CVCF **West Virginia**
CRIME VICTIMS
COMPENSATION FUND
1900 Kanawha Blvd. E, Rm.-W334
Charleston WV 25305-0610

OFFICE OF THE COURT OF CLAIMS

CRIME VICTIMS COMPENSATION FUND

APPLICATION

FOR WEST VIRGINIA CRIME VICTIMS COMPENSATION

⇨ **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 4**) 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 ROOM 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/.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, work loss, mileage to a medical treatment facility and to court for the prosecution of the offender, mental health counseling, and relocation expenses. ★ ADMINISTERED by the West Virginia Court of Claims.
HOW IS THE SYSTEM 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 $10,000.00 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. Damaged or stolen property, including money, is **NOT** recoverable. However, prosthetic devices such as eyeglasses and dentures are compensable.
IS THERE A FILING FEE?	★ No.
DO YOU NEED AN ATTORNEY?	★ No. But if a claimant seeks the services of an attorney to file the claim, 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!

WEST VIRGINIA CRIME VICTIMS COMPENSATION FUND

Office Use Only

Date Received:

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

Office Use Only

Claim No.:

CV- _____ - _____ -____

APPLICATION

PLEASE COMPLETE **ALL SECTIONS** and **PRINT CLEARLY**

VICTIM Information

VICTIM'S FIRST NAME MI VICTIM'S LAST NAME

VICTIM'S MAILING ADDRESS

CITY STATE ZIP CODE

(_____) _____
(AREA CODE) HOME PHONE NUMBER

(_____) _____
(AREA CODE) DAYTIME PHONE NUMBER

E-MAIL ADDRESS (please print clearly)

XXX—XX— _____
SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

_____/_____/_____
DATE OF BIRTH

- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Caucasian / White Non-Latino
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Hispanic or Latino
- ◯ Multiple Races
- ◯ Other _____
- ◯ Not Reported

CLAIMANT Information
(only if not the victim)

CLAIMANT'S FIRST NAME MI CLAIMANT'S LAST NAME

CLAIMANT'S MAILING ADDRESS

CITY STATE ZIP CODE

(_____) _____
(AREA CODE) HOME PHONE NUMBER

(_____) _____
(AREA CODE) DAYTIME PHONE NUMBER

E-MAIL ADDRESS (please print clearly)

RELATIONSHIP TO VICTIM

XXX—XX— _____
SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

_____/_____/_____
DATE OF BIRTH

ADDITIONAL VICTIM INFORMATION

- ◯ Male
- ◯ Female
- ◯ Unknown

- ◯ Single
- ◯ Married
- ◯ Separated
- ◯ Divorced

Are you claiming mileage expense? (Victim ONLY)

◯ To Court ◯ To Medical Treatment Facility

VICTIM EMPLOYMENT INFORMATION

Was the Victim employed on the date of the injury? NO ◯ YES ◯

Did the Victim lose earnings that were not reimbursed? NO ◯ YES ◯

Did the Victim lose work due to injury? NO ◯ YES ◯

EMPLOYER'S **FULL NAME** ADDRESS CITY STATE/ZIP

EMPLOYER'S PHONE NUMBER WORK RELATED REMARKS

CRIME INFORMATION

DATE OF CRIME: _____/_____/_____ **COUNTY OF CRIME**: _____

_____ _____ _____
LOCATION WHERE INJURY OCCURRED CITY STATE/ZIP CODE

_____ _____ _____
POLICE AGENCY CRIME WAS REPORTED TO ADDRESS CITY STATE/ZIP CODE

_____ _____
INVESTIGATING OFFICER'S NAME (if known) WHO REPORTED THE INCIDENT TO POLICE? (IF KNOWN)

_____/_____/_____ _____ _____
Date Reported Time Reported If not reported within 72 hours, explain why

_____ _____ _____
Suspect's Name ☐ Adult ☐ Juvenile 2nd Suspect's Name ☐ Adult ☐ Juvenile 3rd Suspect's Name ☐ Adult ☐ Juvenile

Did the victim know the suspect(s)? ☐ Yes ☐ No _____ If yes, in what way?

Was victim living in same household with suspect(s)? ☐ Yes ☐ No

Please check the box that **most closely** describes the type of crime that occurred:

- ☐ Adult Sexual Assault
- ☐ Arson
- ☐ Assault
- ☐ Child Physical Abuse/Neglect
- ☐ Child Pornography: Production/Possession/Distribution
- ☐ Child Sexual Abuse
- ☐ DUI/DWI Incident
- ☐ Other: _____
- ☐ Elder Abuse
- ☐ Hate Crime: Racial/Religious/Gender/Sexual Orientation/Other
- ☐ Homicide
- ☐ Human Trafficking: Sex/Labor
- ☐ Robbery
- ☐ Stalking
- ☐ Terrorism/Mass Violence

Court Proceedings

Has the suspect(s) been charged? ☐ Yes ☐ No

COURT: ☐ Magistrate Court ☐ Circuit Court ☐ Juvenile Court ☐ Other (Specify) _____

Charge(s) _____

Narrative—In your own words, briefly describe what happened. Please do not write "See police report." Use additional sheets if necessary.

_____

_____

_____

_____

_____

_____

_____

VICTIM'S INJURY INFORMATION

BRIEFLY DESCRIBE VICTIM'S INJURIES

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

Was the victim hospitalized? YES ☐ NO ☐ From _____ DATE to _____ DATE

HOSPITAL NAME (IF DIFFERENT FROM EMERGENCY TREATMENT FACILITY) ADDRESS CITY STATE/ZIP CODE

ADDITIONAL PROVIDERS SEEN: _____ _____

_____ _____

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

VICTIM'S DEATH INFORMATION

DATE OF DEATH _____/_____/_____ DID VICTIM HAVE ANY DEPENDENTS? _____

FUNERAL HOME ADDRESS CITY STATE/ZIP CODE

NAME OF EXECUTOR OR ADMINISTRATOR OF VICTIM'S ESTATE, if any ADDRESS CITY STATE/ZIP CODE

COPIES OF THE FOLLOWING DOCUMENTS SHOULD BE SUBMITTED WITH THE APPLICATION OR AS SOON AS POSSIBLE THEREAFTER:

DEATH CERTIFICATE ~ SOCIAL SECURITY BENEFIT INFORMATION ~ FUNERAL & BURIAL EXPENSES

COURT ORDER FOR ADMINISTRATOR OF ESTATE ~ PROOF OF GUARDIANSHIP ~ BIRTH CERTIFICATES OF VICTIM'S MINOR CHILDREN

INSURANCE AND REIMBURSEMENT SOURCES

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

CHECK ALL COVERAGE TYPES HELD BY THE VICTIM AT TIME OF INCIDENT

- ☐ MEDICAID
- ☐ MEDICARE
- ☐ HEALTH INSURANCE
- ☐ SOCIAL SECURITY
- ☐ AUTO INSURANCE
- ☐ LIFE INSURANCE
- ☐ WORKERS COMPENSATION

INSURANCE COMPANY NAME ADDRESS CITY STATE/ZIP CODE

DEPENDENTS OF VICTIM 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.

☐ Attorney is ATTORNEY OF RECORD
(All communication will be with **ATTORNEY**)

☐ Attorney is ASSISTING ONLY
(All communication will be with **CLAIMANT/VICTIM**)

ATTORNEY'S NAME ADDRESS CITY STATE/ZIP CODE

ATTORNEY'S SIGNATURE TELEPHONE NUMBER ATTORNEY'S EMAIL ADDRESS (please print clearly)

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 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.
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 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**

_____ CLAIMANT'S **PRINTED** NAME

_____ DATE

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me on

_____ (date) by _____ (print name of claimant).

My commission expires: _____

NOTARY SEAL

_____
Notary Public