



Application for Crime Victim Compensation

Section 1 Claimant

A separate application must be completed for each person seeking assistance, per incident. Section 1 must be completed on all applications. The claimant is the person who has incurred expenses or is seeking assistance as a direct result of a crime. If you are filing on behalf of a minor child, incapacitated or deceased victim, put your information in Section 1 and their information in Section 2.

Your Name: _____ Gender M F

Relationship to Victim _____

Mailing Address _____ City/State/Zip _____

Residential Address _____ City/State/Zip _____

SSN _____ Date of Birth _____

Home Telephone _____ Cell phone _____ Other _____

Email address _____

Section 2 Victim

The crime victim is the person who was injured, threatened with injury, or killed due to the crime.

Name: _____ Gender M F

Mailing Address _____ City/State/Zip _____

Residential Address _____ City/State/Zip _____

SSN _____ Date of Birth _____

Home Telephone _____ Cell phone _____ Other _____

Email address _____

Section 3 Crime Information

Date Crime Occurred _____ Location of Crime _____

Type of Crime _____ Date Crime Reported _____

Law Enforcement Agency reported to _____ Case # _____

Has Prosecution Started? Y N Location _____ Prosecution Case # _____

Name of Person who Committed Crime _____

Is the offender a juvenile? Y N

What is the victim's relationship to the offender, if any? _____

Describe Injuries

Section 4 Expenses

Please check the type of expenses you are requesting. Please attach copies of or a list of crime-related bills.

- | | |
|--|--|
| <input type="checkbox"/> Medical and/or dental expenses (Go to Section 5) | <input type="checkbox"/> Funeral or Burial Expenses |
| <input type="checkbox"/> Counseling (Go to Section 5) | <input type="checkbox"/> Moving or Relocation expenses |
| <input type="checkbox"/> Lost wages (Go to Section 6) | <input type="checkbox"/> Security |
| <input type="checkbox"/> Loss of support for dependents of homicide victim | <input type="checkbox"/> Clothing or bedding seized for evidence |
| <input type="checkbox"/> Travel (excluding moving expenses) | <input type="checkbox"/> Other _____ |

EMERGENCY AWARD REQUEST:

An emergency award may be available in certain circumstances.

Do you wish to request an emergency award? Y N

For what type of emergency compensation? Lost wages Relocation Counseling

What is the nature of the emergency? _____

Section 5 Medical Providers and Insurance Information

Complete this section if you are requesting compensation for medical, dental or mental health treatment expenses. Please list your insurance information below as well as providers you have seen in relation to crime-related injuries. If the victim is a minor and is covered by someone else's insurance, then complete the insurance information for the primary insured party.

Health Insurance

Insurance Company Name _____ Policy Number _____

Name of Insured _____

Relationship to victim _____

Please check if you have any of the following to assist you with medical expenses:

- Medicaid
 Medicare
 Denali Kidcare
 Indian Health Services
 Life Insurance
 Worker's Compensation
 Social Security/Disability
 VA Insurance
 Other _____

Auto Insurance (complete only if crime involves a DUI, hit and run or vehicular assault)

Insurance Company Name _____ Policy Number _____

Name of Insured _____

Have you filed an insurance claim related to this crime: Y N

Medical Providers (If you need more room, you may list these on a separate piece of paper and mail it together with your application)

Date of Service	Type of Care (Medical, Dental, Counseling)	Provider Name and Address	City, State, Zip	Phone No.

Section 6 Employer Information

This section need only be completed if lost wages are being requested. Please note that the VCCB may contact your employer to verify lost wages information.

Employer's Business Name _____ Contact Person _____

Mailing Address _____ City/State/Zip _____

Telephone _____ Is/was the victim self employed Y N

Did the victim miss work as a result of crime-related injuries? Y N

Did the crime occur while the victim was on the job or at the workplace? Y N

Section 7 Representative Information

Please complete this section if a victim advocate or attorney has assisted you with completing this application.

Type of Representative Advocate Attorney Other

Name _____ Telephone _____

Address _____

Organization _____ Alaska Bar No. (if applicable) _____

Section 8 Federal Reporting Information

The following information is used for statistical purposes only. It is required in order to comply with Federal Regulations. Please identify the victim's race/ethnicity and any disability.

Race/Ethnicity: White Non-Latino/Caucasian Alaska Native/American Indian Asian Hispanic or Latino
 Native Hawaiian/Other Pacific Islander Black/African-American Hispanic or Latino Other Race
Multiple Races

Disabled: Yes No If yes, physical or mental disability.

Section 9 How Did You Learn About This Program?

- Victim Assistance Program Law Enforcement Prosecutor Hospital
 VCCB Website Poster/Brochure Friend Other _____

Section 10 Civil Suit Information

Have you filed or do you plan to file a civil law suit related to this crime? Yes No

Attorney's Name and Law Firm _____

Address _____ Telephone _____

AUTHORIZATION TO:

Section 11 Information Release

I voluntarily give permission to any hospital, clinic, doctor, mental health treatment provider, social worker, rehabilitation counselor, employer, law enforcement authority, prosecution authority, government agency, insurance company, funeral director or similar persons, or any other person or agency to provide information relating to this application, including medical (including but not limited to history or physical records, consultation reports, pathology reports, discharge summaries, operative reports, x ray and other radiology reports, laboratory reports, chart notes, narrative reports, billing records, and records relating to drug abuse, alcoholism or other substance abuse and sexually transmitted diseases), mental health, and felony conviction records to the Violent Crimes Compensation Board (VCCB) or its representatives, for the purpose of determining eligibility for VCCB benefits. This permission also applies to all sources of recovery for the claimed losses, including, but not limited to, health or medical benefits, unemployment or disability benefits, Social Security benefits and Veteran benefits. I also give permission for the release of federal tax information, including tax returns, for the purpose of verifying income. I hereby waive all legal privileges to any of this information required by the VCCB regarding my claim.

In order to verify or process this application, I agree that the VCCB or its representatives may provide information about this application, and the information contained in this application, to any representative named on this application, government agency, or health care provider or other provider of services, and may pay the provider directly if payment of these services is approved. I agree that a photocopy or fax of this signed form is as valid as the original, and my signature gives permission for the release of all specified information. I agree that this information release is valid from the date of my signature until the claim is closed and that I can cancel this release by writing to the VCCB at any time, save that if any information has already been received and used, it is not subject to cancellation. I understand that all information necessary for use in law enforcement, prosecution, or the collection of restitution may be released to parole, probation, and law enforcement or prosecution authorities.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure and may not be protected by HIPAA or other confidentiality rules any longer. If research-related PHI is used or disclosed for continued research purposes, an expiration date or event does not apply. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization. I understand the information will be used to determine compensation benefits, and that only the information needed to make a decision about compensation benefits will be requested by the compensation program.

Sign:	Date:
Print Name:	Legal Authority to Act on Victim's Behalf:
Records to be disclosed (this box to be completed by VCCB):	
Name:	
SSN:	Birthday (MM/DD/YY)

Section 12 Repayment/Subrogation Agreement

I understand that Alaska law requires me to contact the Violent Crimes Compensation Board if I receive payments from the offender, a civil lawsuit, an insurance program, or any other government or private agency for losses suffered as a direct result of the crime that was the basis for receipt of benefits from the VCCB and that I may be required to refund either the amount of the collateral sum received from the offender, a civil lawsuit, an insurance program, or any other government or private agency, or the amount of compensation paid by the VCCB, whichever is less. I also understand that I may be required to repay any amount received from the VCCB for which it is later determined I was not in fact eligible. I will notify the VCCB if I hire an attorney to represent me in any action related to this crime.

I declare under penalty of perjury that all the information I have provided is true, correct, and completed to the best of my knowledge and belief. I understand that my signature says I agree to all statements in this agreement.

(Parent or guardian must sign if victim is a minor or is incapacitated)

Sign:	Date:
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SECTION 11 AND 12 MUST BE SIGNED AND DATED IN ORDER TO PROCESS THIS CLAIM

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR Parts 160 and 164 and Alaska Statute 18.67.