SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CRIME VICTIMS COMPENSATION PROGRAM

515 Fifth Street, N.W., Suite 109
Washington, D.C. 20001

APPLICATION FOR CRIME VICTIMS COMPENSATION

DATE RECEIVED: _____

CLAIM NUMBER: _____

INSTRUCTIONS	
1. Please type or print clearly in ink. 2. If you need more space, attach additional sheets. 3. If you need assistance completing the form, call (202) 879-4216 or come to the Crime Victims Compensation Program at the address listed above. 4. Attach all medical, hospital, and/or funeral bills and submit them with your application. This will help the processing of your application. 5. The Claimant must sign the application. If the Claimant is under 18 years of age, the application must be signed by the parent or guardian.	**6.** DO NOT INCLUDE costs for lost or damaged property or for pain and suffering. They are not covered by D.C. Law. **7.** If you do not know the answer to a question, please write "unknown" in the space provided. **8.** Please sign the Authorization For Release of Information. **9.** Submitting information that you know is false, or withholding important information is a crime and may result in a fine, and/or imprisonment and forfeiture of compensation. **10.** The total maximum that can be paid in a claim is $25,000. There are sub-limits for certain expenses. **11.** The crime must have occurred in the District of Columbia.

This is an application for:

- ☐ Loss of Earnings
- ☐ Loss of Support
- ☐ Loss of Services
- ☐ Medical/Dental Expenses
- ☐ Funeral Expenses
- ☐ Transportation to Receive Services
- ☐ Mental Health Services
- ☐ Crime Scene Clean-up
- ☐ Replacement Value of Clothing Kept as Evidence (No reimbursement when victim is deceased)
- ☐ Temporary Emergency Housing or Moving Expenses for Victims in Immediate Danger
- ☐ Home Security _____

SECTION 1 – VICTIM/CLAIMANT INFORMATION (A separate application needs to be completed for each victim)

VICTIM'S NAME (The victim is the person injured as a result of a crime.)				
Street Address (Mailing Address)	City	State	Zip Code	Ward
Home Telephone Number	Work Telephone Number			
Date of Birth	Social Security Number			
Additional Means to Contact Victim/Cell Phone/Family Member				
CLAIMANT'S NAME (Person filing application for deceased, incapacitated or minor victim)				
Street Address (Mailing Address)	City	State	Zip Code	Ward
Home Telephone Number	Work Telephone Number/additional contact information			
Date of Birth	Social Security Number			

The following information concerning the victim is used for statistical purposes only.
The victim is/was:

Disabled:	Primary Language:	Race:	Who referred you to the compensation program?
☐ Yes ☐ No Gender: ☐ Male ☐ Female	☐ English ☐ Spanish ☐ Other _____ (Please Specify	☐ Black ☐ White ☐ Hispanic/Latino ☐ Native American/Alaskan ☐ Asian/Pacific Islander ☐ Other _____ (Please Specify)	☐ Law Enforcement Agency ☐ U.S. Attorney's Office ☐ Department of Justice ☐ Hospital ☐ Media (TV, Radio, etc.) ☐ Domestic Violence Intake Center ☐ Other:_____ (Please Specify)

SECTION 2 – CRIME INFORMATION

Type of Crime (please check one)

☐ Arson	☐ Domestic Abuse	☐ Homicide
☐ Assault	☐ Kidnapping	☐ Car jacking
☐ Sexual Abuse	☐ Robbery	☐ Drunk Driving
☐ Cruelty to Children	☐ Reckless Driving	☐ Stalking
☐ Burglary	☐ Threats	☐ Unlawful Use of Explosives

Date of Crime	Date Crime Reported	Agency to Which Crime Was Reported
Police Complaint Number		Officer's Name

In cases of domestic abuse, please indicate Civil Protection Order number (if applicable)

In cases of sexual assault, medical treatment facility name (if applicable)

In cases of child cruelty, please indicate the neglect petition case number

Name of offender(s)

Did victim know offender(s)? ☐ YES ☐ NO, If YES, in what way?
_____

Brief description of crime and injuries;_____

_____

Location of Crime (Street Address) City State 16. Country

NOTE: **If crime did not occur in the District of Columbia, you must file a claim for compensation in the state where the crime occurred.**

SECTION 3 – MEDICAL/DENTAL/MENTAL HEALTH INFORMATION

(LIMITS: MENTAL HEALTH-Adult $3,000, minor $6,000. No sub-limit on medical and dental treatment, but total combined may not exceed $25,000.)

Did you receive medical/dental/or mental health treatment? ☐ Yes ☐ No

Name of Physician, Hospital or Other Provider of Service	Address	City/State/Zip	Phone Number	Amount of Bill
a.				
b.				

PLEASE SUBMIT COPIES OF ALL AVAILABLE BILLS RECEIVED TO DATE. PLEASE ATTACH ALL INSURANCE PAYMENT STATEMENTS AND REJECTIONS.

SECTION 4 – FUNERAL EXPENSES (Funeral Limit $6,000)

Name of Funeral Home/Phone No: (Please attach a copy of the funeral bill)

Name of Cemetery/Phone No: (Please attach a copy of cemetery bill)

Total Amount of Funeral/Cemetery Bill: $ _____Have the Funeral/Cemetery expenses been paid? ☐ YES ☐ NO

If YES, by whom?

_____

(Please submit receipt)

SECTION 5 – LOSS OF SUPPORT FOR SURVIVORS OF HOMICIDE (Limit $2,500 per dependent, no more than $7,500 per claim)

Have you submitted a claim to the Social Security Administration? ☐ YES ☐ NO

Did the victim have dependent(s)? ☐ YES (list dependents on section 8 of this application) ☐ NO

Did the victim provide support? ☐ YES (submit evidence of employment and/or child support) ☐ NO

SECTION 6 – LOSS OF SERVICES AND EXPENSES FOR SUBSTITUTE SERVICES
(Limit $250.00 per week, not to exceed $2,500)

Please list all services such as child care and housekeeping that are no longer provided by the victim as a direct result of the violent crime. Expenses Incurred

1. _____ $ _____

2. _____ $ _____

SECTION 7 – LOSS OF WAGES (Limit: 80% of net pay, up to $10,000 or 1 year, whichever is reached first)

Were you employed at the time of the crime? ☐ Yes ☐ No

Victim's Employer (at time of crime) _____ _____
Name Supervisor

_____
Street Address City State Zip Telephone Number

Gross Salary $ _____ per: ☐ hour ☐ day ☐ week ☐ month Hours Worked _____ per: ☐ day ☐ week

How long were you medically disabled and unable to work as a result of the crime/injuries?

From ____/ ____/ ____ Through ____/ ____/ ____ ☐ Did the crime occur at your job? ☐ Yes ☐ No
Mo. Day Yr. Mo. Day Yr.

Name of doctor who can verify length of disability to work: _____.
(Please submit disability statement)
Did you receive pay from your job, when you were off from work? ☐ Yes ☐ No

_____
Doctor's Name Street Address City State Zip Telephone Number

Self employed applicants for wage loss must attach a copy of their Federal Income Tax Returns for the preceeding 12 months.

EMERGENCY AWARD: Are you experiencing a financial hardship as a result of lost wages? You must have been employed at the same time of the crime. ☐ YES ☐ NO ***NOTE***: An emergency award is an advance of lost wages or reimbursement for crime related expenses)

SECTION 8 – 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 the Crime? Yes or No	Relationship to Victim
1.				
2.				
3.				
4.				

SECTION 9 – INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION

Awards may be decreased by the amount of funds available through 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				
Other (specify)				

SECTION 10 - RESTITUTION

If the court has ordered the offender to make restitution to you (pay you back), complete the following:

Date of Restitution Order	Criminal Case #: _____	Amount
_____/ _____/ _____ Mo. Day Yr.		$

SECTION 11 – TEMPORARY HOUSING AND MOVING EXPENSES (Limit $3,000 for temporary housing and moving expenses) (Limit $1,500 for moving expenses) A referral form may be requested.

Is this an award for temporary housing? ☐ YES ☐ NO
Moving Expenses? ☐ YES ☐ NO, If yes, please submit an approval letter, lease, and deed (private owners)
If YES, amount sought $ _____

SECTION 12 – CLOTHING REPLACEMENT (Limit $100) No reimbursement when victim is deceased.

Are any of the victim's clothes being held by the police or prosecuting attorney as evidence: ☐ YES ☐ NO If YES, what is the reasonable replacement value of the of clothing? $ _____

SECTION 13 - TRANSPORTATION EXPENSES (Limit $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

SECTION 14 - REIMBURSEMENT FOR RENTAL OF A CAR BEING HELD AS EVIDENCE (Limit $2,000)

Note: The Crime Victims Compensation Program can only provide reimbursement, it cannot lease the vehicle for you.

Was your car held as evidence as a result of this crime? ☐ YES ☐ NO
Agency holding car as evidence: _____

Name of Law Enforcement Officer _____ Phone: _____

Car Rental Company: _____ *(Please submit copy of lease agreement)*

SECTION 15 – SECURITY MEASURES FOR THE HOME (LIMIT $1,000)

Are you seeking security measures for your home as a result of the crime? ☐ YES ☐ NO

(Please submit estimates or receipts for services)

SECTION 16 – DECLARATION AND AFFIRMATION

SUBROGATION: If a monetary award is made, I agree to accept it under the provision of D.C. Law 4-509. This law requires that any money received from a civil suit relating to this crime, including settlement, be repaid to the Crime Victims Compensation Program up to the amount awarded under this application.

If the District of Columbia desires, it can file suit against the offender for recovery. Should the District of Columbia decide to sue, it will be responsible for all costs incurred and will recover those costs from monies awarded in the suit. I understand that I must fully cooperate in any such suit instituted by the District of Columbia.

I HEREBY CERTIFY THAT I WILL NOTIFY THE DISTRICT OF COLUMBIA IN THE EVENT THAT I FILE SUIT AGAINST THE OFFENDER OR THE COURT ORDERS THE OFFENDER TO MAKE RESTITUTION TO ME.

I DECLARE UNDER PENALTY OF FINE AND/OR IMPRISONMENT THAT THE INFORMATION CONTAINED IN THIS APPLICATION FOR A CRIME VICTIMS COMPENSATION AWARD IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____
Signature of Victim/Claimant **Date**

_____ _____
and/or Signature and Telephone number of Person Completing this Form **Date**

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CRIME VICTIMS COMPENSATION PROGRAM

515 Fifth Street, N.W., Suite 109
Washington, D.C. 20001
(202) 879-4216
(879) 879-4230 Fax

Name of Victim
Name of Claimant
Claim Number

(Official Use Only)

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize and request any person having information necessary to the administration of my claim to release that information, including all past law enforcement records concerning this claim, to the Superior Court of the District of Columbia Crime Victims Compensation Program. This **release** includes, but is not limited to: private and governmental physicians, mental health service providers, and hospitals; local, state and federal law enforcement agencies or prosecutors' offices; revenue services and court personnel; any employer, private company or governmental agency that is providing, or may provide, medical or monetary benefits. The District of Columbia's Department of Finance and Revenue is specifically authorized to provide the District of Columbia Crime Victims Compensation Program with copies of my District of Columbia tax forms and withholding statements that may be required to make final decision on this claim.

I agree and certify that **no person shall incur any legal** liability to me by releasing any information pursuant to this authorization. A photocopy of the authorization is as effective and valid as the original.

_____ _____

CLAIMANT'S SIGNATURE DATE