APPLICATION FOR CRIME VICTIM COMPENSATION

VC# OFFICE USE ONLY

Please print neatly and fill out both sides **completely**. Contact your **Victim Advocate in the Prosecutor's Office** if you need assistance completing this application. **Attach additional sheets** if necessary.

I. Victim Information *(Separate application for each victim)*

Victim's name _____ Female❑ Male❑ Other❑
Mailing Address _____ Cell./Home Tel. _____
City/State/Zip (**CSZip**)_____ Other Tel. _____
Date of Birth (**DOB**)_____ Age at time of incident _____ SSN _____

II. Claimant Information (*If victim is Claimant, write "same"; if victim is under 18, claimant must be parent or guardian)*

Claimant's name _____ Female❑ Male❑ Other ❑
Mailing Address _____ Cell./Home Tel._____
City/State/Zip (**CSZip**)_____ Other Tel._____
DOB_____ Relationship to victim _____ SSN_____
If filing on behalf of minor dependent(s) of homicide victim, relationship to minor dependent(s) _____

III. Crime Information (*Type of **violent** crime; your **Victim Advocate** can assist you with details)*

❑ assault ❑ child sexual abuse ❑ drunk driving ❑ homicide
❑ sexual assault ❑ terrorizing/threatening ❑ sex trafficking ❑ other _____
Exact location of crime _____ CSZip_____
Date of crime_____ Date crime ended _____ Date crime discovered _____ Date crime reported _____
Adult victims attach an explanation of reason for delay if crime NOT reported within 5 days, or if application NOT filed within 3 years.
Name of Police Department _____ Investigating Officer _____
Name(s) of person(s) who committed crime _____ DOB(s) _____
Relationship to victim (e.g. father, boyfriend, spouse, stranger, etc.) _____
Who referred you? ❑ Police/Sheriff ❑ District Attorney ❑ Media ❑ Hospital/Dr. ❑ Other _____
❑ Victim Advocate (name) _____ Tel._____
Briefly describe the crime and injuries_____
_____

IV. Expenses (*Check types of expenses caused by the crime for which you seek compensation)*

❑ medical services* ❑ caregiver assistance ❑ locks repair/replacement*
❑ medical supplies/pharmacy* ❑ lost wages (for victim only) ❑ counselling for victim*
❑ dental services* ❑ loss of financial support/other expenses* ❑ counselling for family members*
❑ funeral/burial/monument* (in **homicide cases only**) (1) who witnessed crime; or
Name & Address of Funeral Home ❑ crime scene cleaning* (2) in homicides; or
_____ ***Attach copies of bills and/or receipts** (3) in sexual assault cases or
_____ (or send as they become available) catastrophic injury

*Complete **FULLY** for **family or household members** of victim applying for **counselling benefits**:*

Name	**Address/CSZip**	**DOB**	**Relat. to victim**	**Relat. to claimant**

*Complete **FULLY** for **medical service providers** (please list type of service, e.g.: hospital, doctor, mental health):*

Name of Provider	**Agency/Office Name**	**Address/CSZip/Tel.**	**Service**

(*Complete the Employer section for the individual seeking lost wages or caregiver assistance.*

V. Lost Income

Attach 2 recent paystubs. If self- employed, attach your last two years of Federal Income Tax returns)

Employer_____ Contact person _____
Address/CSZip/Tel._____
Dates absent from work due to crime-related injuries **From** _____ **To** _____
Treating physician name for disability statement _____
Treating Physician's Address/CSZip/Tel._____

VI. Homicide Victim Dependents

*(Complete **ONLY** if requesting financial support for dependent(s) of a homicide victim)*

Name of dependent	DOB	SSN	Relat. to Victim

(Attach last two years of victim's Federal Income Tax returns and Social Security benefit award letter for each dependent)

VII. Current Sources of Financial Assistance

*(Check **all** potential sources of **full or partial payment** of expenses)*

❑ MaineCare/Medicaid ❑ Health insurance ❑ Disability benefits ❑ Workers Compensation
❑ Funeral insurance ❑ SSI or TANF ❑ Medicare and/or QMB ❑ Town or City Assistance
❑ Automobile insurance ❑ SSDI ❑ Other (please specify) ❑ None

Names and addresses of applicable insurance companies _____
_____ MaineCare or Policy # _____

Have you filed or do you intend to file a **civil lawsuit**? ❑ yes ❑ no ❑ not sure
If yes, Attorney's name _____
Law Firm's Address/CSZip/Tel._____

VIII. Optional Information on Victim

(For statistical purposes only)

✓ **Age at time of crime:** ❑ 0 - 12 ❑ 13 - 17 ❑ 18 - 24 ❑ 25 - 59 ❑ 60 +

✓ **Race:** ❑ White Non-Latino/Caucasian ❑ Native Hawaiian and Other Pacific Islander
❑ Black/African American ❑ American-Indian/Alaskan-Native ❑ Asian
❑ Hispanic or Latino ❑ Multiple Races ❑ Other Race: _____

✓ **English-speaking?** ❑ yes ❑ no **Primary Language** _____
✓ **Did crime involve bullying or elder abuse?** ❑ yes ❑ no
✓ **Disabled <u>prior</u> to crime?** ❑ yes ❑ no

Information Release

I give permission to any hospital, medical facility, doctor, mental health provider, attorney, insurance company, employer, person or agency to give needed information to the Victims' Compensation (VC) Program in the Office of the Attorney General. I understand that the information will be used to determine my claim for VC benefits only. I do not allow the use or release of this information to any person or entity for any other purpose whatsoever. A photocopy of this signed release shall be treated as the original. This authorization shall expire upon final determination of all my claims for VC Fund benefits unless earlier revoked in writing by me. Pursuant to statute, 5 M.R.S.A. § 3360-D(2), a signed Victims' Compensation application fulfills the requirements under State law, including 22 M.R.S.A. § 1711-C(3), to authorize release of records.

X _____ Date _____
Claimant signature (parent or guardian if victim is a minor)

Agreement and Warning

I understand that the Victims' Compensation (VC) Fund pays only for losses caused by the crime and only if other insurance or benefits do not cover my losses. I agree to repay the VC Fund if I receive money from insurance, restitution, Social Security, or any other source to cover the same losses **paid** from the VC Fund, even if my claim is no longer active. I will notify the VC Program immediately if I receive money from another source, or if I hire an attorney related to this crime, and I direct my attorney to pay back the VC Fund if he or she receives money from any other source to pay the same losses which the VC Fund has paid for me. I swear that the information that I have given in or with this application is true to the best of my knowledge. I will also continue to update the VC Program with accurate information during the processing of my VC Claim, including information about income or benefits for which I apply. **If I make false statements or leave out information to mislead I may be subject to criminal prosecution under 17-A M.R.S.A. § 453 and 17-A M.R.S.A. § 354.**

X _____ Date _____
Claimant signature (parent or guardian if victim is a minor)

<u>Detach and Return</u> completed application to:

Victims' Compensation Program
Office of the Attorney General
6 State House Station
Augusta, ME 04333-0006