



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

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.
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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.
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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.)
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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.
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IS THERE A LIMIT TO THE AMOUNT RECOVERABLE?

- In injury claims, the maximum is \$25,000.00.
 - In death claims, the maximum is \$35,000.00 (including \$6,000.00 for funeral and burial expenses).
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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.
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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.
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IS THERE A FILING FEE?

- No.
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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.
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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

APPLICATION *PLEASE PRINT CLEARLY*

_____ Date Received _____ Record Number

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 CHILD ABUSE OR SEXUAL ASSAULT ALL OTHER ASSAULTS
 HOMICIDE DWI/DUI OTHER VEHICLE CRIMES (NOT DWI/DUI)
 STALKING ROBBERY KIDNAPPING
 ARSON TERRORISM
 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 FROM _____ TO _____
 NO (mm/dd/yyyy) (mm/dd/yyyy)

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 (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

LIST ANY SOURCES OF INSURANCE OR OTHER REIMBURSEMENT

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

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.

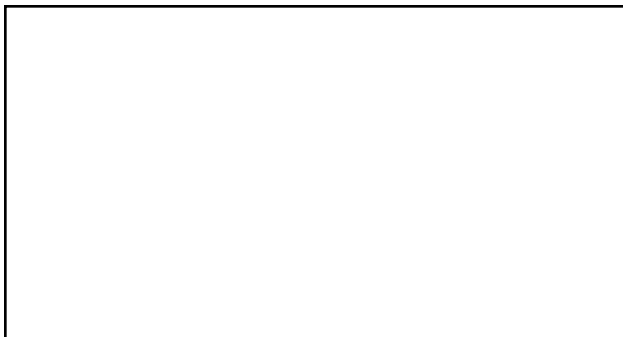
This authorization or a photostatic copy, which will be considered as valid as the original, shall be valid, without further consent by me, until final disposition of this claim.

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: _____