800-469-2120
502-573-2290

CRIME VICTIMS COMPENSATION BOARD
130 Brighton Park Blvd.
Frankfort, Kentucky 40601
website: http://cvcb.ppr.ky.gov

FAX: 502-573-4817

GENERAL INFORMATION AND INSTRUCTIONS ON HOW TO FILL OUT THIS CLAIM FORM

You must use blue ink or type the information. If the crime occurred before July 15, 1998, you have one year to file the claim. If the crime occurred after July 15, 1998, you have five years to file the claim. You must fill out each section completely. If you need assistance in filling out the claim, please call one of the numbers above.

Section I. Information about the victim only.

Section II. If someone other than the victim is filing for assistance, this section must be completed about this person.

Section III. Information about the crime may either be filled out by the victim or the claimant. **You must attach a copy of the police report or criminal complaint taken out.**

Section IV. Allows the victim or the claimant to tell us in your own words what happened. Who did what, when, where and why?

Section V. List the injuries that the victim received as a result of the crime.

Section VI. List all medical bills incurred by the victim that are related to the crime. Each bill that is listed must be attached to the claim form before you send it to us. If a bill is not listed but attached, it will not be considered. If a bill is listed, but not attached, it will not be considered. Each bill must be an **itemized bill and show date of service**. **NO PERSONAL BILLS, EXPLANATION OF BENEFITS FROM INSURANCE COMPANIES, OR NOTICES FROM COLLECTION AGENCIES WILL BE ACCEPTED. IF YOU ATTACH THESE ON YOUR CLAIM FORM, THE FORM WILL BE RETURNED TO YOU AS UNACCEPTED.**

Section VII. What other type of benefits was the victim and/or claimant receiving at the time of the crime or is now receiving as a result of the crime.

Section VIII. Was the victim employed at the time of the crime? **If the victim is asking for lost wages, attach the Employment Verification Form that was filled out by the employer and the Physician Statement that was filled out by the doctor**. If the victim was self-employed, attach a copy of both state and federal tax returns along with the Physician Statement. **If these items are not attached when you send in the claim form, lost wages will not be considered.**

Section IX. This section must be filled out by the person who is filing the claim.

Section X. Fill out only if the victim is deceased. **You must attach the death certificate, and the signed funeral contract showing the claimant is the legally responsible party for funeral expenses.**

Section XI. Fill out only if the victim was supporting you as the surviving spouse and/or had dependent children with the victim. **You must attach all documentation showing amounts and sources of income you are receiving as a result of the death of the victim.**

Section XII. This area is for statistical information only and is supplied to the Federal Government.

Section XIII. Complete if you have filed, or may file a civil lawsuit, restitution was ordered to be paid to you by the court, or any settlement you reached with the assailant.

Section XIV. **Read this section completely. ONCE YOU HAVE READ THIS SECTION AND UNDER STAND IT, SIGN YOUR NAME, DATE THE APPLICATION AND MAIL IT TO THIS OFFICE. IF AN ATTORNEY ASSISTED YOU IN COMPLETING YOUR CLAIM, YOU MUST ALSO HAVE THE ATTORNEY SIGN THE CLAIM.**

REVISED 2/05

Kentucky UNBRIDLED SPIRIT

Revised 02/05

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GENERAL INFORMATION

FOR OFFICE USE ONLY

Fill out this form completely and accurately as possible. All claims will be thoroughly investigated and verified. You must provide the documentation necessary for your type of claim. Mail your completed form and documentation to the above address.

CLAIM NO. _____

INVESTIGATOR: _____

SECTION I. Victim Information

Victim's Name: _____ Soc. Sec. No. _____

Date of Birth: _____ Age: _____ ( ) Male ( ) Female
Mo. Day Year At Time of Crime

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (home): ( ) _____ (work): ( ) _____

SECTION II. Claimant information (if someone other than the victim is filing claim please complete this section)

Your Name: _____ Relationship to Victim _____

Date of Birth: _____ Soc. Sec. No. _____
Mo. Day Year

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (home): ( ) _____ (work): ( ) _____

SECTION III. Crime information (you **must** attach a copy of the police report)

Location of Crime: _____
Address City County

Check One

Assault	( )
Murder	( )
Sexual Assault Adult	( )
Sexual Assault Child	( )
Child Physical Abuse	( )
Domestic Assault	( )
DUI	( )
Other	( )

Date of Crime: _____ Date Reported: _____
Mo. Day Year Mo. Day Year

Crime Reported To: _____
Law Enforcement Agency

Was the Crime Reported within 48 hours of its discovery? ( ) Yes ( ) No
If no, please explain why: _____

Name of the Offender: _____Has the Offender been charged with a crime? ( ) Yes ( ) No

If yes, what charge: _____

What Court: District: _____ Circuit: _____ Juvenile: _____
Case Number Case Number Case Number

SECTION IV. Describe what happened. (If you know the reason for the crime, please tell us)

_____

_____

_____

SECTON V. Describe the injuries.

_____

_____

SECTION VI. Medical Expenses. (You **MUST** list every medical bill you have that is related to the crime. You **MUST** attach the medical bill you listed and it must show date of services and type of service. If a bill is not listed and attached, it **will not** be considered. **Notices from collection agencies will not be accepted.**

If you need additional space, please use separate sheet of paper

Name of Hospital, Doctor, Counselor, and all other related medical bills	Charge	Insurance Paid	Claimant/Victim Paid	Current Balance

SECTION VII. Other sources of payment. (You **must** attach documentation)

Was the victim or claimant, at the time of the crime, covered by: ( ) Medicaid ( ) Workers Comp.

( ) Medicare ( ) Health Insurance ( ) Veterans Benefits ( ) Homeowner's Ins. ( ) Auto Insurance

( ) Other

SECTION VIII. Lost Wages.

What was the claimant/victim's employment status at the time of the crime? ( ) Employed ( ) Unemployed

If employed, did the claimant/victim lose time from work as a result of the injury? ( ) Yes ( ) No

If yes, is the claimant/victim applying for lost wages? ( ) Yes ( ) No

If yes, the attached Employment Verification Form MUST be filled out by the EMPLOYER and attached to this form before returning.

If yes, the attached Physician Statement MUST be filled out by the DOCTOR and attached to this form before returning.

If the claimant/victim was self-employed, a copy of both state and federal tax returns must also be attached to this claim form.

SECTION IX. Financial Information (This information is about the person who is filing for assistance)
Exclude expenses requested in this claim

Total monthly income prior to incident? _____ Paid out per month _____

Total monthly income currently? _____ Pay out per month _____

List **all** sources of income: (include every source of income including spouse's income, food stamps, welfare, child support, Social Security, pensions, Workers Compensation benefits, veterans benefits, AFDC, or any other income. List monthly amounts below)

_____ _____ _____

_____ _____ _____

SECTION X. Funeral Expenses (This section is to be filled out if the victim is deceased)

YOU MUST ATTACH THE FUNERAL CONTRACT SHOWING YOU ARE THE LEGAL RESPONSIBLE PARTY FOR THE FUNERAL EXPENSES OF THE VICTIM

Date of Death: _____ (You **must** attach a copy of the death certificate)
Mo. Day Year

Were any benefits available from any of the following sources: (List any and all amounts received or to be received by the victim or claimant). **This includes any money received from contributions or donations**.

Life Insurance: $ _____ Workers Compensation $ _____

Burial Insurance: $ _____ Social Security $ _____

Estate $ _____ Other $ _____

Name of Funeral Home: _____

Address: _____ Telephone No. _____
Street City State Zip

Amount of Funeral Expenses: $ _____ Have they been paid? ( ) Yes ( ) No

If yes, by whom: _____

Address: _____ Telephone No. _____
Street City State Zip

Relationship to victim: _____

SECTION XI. Loss of support (Fill this out only if you are the surviving spouse of the victim and/or had dependent children)

What was victim's employment status at time of crime? ( ) Employed ( ) Unemployed

If employed, the attached Employment Verification Form **must** be filled out by the **employer** and attached to this form before returning.

What income are you now receiving as a result of the victim's death: (List all amounts being received)
(**You must attach all documentation showing amounts and sources**)

Social Security $ _____ Workers Compensation $ _____

Welfare $ _____ AFDC $ _____ Other $ _____
(From where and amount received)

SECTION XII. Federal Government Information **(Optional for Statistical Use Only)**

Ethnic Group (Victim)
( ) White
( ) Black
( ) American Indian or Alaskan Native
( ) Asian
( ) Hispanic (Mexican, Puerto Rican, Cuban or other Spanish culture)
( ) Multiracial

U.S. Citizen (Victim) ( ) Yes ( ) No
Handicap (Victim) ( ) Yes ( ) No
Federal Crime ( ) Yes ( ) No
Kentucky Resident ( ) Yes ( ) No

Who referred you to the compensation program?
( ) Law Enforcement ( ) Hospital
( ) Victims Advocate ( ) Prosecutor
( ) Other _____

SECTION XIII. Restitution and Civil Lawsuit

Has the victim and/or claimant filed, or planning to file, a civil lawsuit against anyone relating to the injury received as a result of the crime? ( ) Yes ( ) No

If yes, name of attorney: _____

Address: _____ Telephone No. _____
Street City State Zip

Was the offender ordered by the court to pay any restitution? ( ) Yes ( ) No

If yes, amount $ _____ How is it to be paid? _____

SECTION XIV. Authorization and Subrogation

VERIFICATION OF APPLICATION: I, hereby certify, subject to penalty, fine or imprisonment, that the information contained in this application for Crime Victims Compensation is true and correct to the best of my knowledge.

SUBROGATION: In consideration of the payment received from the Crime Victims Compensation Board, I agree to repay the full amount I received from the fund in the event I recover damages or compensation from the offender or from any other public or private source as a result of the injuries or death which was the basis of my claim for compensation from the fund. I understand that compensation from any other public or private source includes, but is not limited to, receipt of insurance, Medicare, Medicaid, Workers Compensation, disability pay, etc. I further agree and understand that no part of recovery due the Crime Victims Compensation Board may be diminished by any collection fees or for any other reason whatsoever.

Should I choose to recover damages or compensation for the injury or death from any source, I agree to promptly notify the Crime Victims Compensation Board by sending copies of any pleadings, settlement proposals, and any other documents relative thereto. I further agree to fully cooperate with the Crime Victims Compensation Board should the Board decide to institute an action against any person or entity for the recovery of all or any part of the compensation I received from the fund.

MEDICAL/PSYCHIATRIC/EMPLOYMENT RELEASE: I hereby authorize any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility, or any other person or firm to release any and all information requested. I understand and acknowledge that my mental health records may contain confidential remarks made by me, information regarding drug or alcohol abuse, HIV status, or other personal data. I further agree and hold blameless any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility or any staff person of any and all liability for the release of these records.

SIGNATURE:_____ **DATE**: _____

You are not required to have an attorney assist in submitting your application. If an attorney does assist you, the attorney must sign this application.

Attorney's Name: _____ Soc. Sec. No. or Fed. ID _____
Address: _____ Telephone No. _____

Attorney's Signature: _____

Revised 11/04

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EMPLOYMENT VERIFICATION
(to be completed by employer only)

Employee's Name: _____ Soc. Sec. No. _____

Date of Crime: _____ Was the victim employed at the time of crime? ( ) Yes ( ) No

If yes, complete the following:

Employer's Name: _____

Address: _____

Telephone No.: _____ Date employed: _____

Did the victim miss any time from work because of injuries from the crime? ( ) Yes ( ) No
If yes, from _____ to _____

The items listed below are to be **WEEKLY AMOUNTS**:

Gross Earnings $ _____ Federal Tax Withheld $ _____

State Tax Withheld $ _____ Social Security Withheld $ _____

Other Deductions (itemized) $ _____ Typical days worked per week? M-T-W-Th-F-Sat-Sun
(please circle)

Average work hours per week: _____ **Average overtime per week**: _____

Net Take Home Earning Per Week? _____

Has the victim returned to work? ( ) Yes ( ) No
Did the victim's wage continue while off work? ( ) Yes ( ) No
If yes, complete the following:

		Amount Per Week	From date to date
_____	Workers Comp	$ _____	_____ to _____
_____	Unemployment	$ _____	_____ to _____
_____	Private or Health	$ _____	_____ to _____
_____	Vacation	$ _____	_____ to _____
_____	Sick	$ _____	_____ to _____
_____	Employers Group	$ _____	_____ to _____
_____	Disability	$ _____	_____ to _____
_____	Union	$ _____	_____ to _____
_____	Other, specify	$ _____	_____ to _____

_____
Signature and Title

SUBSCRIBED AND SWORN TO BEFORE ME BY _____

THIS _____ **DAY OF** _____, **19** _____

MY COMMISSION EXPIRES _____

_____
NOTARY PUBLIC

Revised 11/04

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PHYSICIAN STATEMENT
(**to be completed by doctor ONLY)**

Victim/Patient Name: _____

Type of injury: _____

Date of injury: _____

Date(s) Victim unable to work: From _____ to _____

Did victim suffer permanent disability? ( ) Yes ( ) No

If yes, please state the victim's percentage of permanent disability to the body as a whole in accordance with the AMA Guidelines.

COMMENTS:

Name of Attending Physician: _____

Address:_____

Telephone Number: _____ Federal ID Number: _____

Signature: _____ Date: _____

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MENTAL HEALTH COUNSELOR'S REPORT
(to be completed by counselor ONLY)

Person receiving services: _____

Social Security No. _____ **Crime Date:** _____

Is the trauma and the treatment a direct result of this crime? YES _____ **NO** _____

Presenting Complaint: _____

Diagnosis of Record: _____

PROGNOSIS: _____

Description of injury and/or psychological trauma as related to the crime:

_____

_____

_____

_____

HEALTH INSURANCE CARRIER:

_____

Company Name **Telephone No.**

_____

Mailing Address **City/State/Zip**

**** PLEASE ATTACH A SEPARATE TREATMENT PLAN***

_____

Authorized Signature of Treating Therapist/Counselor **Telephone No./Extension**

_____

Licensed Specialty Type

_____

Full Mailing Address

_____

Professional License No./Federal ID No.