

VICTIM'S INJURY Information

BRIEFLY DESCRIBE VICTIM'S INJURIES _____

WHERE WAS VICTIM TAKEN FOR EMERGENCY TREATMENT? ADDRESS CITY STATE/ZIP CODE

WAS VICTIM HOSPITALIZED? YES FROM _____ TO _____
 NO

HOSPITAL NAME (IF DIFFERENT FROM ABOVE) ADDRESS CITY STATE/ZIP CODE

**MEDICAL EXPENSES - SUBMIT A COPY OF ALL OF THE VICTIM'S ACTUAL MEDICAL BILLS.
INSURANCE STATEMENTS ARE NOT ACCEPTABLE.**

VICTIM'S DEATH Information

DATE OF DEATH FUNERAL HOME ADDRESS CITY STATE/ZIP CODE

EXECUTOR OR ADMINISTRATOR OF VICTIM'S ESTATE ADDRESS CITY STATE/ZIP CODE

COPIES OF THE FOLLOWING DOCUMENTS SHOULD BE SUBMITTED WITH THE APPLICATION:

- DEATH CERTIFICATE - BIRTH CERTIFICATE OF VICTIM'S MINOR CHILDREN - SOCIAL SECURITY BENEFITS BEING PAID - FUNERAL & BURIAL EXPENSES - PROOF OF GUARDIANSHIP

INSURANCE AND REIMBURSEMENT Sources

LIST ANY SOURCES OF INSURANCE OR OTHER REIMBURSEMENT

EXAMPLES: - MEDICAID - MEDICARE - HEALTH - AUTO - WORKERS' COMP - SOCIAL SECURITY - LIFE

By law, you must first use all existing sources of financial assistance or reimbursement before receiving payments from the Crime Victims Compensation Fund.

NAME _____

ADDRESS _____

CITY STATE/ZIP CODE

VICTIM'S EARNING LossesWAS VICTIM EMPLOYED ON DATE OF INJURY? YES NODID VICTIM LOSE EARNINGS NOT REIMBURSED? YES NO LIST AMOUNT OF EARNINGS LOSS IN DOLLARS \$ _____DID VICTIM LOSE WORK DUE TO INJURY? YES NO LIST DAYS VICTIM WAS UNABLE TO WORK DUE TO INJURY _____

EMPLOYER'S FULL NAME EMPLOYER'S FULL MAILING ADDRESS EMPLOYER'S CITY / STATE / ZIP CODE

EMPLOYER'S TELEPHONE NUMBER WORK-RELATED REMARKS

DEPENDENT'S Information*A DEPENDENT IS ONE WHO HAS RECEIVED OVER ONE HALF OF HIS/HER SUPPORT FROM THE VICTIM.*

DEPENDENT'S NAME DEPENDENT'S FULL ADDRESS RELATIONSHIP TO VICTIM DATE OF BIRTH

ATTORNEY Information (if applicable)

You are not required to have an attorney to file your application. However, if you do, the attorney fees are paid by the Crime Victims Fund in addition to any award.

- ATTORNEY ASSISTING ONLY WITH THIS APPLICATION
(ALL COMMUNICATIONS WILL BE WITH CLAIMANT/VICTIM)
- ATTORNEY IS ATTORNEY OF RECORD
(ALL COMMUNICATIONS WILL BE WITH ATTORNEY)

ATTORNEY'S NAME ADDRESS CITY STATE/ZIP CODE

ATTORNEY'S SIGNATURE ATTORNEY'S TELEPHONE NUMBER

CLAIMANT'S RELEASE**Important:**

This affidavit is part of your application and must be completed and signed in the presence of a notary.

I, the claimant, hereby state UNDER THE PENALTIES OF PERJURY AND FALSIFICATION that this application of three pages has been prepared or read by me and that the information given herein, including attached bills, records, or certificates, is true and complete.

Further, I hereby authorize any person (including any physician, health care or health services provider, organization, law enforcement or governmental agency, including the Social Security Administration), to release to the West Virginia Court of Claims upon its request, a copy of any report, document, record, criminal record or other information (including copies of my West Virginia state income tax returns and related records for the years requested), in any way relating to my claim for an award of compensation on behalf of

_____, a victim of criminally injurious conduct.

PRINT VICTIM'S NAME

I also authorize release of medical records or other information regarding my treatment, hospitalization, and/or outpatient care including behavioral health, drug/alcohol, acquired immunodeficiency syndrome (AIDS), tests for infection with acquired immunodeficiency syndrome (HIV), blood alcohol serum tests, sexual assault/sexual abuse examinations, and those test results.

This authorization or a photostatic copy, which will be considered as valid as the original, shall be valid, without further consent by me, until final disposition of this claim.

THIS FORM MUST BE SIGNED BEFORE A NOTARY

CLAIMANT'S SIGNATURE (SIGN ONLY BEFORE A NOTARY)

CLAIMANT'S PRINTED NAME

DATE

As a duly appointed Notary Public, I hereby certify that the above listed person (claimant) has personally appeared before me and I have witnessed the signature that is affixed hereon.

NOTARY PUBLIC SIGNATURE

MY COMMISSION EXPIRES: _____

NOTARY SEAL