of professional movers, moving equipment rental, temporary storage, first month’s rent, and loss of a security deposit
SECTION I - MEDICAL PROVIDERS
List the name and addresses of the medical providers who gave crime-related treatment. List additional providers on a separate sheet or attach copies of billing statements.

Name of provider: __________________________________________________________________________________________
Address: __________________________________________________________________________________________________
Name of provider: __________________________________________________________________________________________
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SECTION J – DEPENDENTS
If a deceased victim had dependents that they were legally responsible for, the dependents may be eligible for loss of support benefits and/or survivor mental health benefits.

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<th>Name</th>
<th>Relationship</th>
<th>Date of birth</th>
<th>Social Security Number</th>
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If you are applying for loss of support benefits for a minor victim, please provide a copy of the statement from Social Security showing the benefits paid. You may submit this application and provide Social Security documentation once received.
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 (The Virginia Victims Fund) may pay any award for my benefit directly to the person or entity to which I owe a payment as a result of the crime. I understand VVF 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 VVF award. In the event I fail to repay a VVF 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 (The Virginia Victims 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 further authorize the Criminal Injuries Compensation Fund (The Virginia Victims Fund) to disclose any and all information in my claim file, except those documents legally protected from dissemination, to the Victim Witness Assistance Program in the locality handling my case.

I HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS ABOVE. I swear or affirm that I am the Claimant; I have reviewed and understand all of the requirements of VVF. 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 (The Virginia Victims 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.