



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 or incapacitated 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 _____
Are you a legislative employee? Y N

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"/> 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 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.

Race/Ethnicity: White Alaska Native American Indian

African-American Hispanic Asian/Pacific Islander

Disabled: Yes No

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 _____

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, and billing records), 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 Alaska and Federal Laws require the compensation program to keep any confidential information it receives confidential. I understand that all information necessary for use in law enforcement, prosecution, or the collection of restitution may be released to parole, probation, law enforcement or prosecution authorities.

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.

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

Records to be disclosed (this box to be completed by VCCB):	
Name:	
SSN:	Birthday (MM/DD/YY)

Section 12 My Agreement to the VCCB

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. I also understand that I may be required to repay the VCCB for any amount for which it is later determined I was not 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.

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

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

Application checklist:

- Have you completed all relevant sections and signed sections 11 and 12?
- Have you listed all of the doctors, counselors, hospitals, clinics and/or dentists in the provider section of the application that you have seen as a direct result of the incident?
- Did you provide the name of the law enforcement agency where the crime was reported?
- Did you provide a police report number?

Information:

For information about collecting restitution call the District Attorney's office.

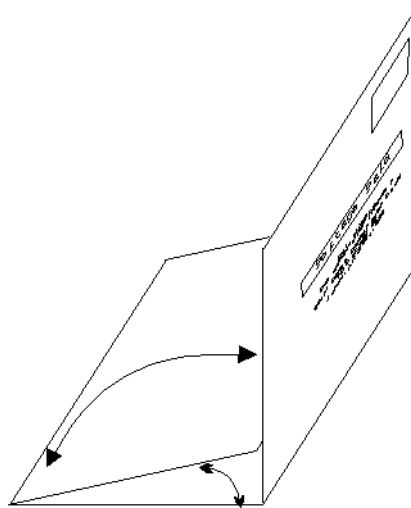
If you would like information concerning your rights as a victim please call the Office for Victim's Rights at 1-866-274-2620.

If you just need to talk to someone, please call Victims for Justice at 1-888-835-1213.

For information about the crime victim compensation program and requirements call 1-800-764-3040 or in Juneau 465-3040. Our fax number is 907-465-2379.

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**VIOLENT CRIMES COMPENSATION BOARD
PO BOX 110230
JUNEAU, AK 99811-0230**