Violent Crimes Compensation Board

Application for Crime Victim Compensation

- Include any documentation you may have available. If you have a copy of the police report, copies of medical, dental and/or counseling bills; and any other crime-related information, please send with the application. If you do not have any of this documentation, you do not need to wait to mail the application. Information can be provided to our office as it becomes available.
- If you require additional space on any section of the application, please attach a separate sheet of paper.
- If your address or phone number changes, it is important to update your information with our office.
- For assistance in completing the application, you may call our office at 1-800-764-3040. Victim advocates at local shelters, victim-witness paralegals at the prosecutor's office, and victim-witness coordinators at local police departments may also be available to assist you.
- Return the completed application to the below address:

  VCCB
  PO Box 110230
  Juneau, AK 99811

  Fax: 1-907-465-2379

  Email: doa.vccb@alaska.gov

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.

- □ Medical and/or dental expenses (Go to Section 5)
- □ Counseling (Go to Section 5)
- □ Lost wages (Go to Section 6)
- □ Loss of support for dependents of homicide victim
- □ Travel (excluding moving expenses)
- □ Funeral or Burial Expenses
- □ Moving or Relocation expenses
- □ Security
- □ Clothing or bedding seized for evidence
- □ 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:**

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.