Claim Form

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

VIRGINIA VICTIMS FUND
Helping Innocent Victims of Crime
OFFICIALLY CRIMINAL INJURIES COMPENSATION FUND

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.
* If you receive additional bills and/or benefits statements for continuing treatment, mail them to VVF at that time.

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, unless there is good reason for the delay

THE VICTIM

- cooperated with law-enforcement agencies and the courts in the investigation/prosecution
- 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 doctors' 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 insurance(s)
- if you are uninsured and went to a hospital, apply for the hospital's financial assistance program
- provide all requested documentation

If the victim is a minor or is mentally incompetent:

- provide proof that you are the person 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 info@virginiavictimsfund.org
- 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.

Updated 07/01/2019

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
☐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:**_____

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

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

Who referred you to the Virginia Victims Fund?

☐Victim Witness
☐Police Department
☐Commonwealth Attorney
☐Medical Provider
☐Funeral Home
☐Friend
☐Media
☐Internet
☐Other Government Agency
☐SAFE Coordinator
☐Other

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

Other_____If applicable, please provide proof of guardianship or Power of Attorney *(attorney or medical Power of Attorney not accepted)*

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: _____

Crime Type:

☐Abduction
☐Arson-Fatal
☐Arson-Non-Fatal
☐Assault
☐Assault-Child Abuse
☐Assault-DUI
☐Breaking & Entering
☐Hit and Run-Assault
☐Hit and Run-Homicide
☐Homicide
☐Homicide-DUI
☐Human Trafficking: Sex/Labor
☐Other
☐Robbery
☐Robbery-Carjacking
☐Sexual Crime-Adult
☐Sexual Crime-Child
☐Stalking
☐Terrorism-Assault
☐Terrorism-Homicide

Type of Victimization:

☐ Bullying ☐Domestic and Family Violence ☐Elder Abuse ☐ Hate Crime ☐Mass Violence

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SECTION D – REPORTING INFORMATION

Was the crime reported to law enforcement within 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 THE 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 ADDITIONAL OFFENDERS ON A SEPARATE SHEET AND SUBMIT WITH THIS CLAIM FORM.

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

Has a civil lawsuit been 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: _____
(Complete Mailing)

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

Telephone: _____

PLEASE LIST ANY ADDITIONAL EMPLOYERS ON A SEPARATE SHEET AND SUBMIT WITH THIS CLAIM FORM.

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

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

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

SECTION G – INSURANCE/COLLATERAL RESOURCES

Are the victim's crime-related expenses covered by health insurance? ☐Yes ☐No

IF YES: **Policy Number: _____ Group Number: _____**

Name of Private Health Insurance Carrier:_____

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

Address: _____
(Complete Mailing)

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

IF NO:

If victim does 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 the charity care application *before* payment can be made.

Did the victim apply for hospital charity care? ☐Yes ☐No

IF YOU ARE APPLYING FOR REIMBURSMENT OF CRIME SCENE CLEAN-UP EXPENSES:
Does the victim have homeowner's or renter's insurance? ☐Yes ☐No

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

Name:_____**Policy Number:** _____

Address: _____
(Complete Mailing)

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

IF AN AUTOMOBILE WAS INVOLVED IN THE CRIME:
Does the victim have automobile insurance coverage? ☐Yes ☐No

Claimant's Auto Insurance:_____**Policy Number:** _____

Address:_____
(Complete Mailing)

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

Does the offender have automobile insurance coverage? ☐Yes ☐No ☐Unknown

Offender's Auto Insurance:_____**Policy Number:** _____

Address: _____
(Complete Mailing)

_____
(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: _____
(Complete Mailing)

_____
(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 claim, detailed receipts or copies of cancelled checks are required to consider reimbursement to anyone other than the funeral home.

SECTION H – EXPENSES *(caps are based on the policy effective at the time of crime)*

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 $10,000)**
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 *(the offender must have a legal obligation to support the victim)*

☐**Crime Scene Clean-Up**
cleaning of items damaged as a result of the crime *(personal property not included)*

☐**Temporary Housing**
housing necessary when a previous dwelling is rendered unsafe by the crime *(30-day maximum; bill must be in victim's name)*

☐**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 (up to $1,000)**
reimbursement for doors, locks, windows, and purchase and installation of home security system

☐**Prescriptions**
reimbursement for medication that was prescribed as a result of the crime *(please submit pharmacy print-out or "bag tags")*

☐**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, rent, and
loss of a security deposit *(dated/signed contracts required)*

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 detailed, itemized billing statements.

Name of provider: _____

Address: _____

Name of provider: _____

Address: _____

Name of provider: _____

Address: _____

Name of provider: _____

Address: _____

Name of provider: _____

Address: _____

Name of provider: _____

Address: _____

Name of provider: _____

Address: _____

SECTION J – DEPENDENTS

If a deceased victim had dependents for whom they were legally responsible, the dependents may be eligible for loss of support benefits and/or survivor grief counseling. Please provide the following information for each dependent.

Name	Relationship	Date of birth	Social Security Number

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 approved. You may submit the VVF Claim Form now and provide Social Security documentation once you receive it.

Notarized Agreement

These terms are set forth fully in Virginia Code §§ 19.2-368.1-19.2-368.18. **Your application will <u>not</u> 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 (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 recover damages through civil litigation, 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 (Virginia Victims Fund), or its representative, any information requested, including tax data and prior police records, required 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 (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 (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.