CRIME VICTIMS COMPENSATION FUND
1900 KANAWHA BLVD E RM W-334
CHARLESTON WV 25305-0610

OFFICE OF THE COURT OF CLAIMS

CRIME VICTIMS COMPENSATION FUND

APPLICATION

FOR WEST VIRGINIA CRIME VICTIMS COMPENSATION

Revised February 2011

- Include all the documentation you can - if you have a copy of the police report, hospital or doctor bills, please send with the application.
- If you do not have this documentation, do not wait to mail the application if you are near the two-year deadline. Send the application as soon as you have it completed and follow-up with the documentation later.
- ***Keep this page so that you will have our address and telephone number.***
- Be sure to let us know of any address or telephone number changes.
- If you need help completing the application, contact us or check with your local prosecuting attorney's Victim Assistance Coordinator, if available.
- Sign this Application (Page 3) in front of a notary public.

Failure to notarize will delay the processing of your claim.

Mail your completed application to:

CRIME VICTIMS COMPENSATION FUND
1900 KANAWHA BLVD E RM W-334
CHARLESTON WV 25305-0610

304.347.4850
877.562.6878 (toll free)
Fax 304.347.4915
e-mail: cvictims@wvlegislature.gov
www.legis.state.wv.us/joint/victims/main.cfm

INFORMATION

THE WEST VIRGINIA CRIME VICTIMS COMPENSATION FUND	✦ Provides financial assistance to victims of crime for related expenses that cannot be reimbursed from insurance or other sources. ✦ Compensation for medical, funeral/burial expenses, earning losses, mileage to a medical treatment facility and to court for the prosecution of the offender, mental health counseling, crime scene cleanup, and relocation expenses. ✦ Administered by the West Virginia Court of Claims.
HOW THE SYSTEM IS FUNDED	✦ Every person who is convicted of or pleads guilty to a misdemeanor or felony offense, other than a non-moving traffic violation, is assessed additional court costs, which are transmitted to the State Treasurer for deposit into the Crime Victims Compensation Fund. ✦ No tax dollars are used.
WHO CAN FILE A CLAIM?	✦ Any innocent victim who suffers personal injury as the result of a crime. ✦ Any individual who is the dependent of a deceased victim of crime. (A dependent is one who has received over one half of his/her support from the victim.)
WHAT IS REQUIRED?	✦ The crime must be reported to law enforcement officials within 72 hours. ✦ The claimant must fully cooperate with law enforcement officials. ✦ The claim for compensation must be filed within 2 years of the date of the crime.
IS THERE A LIMIT TO THE AMOUNT RECOVERABLE?	✦ In injury claims, the maximum is $35,000.00. ✦ In death claims, the maximum is $50,000.00 (including $7,000.00 for funeral and burial expenses).
HOW IS A CLAIM PROCESSED?	✦ The Claim Investigator reviews the claim and files a Finding of Fact and Recommendation. ✦ A Judge of the Court of Claims evaluates the claim without a hearing and renders a decision. ✦ A hearing on the matter will be held if either the claimant or the Claim Investigator disagrees with the decision rendered.
IS THE LOSS OF OR DAMAGE TO PROPERTY RECOVERABLE?	✦ No. Lost, damaged, or stolen property or MONEY is **not** subject to an award. However, prosthetic devices, eyeglasses, dentures, etc., are compensable.
IS THERE A FILING FEE?	✦ No.
DO YOU NEED AN ATTORNEY?	✦ No. If a claimant seeks the services of an attorney, reasonable fees will be paid by the Fund at no cost to the claimant.

If you are not sure of your eligibility, call us for additional information. We care!

Office Use Only

Date Received: ________________

Claim No.: CV- ________________

Judge: ________________

WEST VIRGINIA CRIME VICTIMS COMPENSATION FUND

1900 Kanawha Blvd., E., Room W-334
Charleston, WV 25305-0610

Voice: 304.347.4850 & 877.562.6878
Fax: 304.347.4915
Email: cvictims@wvlegislature.gov

APPLICATION

PLEASE COMPLETE ALL SECTIONS and PRINT CLEARLY

IMPORTANT: **DATE OF CRIME** ______/________/________

COUNTY WHERE CRIME OCCURRED: ______________________

CLAIMANT Information

Section 1

____
CLAIMANT'S FIRST NAME MI CLAIMANT'S LAST NAME

____
MAILING ADDRESS

____
CITY STATE/ZIP CODE

____
E-MAIL ADDRESS (please print clearly)

RELATIONSHIP TO VICTIM: ☐ SELF ☐ OTHER (SPECIFY):________________

Section 2

DATE OF BIRTH: ________________

SOCIAL SECURITY NUMBER: ________________

MALE OR FEMALE: ________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

HOME PHONE: ( ) -

WORK PHONE: ( ) -

Section 3 **EMPLOYMENT (earning losses)**

DID CLAIMANT HAVE AN EARNINGS LOSS DUE TO THIS CRIME? NO ☐ IF YES, LIST AMOUNT OF EARNINGS LOSS $________________

IF YES, LIST DAYS UNABLE TO WORK DUE TO INURY: ________________

EMPLOYER'S FULL NAME:________________ EMPLOYER'S TELEPHONE NUMBER: ________________

EMPLOYER'S FULL MAILING ADDRESS: ________________
Street or PO Box Number City State Zip

WORK-RELATED REMARKS:________________

VICTIM Information

IF CLAIMANT IS THE VICTIM, SKIP SECTIONS 4 AND 5

Section 4

____
VICTIM'S FIRST NAME MI VICTIM'S LAST NAME

____
MAILING ADDRESS

____
CITY STATE/ZIP CODE

____
E-MAIL ADDRESS (please print clearly)

Section 5

DATE OF BIRTH: ________________

SOCIAL SECURITY NUMBER: ________________

MALE OR FEMALE: ________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

HOME PHONE: ( ) -

WORK PHONE: ( ) -

NARRRATIVE - In our own words, **briefly describe** what happened. Use additional paper if necessary. Do not write “See Police Report”.

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Revised February 2011

Section 6 VICTIM'S INJURY INFORMATION

BRIEFLY DESCRIBE VICTIM'S INJURIES ____________________

WHERE WAS VICTIM TAKEN FOR EMERGENCY TREATMENT? ____________________
NAME

____
COMPLETE ADDRESS

WAS VICTIM HOSPITALIZED? WHERE IF NOT SAME AS EMERGENCY TREATMENT FACILITY? IF YES:

HOSPITAL ____________________
NAME AND ADDRESS

FROM ____/____/____ TO ____/____/____

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

Section 7 VICTIM'S DEATH INFORMATION

DATE OF DEATH ____/____/____ DID VICTIM HAVE ANY DEPENDENTS? ____________

FUNERAL HOME ____________________
NAME ADDRESS/CITY/STATE/ZIP

NAME OF EXECUTOR OR ADMINISTRATOR OF VICTIM'S ESTATE, IF ANY ____________________

ADDRESS/CITY/STATE/ZIP ____________________

COPIES **OF THE FOLLOWING DOCUMENTS SHOULD BE SUBMITTED WITH THE APPLICATION or SOON THERE AFTER:**

- DEATH CERTIFICATE - SOCIAL SECURITY BENEFITS BEING OR TO BE PAID - FUNERAL & BURIAL EXPENSES

Section 8 INSURANCE and REIMBURSEMENT Sources

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

CHECK ALL SOURCES OF INSURANCE OR OTHER REIMBURSEMENT:

☐ MEDICAID ☐ MEDICARE ☐ HEALTH ☐ SOC SEC ☐ WORKERS' COMP

IF ☐ AUTO **OR** ☐ LIFE **SPECIFY BELOW**:

____________________ ____________________
INSURANCE COMPANY NAME ADDRESS/CITY/STATE/ZIP

Section 9 OTHER EXPENSES

VICTIM'S MILEAGE EXPENSES REQUESTED? IF YES, PLEASE SPECIFY ____________________

Mileage permitted for **victim**: - travel to court hearings - travel to and from medical treatment facility

Section 10 POLICE and COURT Information

DATE REPORTED ____/____/____

LOCATION WHERE CRIME OCCURRED ____________________

TYPE OF CRIME (example: - assault - murder - kidnapping): ____________________

POLICE AGENCY ____________ ADDRESS ____________ CITY ____________

SUSPECTS' NAME (1)____________(2)____________(3)____________

IF ARRESTED, WHICH COURT (example: - Magistrate - Circuit - Juvenile - Federal): ____________

Section 11 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 IS **ATTORNEY OF RECORD** ☐ ATTORNEY IS **ASSISTING ONLY**

____
ATTORNEY'S NAME ADDRESS CITY STATE/ZIP CODE

____
ATTORNEY'S SIGNATURE TELEPHONE NUMBER ATTORNEY'S EMAIL ADDRESS

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 Human Immunodeficiency Virus (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 for **twelve months** from the affixed date.

THIS FORM MUST BE SIGNED BEFORE A NOTARY

______________________________________	______________________________________	__________________
CLAIMANT'S SIGNATURE **(SIGN ONLY BEFORE A NOTARY)**	CLAIMANT'S PRINTED NAME	DATE

NOTARY SEAL

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: ______________________________