

West Virginia Crime Victims Compensation Fund

e:\cvcf\application\cvapplication_webb.p65
Revised 8/20/98

1900 Kanawha Blvd., E., Room W-334
Charleston, West Virginia 25305-0610
(304) 347-4850 1-877-562-6878 (WV only)
www.legis.state.wv.us/coc/victims/main.html
ctclaims@mail.wvnet.edu

PAGE 1

OFFICE USE ONLY

CLAIM NUMBER

CV-

INTERNET INSTRUCTIONS

1. Complete form on screen
2. Print and mail 2 originals
3. Have each Page 4 notarized

APPLICATION

VICTIM/CLAIMANT	1. VICTIM NAME (FIRST-MIDDLE-LAST)		MAIDEN NAME		11. CLAIMANT NAME (IF VICTIM, CHECK <input type="checkbox"/> AND GO TO LINE 20)	
	2. PRESENT ADDRESS-STREET				12. PRESENT ADDRESS-STREET	
	3. CITY		COUNTY		13. CITY	
	4. STATE		ZIP		14. STATE	
	5. PHONE - HOME		6. PHONE - WORK		15. PHONE - HOME	
	7. SOCIAL SECURITY NUMBER		8. BIRTH DATE		17. SOCIAL SECURITY NUMBER	
	9. SEX <input type="checkbox"/> M <input type="checkbox"/> F		10. MARITAL STATUS (CHECK ONE) <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED		19. RELATIONSHIP TO VICTIM	
	20. DATE OF INJURY		21. TIME OF INJURY AM PM		22. LOCATION (WHERE INJURY OCCURRED)	
					COUNTY	
	CRIME	23. CRIME REPORTED TO LAW ENFORCEMENT AGENCY (AGENCY - STREET - CITY - STATE - ZIP)				
24. DATE REPORTED		25. TIME REPORTED AM PM		26. WHO NOTIFIED LAW ENFORCEMENT AGENCY?		
27. IF NOT REPORTED WITHIN 72 HOURS, WHY NOT?						
28. SUSPECTED OFFENDER(S)						
				<input type="checkbox"/> ADULT <input type="checkbox"/> JUVENILE <input type="checkbox"/> ADULT <input type="checkbox"/> JUVENILE		
29. WAS VICTIM OR CLAIMANT RELATED TO OFFENDER(S)? <input type="checkbox"/> NO <input type="checkbox"/> YES (SPECIFY)				30. WAS VICTIM OR CLAIMANT LIVING IN SAME HOUSEHOLD WITH OFFENDER(S)? <input type="checkbox"/> NO <input type="checkbox"/> YES		
31. HAS OFFENDER(S) BEEN CHARGED? <input type="checkbox"/> NO EXPLAIN: <input type="checkbox"/> YES COURT NAME: CHARGE(S):						
NARRATIVE	32. BRIEFLY DESCRIBE WHAT HAPPENED:					

West Virginia Crime Victims Compensation Fund Application

PAGE 2

MEDICAL

33. BRIEFLY DESCRIBE VICTIM'S INJURIES	
34. WHERE WAS VICTIM TAKEN FOR EMERGENCY TREATMENT?	NAME - ADDRESS - CITY - STATE - ZIP
35. PHYSICIAN TREATING VICTIM	NAME - ADDRESS - CITY - STATE - ZIP
36. SECOND PHYSICIAN OR DENTIST TREATING VICTIM	NAME - ADDRESS - CITY - STATE - ZIP
37. HOSPITALIZED? <input type="checkbox"/> NO <input type="checkbox"/> YES	DATE FROM: _____ DATE TO: _____ HOSPITAL NAME - ADDRESS - CITY - STATE - ZIP
38. SECOND HOSPITAL OR CLINIC'S NAME - ADDRESS - CITY - STATE - ZIP	

DEATH

39. DID VICTIM DIE FROM INJURIES? <input type="checkbox"/> NO <input type="checkbox"/> YES	DATE OF DEATH <input style="width: 100px;" type="text"/>	IF YES, ATTACH COPIES OF:
		1. VICTIM'S DEATH CERTIFICATE 2. VICTIM'S MARRIAGE LICENSE (IF APPLICABLE) 3. BIRTH CERTIFICATES OF VICTIM'S MINOR CHILDREN
40. FUNERAL DIRECTOR'S NAME - ADDRESS - CITY - STATE - ZIP		
41. EXECUTOR OR ADMINISTRATOR OF VICTIM'S ESTATE (ATTACH DOCUMENT) NAME - ADDRESS - CITY - STATE - ZIP		

EXPENSES

42. EXPENSES INCURRED AS A RESULT OF THE INJURY OR DEATH (COPIES OF ITEMIZED BILLS MUST BE ATTACHED)		AMOUNT	DATE INCURRED
TO WHOM OWED - ADDRESS - CITY - STATE - ZIP			
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			

WORK LOSS

43. VICTIM'S EMPLOYMENT STATUS IMMEDIATELY PRIOR TO INJURY.	A. WAS VICTIM EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES	B. DID VICTIM LOSE EARNINGS NOT REIMBURSED? <input type="checkbox"/> NO <input type="checkbox"/> YES	C. DID VICTIM LOSE WORK DUE TO INJURY? <input type="checkbox"/> NO <input type="checkbox"/> YES
D. WAGE EARNINGS \$ PER	E. REMARKS		
F. EMPLOYER'S NAME - ADDRESS - CITY - STATE - ZIP			TELEPHONE NUMBER
44. SPOUSE'S EMPLOYMENT STATUS IMMEDIATELY PRIOR TO INJURY.	A. WAS SPOUSE EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES		
B. SPOUSE'S EMPLOYER NAME - ADDRESS - CITY - STATE - ZIP			TELEPHONE NUMBER

West Virginia Crime Victims Compensation Fund Application

COLLATERAL SOURCES

45. ARE MEDICAL OR LOSS OF INCOME BENEFITS AVAILABLE FROM ANY SOURCE OTHER THAN UNDER THE VICTIMS OF CRIME ACT? CHECK "YES" OR "NO" BOXES FOR ALL SOURCES.

YES <input type="checkbox"/>	NO <input type="checkbox"/>	OFFENDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	MEDICARE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	HEALTH INSURANCE COVERAGE (POLICY NO.) _____
<input type="checkbox"/>	<input type="checkbox"/>	BANKRUPTCY	<input type="checkbox"/>	<input type="checkbox"/>	SOCIAL SECURITY	<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID (CASE NO.) _____
<input type="checkbox"/>	<input type="checkbox"/>	LIFE INSURANCE	<input type="checkbox"/>	<input type="checkbox"/>	VETERAN'S ADMIN.	<input type="checkbox"/>	<input type="checkbox"/>	OTHER (SPECIFY) _____
<input type="checkbox"/>	<input type="checkbox"/>	WORKERS' COMPENSATION	<input type="checkbox"/>	<input type="checkbox"/>	EMPLOYER'S WAGE CONTINUATION PROGRAM			

ENTER IDENTIFYING INFORMATION BELOW FOR ANY BOX CHECKED "YES", EVEN IF AMOUNT IS PRESENTLY UNKNOWN.

BENEFITS RECEIVED OR AVAILABLE (HEALTH, LIFE, OR OTHER INSURANCE SETTLEMENTS, ETC)

SOURCE NAME - ADDRESS - CITY - STATE - ZIP	AMOUNT	DATE RECEIVED
1.		
2.		
3.		
4.		

46. HAS A CIVIL ACTION BEEN FILED AGAINST THE OFFENDER(S) AS A RESULT OF THIS INJURY? YES NO

IF YES, NAME OF COURT _____	CASE NUMBER _____	AMOUNT OF SETTLEMENT OR JUDGMENT \$ _____	AMOUNT EXPECTED, IF NOT YET RECEIVED \$ _____
-----------------------------	-------------------	---	---

DEPENDENTS

47. SPOUSE OF VICTIM ADDRESS - CITY - STATE - ZIP _____ SOC. SEC. NUMBER _____ BIRTH DATE _____

48. IF VICTIM WAS KILLED, LIST ALL MINOR CHILDREN OF VICTIM WHETHER OR NOT THEY WERE DEPENDENT UPON THE VICTIM. ALSO LIST ALL DEPENDENTS OF VICTIM.

NAME - ADDRESS - CITY - STATE - ZIP	RELATIONSHIP TO VICTIM	DATE OF BIRTH	AMOUNT OR % OF SUPPORT
1.			
2.			
3.			
4.			

49. GUARDIAN OF CHILDREN ADDRESS - CITY - STATE - ZIP _____ TELEPHONE _____

REMARKS

50. REMARKS:

ATTORNEY

51. ATTORNEY

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

TO BE COMPLETED BY ATTORNEY (IF APPLICABLE)

CHECK ONE

ASSISTING ONLY ATTORNEY OF RECORD

ATTORNEY'S NAME _____ SOC. SEC. OR FEIN NUMBER _____

ADDRESS - CITY - STATE - ZIP _____ TELEPHONE _____

SIGNATURE _____

West Virginia Crime Victims Compensation Fund

1900 Kanawha Blvd., E., Room W-334
Charleston, West Virginia 25305-0610
(304) 347-4850
1-800-642-8650 (WV only)
ctclaims@mail.wvnet.edu

www.legis.state.wv.us/coc/victims/main.html

CLAIMANT'S RELEASE

I, the claimant, hereby state UNDER THE PENALTIES OF PERJURY AND FALSIFICATION that this application of four 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.
(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.

NOTICE: Failure to notarize will delay the processing of your claim.

Note: Sign and date EACH COPY of this page. _____ /_____/_____
CLAIMANT'S SIGNATURE DATE

My commission expires: _____

NOTARY PUBLIC