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

- 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
ctclaims@mail.wvnet.edu

Revised 01/10/06

| 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.<br>• 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.<br>• 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.<br>• No tax dollars are used. |
| WHO CAN FILE A CLAIM? | • Any innocent victim who suffers personal injury as the result of a crime.<br>• 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.<br>• The claimant must fully cooperate with law enforcement officials.<br>• 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 $25,000.00.<br>• In death claims, the maximum is $35,000.00 (including $6,000.00 for funeral and burial expenses). |
| HOW IS A CLAIM PROCESSED? | • The Claim Investigator reviews the claim and files a Finding of Fact and Recommendation.<br>• A Judge of the Court of Claims evaluates the claim without a hearing and renders a decision.<br>• 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 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!*

**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: ctclaims@mail.wvnet.edu

**OFFICE USE ONLY**

CV- _____
CLAIM NUMBER

Date Received _____ Record Number _____



# APPLICATION ***PLEASE PRINT CLEARLY***

## VICTIM Information

VICTIM'S FIRST NAME _____ MI _____ VICTIM'S LAST NAME _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

(AREA CODE) HOME PHONE NUMBER _____ (AREA CODE) WORK NUMBER _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH (mm/dd/yyyy) _____

☐ MALE ☐ FEMALE | ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

## CLAIMANT Information (only if not the victim)

CLAIMANT'S FIRST NAME _____ MI _____ CLAIMANT'S LAST NAME _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

(AREA CODE) HOME PHONE NUMBER _____ (AREA CODE) WORK NUMBER _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH (mm/dd/yyyy) _____

RELATIONSHIP TO VICTIM _____

## CRIME Information

DATE OF INJURY _____ TIME OF INJURY _____ LOCATION WHERE INJURY OCCURRED _____ COUNTY WHERE INJURY OCCURRED _____

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

DATE REPORTED (mm/dd/yyyy) _____ TIME REPORTED _____ IF NOT REPORTED WITHIN 72 HOURS, EXPLAIN WHY NOT. _____ WHO REPORTED THE INCIDENT TO POLICE? _____

SUSPECT'S NAME _____ ☐ ADULT ☐ JUVENILE 2ND SUSPECT'S NAME _____ ☐ ADULT ☐ JUVENILE 3RD SUSPECT'S NAME _____ ☐ ADULT ☐ JUVENILE

DID 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 to the right that best describes the type of crime that occurred:

☐ ADULT SEXUAL ASSAULT
☐ HOMICIDE
☐ STALKING
☐ ARSON
☐ CHILD ABUSE OR SEXUAL ASSAULT
☐ DWI/DUI
☐ ROBBERY
☐ TERRORISM
☐ ALL OTHER ASSAULTS
☐ OTHER VEHICLE CRIMES (NOT DWI/DUI)
☐ KIDNAPPING
☐ OTHER (SPECIFY) _____

HAS THE SUSPECT(S) BEEN CHARGED? ☐ YES ☐ NO PLEASE EXPLAIN _____

COURT NAME _____ CHARGE(S) _____

**NARRATIVE - In your own words, briefly describe what happened.**

☐ ***Check if you want a copy of this completed application mailed to you.***

## 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 ☐ NO FROM (mm/dd/yyyy) TO (mm/dd/yyyy)

HOSPITAL NAME (IF DIFFERENT FROM ABOVE) ADDRESS CITY STATE ZIPCODE

**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 (mm/dd/yyyy) 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

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

LIST ANY SOURCES OF INSURANCE OR OTHER REIMBURSEMENT

☐ *MEDICAID* ☐ *MEDICARE* ☐ *HEALTH* ☐ *WORKERS' COMP* ☐ *SOCIAL SECURITY*

**If** ☐ *AUTO* **or** ☐ *LIFE* **specify...** INSURANCE COMPANY NAME

ADDRESS

CITY STATE ZIP CODE

## VICTIM'S EARNING Losses

WAS VICTIM EMPLOYED ON DATE OF INJURY? ☐ YES ☐ NO

DID 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

(AREA 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.*

| | DEPENDANT'S NAME | DEPENDANT"S FULL ADDRESS | RELATIONSHIP TO VICTIM | DATE OF BIRTH (mm/dd/yyyy) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

## 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 (AREA CODE) 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 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, 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

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:_____