

<b>Claimant Name:</b>	<b>Date of Birth:</b>
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**SUPERIOR COURT OF THE DISTRICT OF COLUMBIA  
CRIME VICTIMS COMPENSATION PROGRAM (CVCP) APPLICATION**

**PART I – ELIGIBILITY**

<b>DATE APPLICATION FILED:</b>		
<b>CLAIMANT NAME (the person seeking compensation):</b> <i>If you are assisting someone in filling out this form, answer all questions as if you are the claimant.</i>		
Choose all that apply:		
<input type="checkbox"/> I am the victim		
<input type="checkbox"/> I am a secondary victim (please check the box that applies):		
<input type="checkbox"/> I am the victim’s spouse, child, grandchild, parent, sibling, parent-in-law		
<input type="checkbox"/> I resided in the victim’s household at the time of the crime		
<input type="checkbox"/> I was wholly or partially dependent on the victim for care and support		
<input type="checkbox"/> I paid the medical, funeral, or burial expenses caused by the crime		
<input type="checkbox"/> I had close ties to the victim		
<input type="checkbox"/> I witnessed the crime		
Victim’s name: _____		
<input type="checkbox"/> I am filing on behalf of a victim		
<input type="checkbox"/> I am filing on behalf of a secondary victim		
My address:		
City:	State:	Zip:
Preferred phone:		Alternate phone:
Date of birth:	Email:	
Primary Language:	Pronouns (optional):	
Race:		
<b>If you are filing on behalf of a victim or secondary victim, please provide their information:</b>		
Name:		
Address:		
City:	State:	Zip:
Phone:	Date of birth:	
Relationship to victim/secondary victim: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Personal Representative <input type="checkbox"/> Other _____(please describe relationship)		



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## PART II – COMPENSATION

CHECK THE BOX FOR ANY ASSISTANCE YOU ARE REQUESTING	THEN COMPLETE
<input type="checkbox"/> Temporary Emergency Housing or Moving Expenses for Victims in Immediate Danger	Section 1
<input type="checkbox"/> Medical Expenses / Dental Expenses / Mental Health Services	Section 2
<input type="checkbox"/> Funeral Expenses	Section 3
<input type="checkbox"/> Loss of Earnings/Wages	Section 4
<input type="checkbox"/> Loss of Support for Survivors of Homicide	Section 5
<input type="checkbox"/> Compensation for any Secondary Victims or Dependents	Section 6
<input type="checkbox"/> Loss of Services and Expenses for Substitute Services	Section 7
<input type="checkbox"/> Replacement of Clothing held as Evidence	Section 8
<input type="checkbox"/> Security Measures for the Home	Section 9
<input type="checkbox"/> Crime Scene Clean-up	Section 10
<input type="checkbox"/> Transportation to Receive Services	Section 11
<input type="checkbox"/> Reimbursement for Alternate Transportation because Car Held in Evidence	Section 12
<input type="checkbox"/> Veterinary Expenses	Section 13
<input type="checkbox"/> Restitution Agreement (if the offender is ordered to pay you money in a criminal case)	Section 14
<input type="checkbox"/> Other (specify)	
<b>ALL APPLICANTS MUST COMPLETE SECTION 15: COLLATERAL RESOURCES</b>	

SECTION 1 – TEMPORARY HOUSING AND MOVING EXPENSES – Rule 29	
Limit: up to \$3,000 for temporary housing and up to \$1,500 for moving expenses	
Are you requesting temporary housing?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you requesting moving expenses?	<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, submit a copy of lease.
A referral form must also be submitted.	<input type="checkbox"/> Check here if referral is attached

SECTION 2 – MEDICAL / DENTAL / MENTAL HEALTH INFORMATION- Rule 13, Rule 24				
Limit: Mental Health up to \$3,000 for Adults and up to \$6,000 for Minors				
Medical and Dental: up to \$25,000 max (includes all other compensation award)				
Did you receive medical/dental/or mental health treatment related to the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name of Doctor, Hospital, or Other Provider	Street Address	City/State/Zip	Phone number	Bill amount
Add additional providers on a separate piece of paper. Submit copies of all available bills received to date. Attach all insurance payment statements and rejections. <b>YOU WILL BE REQUIRED TO COMPLETE AUTHORIZATION AND RELEASE FORMS</b>				

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<b>SECTION 3 – FUNERAL EXPENSES – Rule 25</b>	
Limit: up to \$10,000	
Name of Funeral Home / Phone No:	(Attach a copy of the bill)
Name of Cemetery/Phone No:	(Attach a copy of bill)
Total Amount of Funeral/Cemetery Bill: \$	
Have the Funeral/Cemetery expenses been paid?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, by whom? _____	
Please submit receipt	

<b>SECTION 4 – LOSS WAGES/EARNINGS -Rule 28</b>	
Limit: a total period of up to 52 weeks after the date of the crime, in an amount not to exceed the lesser of 80% of the victim’s net pay or \$10,000	
Was victim employed at the time of the crime? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of last employment:
Name of Victim’s Employer (at the time of crime):	Supervisor’s name:
Employer Street Address:	Employer phone number:
City, State, Zip Code:	
Gross Salary \$ _____ per: <input type="checkbox"/> hour <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year	
Hours Worked _____ per: <input type="checkbox"/> day <input type="checkbox"/> week	
Are you unable to work as a result of the crime/injuries?	<input type="checkbox"/> YES <input type="checkbox"/> NO
How long have you been unable to work as a result of the crime/injuries? From ___/___/___ through ___/___/___ Mo. Day Yr. Mo. Day Yr.	
Name of doctor who can verify length of disability to work: (Please submit disability statement from the verifying doctor)	
Doctor’s address:	
Doctor’s phone number:	
Did you receive pay from you job when you were off work?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you self-employed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, you must attach a copy of your Federal Income Tax Returns for the last 12 months preceding crime.	

**YOU WILL BE REQUIRED TO COMPLETE AUTHORIZATION AND RELEASE FORMS**

<b>EMERGENCY AWARD IF EMPLOYED AT TIME OF CRIME: Limit up to \$1,000 – Rule 37</b>	
Are you experiencing a financial hardship as a result of lost wages?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>NOTE:</b> The emergency award will be deducted from any final award. If the emergency award is greater than the final award, the claimant must repay the difference. If compensation is not awarded, the claimant must repay the emergency award in its entirety.	

<b>SECTION 5 – LOSS OF SUPPORT FOR SURVIVORS OF HOMICIDE – Rule 30</b>	
Limit: \$2,500 per dependent, not to exceed \$7,500 per victimization	
Have you submitted a claim to Social Security Administration?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Did the victim have dependents?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, list dependents in section 6	
Did the victim provide support?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, submit evidence of employment and/or child support	
<b>YOU WILL BE REQUIRED TO COMPLETE AUTHORIZATION AND RELEASE FORMS</b>	

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**SECTION 6 – SECONDARY VICTIMS and DEPENDENTS**

Submit copies of birth certificates for children. Please list the victims' dependents and household members and indicate whether they will seek mental health counseling, because of this crime.

Please complete the following information about dependents. (Dependent means a person wholly or partially dependent upon a victim for care or support and includes a child of the victim born after the victim's death.)

Name	Date of Birth	Address	Seeking counseling due to crime?	Relationship to victim
			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> YES <input type="checkbox"/> NO	
			<input type="checkbox"/> YES <input type="checkbox"/> NO	

**SECTION 7 – LOSS OF SERVICES AND EXPENSES FOR SUBSTITUTE SERVICES – Rule 31**

Limit: up to \$200.00 per week, not to exceed \$2,500

Please list all services such as childcare and housekeeping that are no longer provided by the victim as a direct result of the crime.

SERVICES	EXPENSES INCURRED

**SECTION 8 – CLOTHING REPLACEMENT – Rule 27**

Limit: up to \$100 (No reimbursement when victim is deceased)

Are any of the victim's clothes being held by law enforcement officials for evidence?  YES  NO  
List items of clothing being held: \_\_\_\_\_

**SECTION 9 – SECURITY MEASURES FOR THE HOME – Rule 32**

Limit: up to \$1,000

Are you seeking security measures for your home as a result of the crime?  YES  NO  
Please submit bill or receipt for services.

**SECTION 10 – CRIME SCENE CLEAN UP – Rule 26**

Limit: up to \$1,000

Are you seeking reasonable cost associated with cleaning up the crime scene?  YES  NO  
Please submit bill or receipt for services.

**SECTION 11 - TRANSPORTATION EXPENSES – Rule 35**

Limit: up to \$100 local travel and \$500 necessary out of state travel

Do you need assistance with the cost of transportation to receive treatment or services as a result of the crime?  YES  NO

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**SECTION 12 - REIMBURSEMENT FOR ALTERNATE TRANSPORTATION** (when victim or secondary victim's car is being held by the police as evidence or to collect evidence) – **Rule 33**  
Limit: up to \$2,000

Was your car held as evidence by the police as a result of this crime?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Agency holding car as evidence:		
Name and phone number of Law Enforcement Officer:		
Please submit copy of transportation receipts.		

**SECTION 13 – VETERINARY EXPENSES**  
Limit: up to \$1000

Did your animal receive veterinary treatment as a result of animal cruelty?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please submit copy of bill.		

**SECTION 14 – RESTITUTION & DAMAGES**  
If a court ever orders payment to you because of the crime, you must inform the Crime Victims Compensation Program.

Has a judge ordered payment to you (victim or claimant) because of the crime?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Court case #:		

**SECTION 15 – INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION**

The Crime Victims Compensation Program must consider all collateral resources (other assistance available to you) when reviewing a compensation application.  
**YOU MAY BE REQUIRED TO COMPLETE SEPARATE AUTHORIZATION AND RELEASE FORMS FOR DOCUMENTATION OF YOUR COLLATERAL SOURCES**

Source	YES	NO	Status of Application	Amount Paid
Health Insurance				
Automobile Insurance				
Workman's Compensation				
Medicare				
Medicaid				
Veteran's Administration				
TANF				
Vacation/Annual/Sick/Pay				
Food Stamps				
Disability Benefits				
Dental Insurance				
Life Insurance				
Burial Insurance				
Unemployment Benefits				
Social Security				
Child and Family Services Agency (Payment of Counseling Expenses)				
Section 8/HUD Housing				
Veterinary insurance				

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**DECLARATION AND AFFIRMATION**

- I understand CVCP will obtain official law enforcement records or court documents related to my claim.
- I understand that I cannot receive reimbursement until CVCP verifies costs and treatment for injuries or trauma from the crime.
- CVCP will notify me if my claim is approved or denied.
- I must also notify CVCP if I sue the offender or if the court orders the offender to pay me restitution. I understand that if I get any money from a lawsuit related to the crime or the court orders restitution, I may have to repay funds I received from CVCP also relating to the same crime.
- If the District of Columbia chooses, it can file its own lawsuit against the offender to recover the money CVCP paid. If the District of Columbia sues the offender to get the funds back, I must fully cooperate with the lawsuit.

**I HEREBY CERTIFY THAT I WILL NOTIFY THE CRIME VICTIMS COMPENSATION PROGRAM IN THE EVENT THAT I FILE SUIT AGAINST THE OFFENDER OR THE COURT ORDERS THE OFFENDER TO MAKE RESTITUTION TO ME.**

**I UNDERSTAND THAT IT IS A MISDEMEANOR TO KNOWINGLY SUBMIT FALSE INFORMATION CONCERNING A CLAIM, AND I CERTIFY THAT THE INFORMATION CONTAINED IN THIS ELIGIBILITY APPLICATION, THE COMPENSATION APPLICATION AND ANY DOCUMENT SUBMITTED FOR A CRIME VICTIMS COMPENSATION AWARD IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. See D.C. Code § 4-513.**

\_\_\_\_\_  
**Signature of Victim/Secondary Victim or Person Filing on Behalf of Victim/Secondary Victim**

\_\_\_\_\_  
**Date**

**Check here if photo ID attached**  
*If no ID provided, a staff member will contact you for another way to confirm your identity.*

Please submit completed application by email to [CVCPapplications@dcsc.gov](mailto:CVCPapplications@dcsc.gov) or by mail or in person to 515 5th Street, NW #109, Washington, D.C. 20001; or see remote sites.

**Please allow 5 business days for a CVCP team member to review your compensation application. If you have any questions, please call 202 879-4216.**