APPLICATION FOR CRIME VICTIM COMPENSATION

(Please PRINT CLEARLY and fill out both sides)

1. Crime victim and applicant's information:

CRIME VICTIM'S NAME: _____ TYPE OF CRIME: _____

ADDRESS: _____

MAIL WILL BE SENT TO THE ADDRESS YOU PUT ON THIS LINE. IF YOU DO NOT WANT MAIL SENT TO YOUR HOME ADDRESS PLEASE PROVIDE AN ALTERNATIVE ADDRESS.

CITY/STATE: _____ ZIP: _____ PHONE: (_____)_____

CRIME VICTIM'S DATE OF BIRTH: _____ CRIME VICTIM'S SOCIAL SECURITY #: _____

NAME OF **APPLICANT** IF NOT VICTIM: _____ RELATIONSHIP TO VICTIM: _____

PARENT, GUARDIAN, OR VICTIM'S SURVIVOR

NAMED APPLICANT'S SOCIAL SECURITY #: _____ APPLICANT'S PRIMARY LANGUAGE: _____

DO YOU NEED APPLICATION(S) FOR OTHER FAMILY MEMBERS OR HOUSEHOLD MEMBERS? ☐ YES ☐ NO IF YES, HOW MANY? _____

2. CRIMINAL REPORT AND INVESTIGATION INFORMATION:

CITY OR LOCATION OF CRIME: _____ VICTIM'S INJURIES: _____

CRIME DATE: _____ CRIME DISCOVERY DATE: _____ CRIME REPORT DATE: _____

INVESTIGATING LAW ENFORCEMENT AGENCY: _____ L.E. CASE #: _____

INVESTIGATING OFFICER'S NAME: _____ OFFENDER NAME(S): _____

3. PLEASE MARK THE CRIME RELATED EXPENSES FOR WHICH THE CRIME VICTIM OR THE APPLICANT SEEKS COMPENSATION:

- ☐ LOST WAGES DUE TO CRIME RELATED INJURIES
- ☐ LOST WAGES TO ATTEND JUSTICE PROCEEDINGS
- ☐ VICTIM'S MEDICAL OR DENTAL EXPENSES
- ☐ TRANSPORTATION/MILEAGE EXPENSES
- ☐ VICTIM'S COUNSELING EXPENSES
- ☐ FUNERAL AND BURIAL EXPENSES
- ☐ CRIME SCENE CLEAN UP OF A RESIDENCE
- ☐ REPLACEMENT OF HOME SECURITY ITEMS
- ☐ REPLACEMENT OF CLOTHES OR BEDDING HELD AS EVIDENCE
- ☐ CHILD OR DEPENDENT ADULT CARE EXPENSES
- ☐ OTHER COUNSELING EXPENSES: VICTIM'S IMMEDIATE FAMILY OR HOUSEHOLD MEMBER(S)

CRIME RELATED EXPENSES OF A HOMICIDE VICTIM'S SURVIVOR(S):

☐ LOST WAGES ☐ COUNSELING ☐ MEDICAL CARE ☐ TRANSPORTATION/MILEAGE

DOES THE CRIME VICTIM HAVE MINOR CHILDREN OR OTHER FINANCIAL DEPENDENTS? ☐ YES ☐ NO IF YES, HOW MANY? _____

4. IF THE VICTIM LOST WAGES AS A RESULT OF THE CRIME, COMPLETE THE FOLLOWING:

EMPLOYER: _____ CONTACT PERSON: _____

PHONE: _____ ADDRESS: _____ CITY, STATE, ZIP: _____

5. LIST YOUR INSURANCE COMPANY NAME, ADDRESS, AND POLICY NUMBER FOR EACH OF THESE INSURANCE TYPES:

☐ I HAVE NO INSURANCE.

☐ HEALTH: _____

☐ MEDICAID OR MEDICARE: _____

☐ WORKER COMPENSATION: _____

☐ AUTOMOBILE, HOME, OR BOAT: _____

6. THE FOLLOWING INFORMATION ABOUT YOUR CURRENT STATUS IS NECESSARY TO COMPLY WITH FEDERAL REGULATIONS.

1. GENDER: ☐ MALE ☐ FEMALE **2. AGE:** ☐ 17 OR UNDER ☐ 18-63 ☐ 64 & OVER **3. DISABLED:** ☐ YES ☐ NO

4. ETHNICITY: ☐ WHITE ☐ NATIVE AMERICAN ☐ AFRICAN AMERICAN ☐ ASIAN OR PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER

5. REFERRED TO PROGRAM BY: ☐ POLICE/SHERIFF ☐ COUNTY ATTORNEY ☐ MEDIA ☐ HOSPITAL ☐ VICTIM SERVICES ☐ OTHER