

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA CRIME VICTIMS COMPENSATION PROGRAM

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



APPL

APPLICATION FOR CRIME VICTIMS COMPENSATION

DATE RECEIVED: _____

CLAIM NUMBER: _____

INSTRUCTIONS

- | | |
|--|---|
| <ol style="list-style-type: none"> 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 proof of crime (e.g. Law enforcement report, Protection Order, SANE Receipt, Neglect Petition). 5. Attach all medical, hospital, and/or funeral bills and submit them with your application. This will help the processing of your application. 6. 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. | <ol style="list-style-type: none"> 7. DO NOT INCLUDE costs for lost or damaged property or for pain and suffering. They are not covered by D.C. Law. 8. If you do not know the answer to a question, please write "unknown" in the space provided. 9. Please sign the Authorization for Release of Information. 10. 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. 11. The total maximum that can be paid in a claim is \$25,000. There are sub-limits for certain expenses. 12. The crime <u>MUST</u> have occurred in the District of Columbia. |
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This is an application for:

- | | |
|---|---|
| <input type="checkbox"/> Loss of Earnings | <input type="checkbox"/> Mental Health Services |
| <input type="checkbox"/> Loss of Support | <input type="checkbox"/> Crime Scene Clean-up |
| <input type="checkbox"/> Loss of Services | <input type="checkbox"/> Replacement Value of Clothing Kept as Evidence
(No reimbursement when victim is deceased) |
| <input type="checkbox"/> Medical/Dental Expenses | <input type="checkbox"/> Temporary Emergency Housing or Moving Expenses for Victims in
Immediate Danger |
| <input type="checkbox"/> Funeral Expenses | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Transportation to Receive Services | |
| <input type="checkbox"/> 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 Last Employment

Date of Birth Social Security Number

Additional Means to Contact Victim/Cell Phone/Family Member /Email

CLAIMANT'S NAME (Person filing application for deceased, incapacitated or minor victim)

RELATIONSHIP TO 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

SECTION 1 (continued) – VICTIM INFORMATION

NOTE: The following information concerning the victim is used for statistical purposes **only**.

<p>Disabled:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gender:</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Reported</p>	<p>Primary Language:</p> <p><input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other</p> <p>_____</p> <p>(Please Specify)</p>	<p>Race:</p> <p><input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Hawaii/Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple races <input type="checkbox"/> Not Reported</p>	<p>Who referred you to the compensation program?</p> <p><input type="checkbox"/> Law Enforcement Agency <input type="checkbox"/> U.S. Attorney’s Office <input type="checkbox"/> Department of Justice <input type="checkbox"/> Hospital <input type="checkbox"/> Media (TV, Radio, etc.) <input type="checkbox"/> Domestic Violence Intake Center <input type="checkbox"/> Other: _____</p> <p>(Please Specify)</p>
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SECTION 2 – CRIME INFORMATION

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

TYPE OF CRIME (please check one)

- | | | |
|--|---|--|
| <input type="checkbox"/> Arson | <input type="checkbox"/> Domestic Abuse | <input type="checkbox"/> Homicide |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Kidnapping | <input type="checkbox"/> Car jacking |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Robbery | <input type="checkbox"/> Drunk Driving |
| <input type="checkbox"/> Cruelty to Children | <input type="checkbox"/> Reckless Driving | <input type="checkbox"/> Stalking |
| <input type="checkbox"/> Burglary | <input type="checkbox"/> Threats | <input type="checkbox"/> Other: _____ |

TYPE OF VICTIMIZATIONS

Is this crime related to:

Bullying	Domestic/Family Violence	Elder Abuse/Neglect	Hate	Mass Violence
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown				

Date of Crime	Date Crime Reported	Agency to Which Crime Was Reported
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Police Complaint Number	Officer’s Name
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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	Country
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SECTION 3 – MEDICAL/DENTAL/MENTAL HEALTH INFORMATION

*MENTAL HEALTH LIMIT: \$3,000 for Adults and \$6,000 for Minors

*MEDICAL AND DENTAL (in total) LIMIT: \$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**

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 NOIf 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 NODid the victim have dependent(s)? YES (list dependents on section 8 of this application) NODid 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 Date of last employment: _____

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 ____/____/____ Mo. Day Yr.	Criminal Case #: _____	Amount \$ _____
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SECTION 11 – TEMPORARY HOUSING AND MOVING EXPENSES

Limit: \$3,000 for temporary housing and \$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 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. Code § 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



SUPERIOR COURT OF THE DISTRICT OF COLUMBIA 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