COMMONWEALTH OF KENTUCKY
CRIME VICTIMS COMPENSATION BOARD
130 Brighton Park Blvd., Frankfort, KY 40601
800-469-2120 / 502-573-2290
cvcb.ky.gov

CRIME VICTIMS COMPENSATION

GENERAL INFORMATION AND INSTRUCTIONS ON FILING A CLAIM

Following the instructions below will speed the processing of your claim:

- Read the application thoroughly and provide all requested documentation.
- Print legibly in ink, or type information. **SIGN ON PAGE 5, SECTION XIV.**
- **A copy of a police report or other documentation will be required. If you cannot obtain a copy, state this in your application and the CVCB staff will contact law enforcement.**
- Mail this completed form, along with all required documentation, to the address above.
- The victim must be an innocent victim of a crime or some conduct that could be charged as a crime (a conviction is not required).
- The claimant filing on behalf of a victim can be a third party who is required to pay for the victim's crime-related bills; a legal guardian; a victim's attorney or power of attorney; the parent of a minor child; a surviving spouse, parent, or child of a victim of criminally injurious conduct who died as a direct result of such conduct who has paid or owes expenses related to the crime.
- Only qualifying expenses for which the victim/claimant has no other source of payment can be considered.
- Incident must be reported to law enforcement within 48 hours; or, if not reported within the required time, a justifiable reason must be provided.
- Victim/claimant must cooperate with law enforcement and the prosecution (i.e. testify and/or provide whatever truthful information is required to prosecute the alleged offender).
- The deadline for filing is five years from the time of the crime, unless good cause can be provided for the delay.
- CVCB does not pay for any property loss, except corrective lenses and dentures destroyed or lost as a result of the crime.
- The amounts the CVCB can pay are capped at $5,000 for funeral / burial expenses, and $25,000 total for all expenses resulting from the crime.
- Employment Verification Form and Physician Statement: complete only if applying for lost wages
- Mental Health Counselor's Report: complete only if applying for mental health counseling or where applicable for lost wages.
- Applications without a government-issued ID number for claimant and/or victim cannot be accepted.

IMPORTANT

To expedite the review of your claim, fill out this form completely and as accurately as possible. You must provide the documentation necessary for your type of claim. All claims will be thoroughly investigated and verified.

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FAX: 502-573-4817

FOR OFFICE USE ONLY

CLAIM NO: _____

INVESTIGATOR: _____

SECTION I Victim Information *(to be filled out by victim or claimant)*

Victim's Name: _____ SS # or other Gov't issued ID #. _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female
Month Day Year At time of Crime

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone (home): _____ (work): _____ (cell): _____

E-mail: _____

SECTION II Claimant (other than victim) Information *(to be filled out by person filing on behalf of a victim)*

Claimant's name: _____ Relationship to victim: _____

Date of Birth: _____ SS # or other Gov't issued ID #_____
Month Day Year

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone (home): _____ (work): _____ (cell): _____

E-mail: _____

SECTION III Crime Information ***(ATTACH A COPY OF THE POLICE REPORT)***

Type of Crime
(Check One)
- ☐ Assault
- ☐ Homicide (murder)
- ☐ Sexual Assault Adult
- ☐ Sexual Assault Child
- ☐ Child Physical Abuse
- ☐ Domestic Assault
- ☐ DUI
- ☐ Other _____

Location of Crime: _____
Address City County

Date of Crime: _____ Date Reported: _____
Month Day Year Month Day Year

Crime Reported To: _____
Law Enforcement Agency

Was the crime reported within 48 hours of its discovery? ☐ Yes ☐ No

If no, please explain why: _____

Name of Offender: _____

Has Offender been charged with a crime? ☐ Yes ☐ No If yes, what charge? _____

What Court? District: _____ Circuit: _____ Juvenile: _____
Case Number Case Number Case Number

SECTION IV. Describe what happened. *(If you know the reason for the crime, please explain)*

_____

_____

_____

SECTION V. Describe the injuries.

_____

_____

_____

SECTION VI. Medical Expenses

Each bill must be listed below in order to be considered. Each must be a direct result of the crime, and each must have attached itemized documentation including date and type of service. **Notices from collection agencies will not be accepted. If you need additional space, please attach a separate sheet of paper.**

Name of hospital, doctor, counselor and all other related medical bills	Charge	Insurance Paid	Claimant / Victim Paid	Current Balance

SECTION VII. Other sources of payment

Please check everything that applies regarding coverage to victim or claimant at the time of the crime, or as a result of the crime:

☐ Medicaid ☐ Medicare ☐ Workers Comp ☐ Health Insurance

☐ Homeowner's Insurance ☐ Auto Insurance ☐ Veterans Benefits ☐ Other _____

(You must include documentation/copies of the following, if applicable, when applying for payment of funeral expenses)

☐ Life Insurance ☐ Burial Insurance

SECTION VIII. Lost Wages

What was the claimant / victim's employment status at the time of the crime? ☐ Employed ☐ Unemployed

If employed, did that claimant / victim lose time from work as a result of the injury? ☐ Yes ☐ No

If yes, is the claimant applying for lost wages? ☐ Yes ☐ No

If yes, attach the Employment Verification Form (pg. 6), which **MUST** be filled out by the **EMPLOYER** and **NOTARIZED.**

If yes, attach the Physician Statement (pg. 7) and/or the Mental Health Counselor Report (pg. 8), which **MUST** be filled out and signed by the **DOCTOR** and/or the **THERAPIST.**

If the claimant / victim was self-employed, attach a copy of both state and federal tax returns covering the period of the crime.

SECTION IX. Financial Information *(This information is about the person for whom assistance is requested).*
Exclude expenses requested in this claim.

Total monthly income prior to incident _____ Expenses paid out per month _____

Total current monthly income _____ Expenses paid out per month _____

List ALL sources of income: (include every source of income including spouse's income, food stamps, welfare, child support, Social Security, pensions, Workers Compensation benefits, veterans' benefits, AFDC, or any other income.
List monthly amounts below.

_____ _____ _____

_____ _____ _____

_____ _____ _____

SECTION X. Funeral / Burial Expenses *(This section is to be filled out only if the victim is deceased)*

REIMBURSEMENT OR PAYMENT FOR FUNERAL/BURIAL EXPENSES CANNOT EXCEED $5,000

THE FUNERAL CONTRACT SHOWING THE LEGALLY RESPONSIBLE PARTY MUST BE ATTACHED

Date of Death: _____
Month Day Year

List benefits available from any of the following sources: (List any and all amounts received or to be received by the victim or claimant). **This includes any money received from contributions or donations.**

Life Insurance: $_____ Workers Comp: $_____ Funeral/Burial Insurance: $ _____

Social Security: $ _____ Estate: $ _____ Other: $_____

Name of Funeral Home: _____

Address: _____ Telephone No. _____
Street City State Zip

Amount of Funeral Expenses: $ _____ Have they been paid? ( ) Yes ( ) No

If yes, by whom: _____ Relationship to victim: _____

Address: _____ Telephone No. _____
Street City State Zip

SECTION XI. Loss of Support *(Fill out this section if you are financially dependent on the victim, or filing for someone who is financially dependent on the victim).*

The victim's employment status at time of crime: ☐ Employed ☐ Unemployed

*If employed, the attached Employment Verification Form **MUST** be filled out and signed by the **EMPLOYER** and **NOTARIZED.***
List income you now receive as a result of the victim's death. (**You must list all amounts being received and attach all documentation showing amounts and sources).**

Social Security: $ _____ Workers Comp: $ _____ Welfare: $_____

AFDC: $ _____ Other: $ _____
(Source and Amount Received)

SECTION XII. Federal Government Information *(Optional / for Statistical Use Only)*

Ethnic Group (Victim)
- ☐ White
- ☐ Black
- ☐ American Indian or Alaskan Native
- ☐ Hispanic (Mexican, Puerto Rican, Cuban or other Spanish culture)
- ☐ Multiracial

☐ U.S. Citizen ☐ Federal Crime
☐ Handicap ☐ Kentucky Resident

Who referred you to the compensation program?
- ☐ Law Enforcement ☐ Hospital
- ☐ Victim Advocate ☐ Prosecutor
- ☐ Judge ☐ Other_____

SECTION XIII. Restitution and Civil Lawsuit *(Enter information regarding any payments the court has ordered to be paid to you by the offender or any settlement you have received or will receive as the result of a lawsuit)*

The victim and/or claimant filed or plans to file a civil lawsuit against anyone relating to the injury received as a result of the crime. ☐ Yes ☐ No

If yes, name of attorney: _____

Address: _____ Telephone: _____
Street City State ZIP Code

The offender was ordered by the court to pay restitution. ☐ Yes ☐ No If yes, amount: $ _____

How is it to be paid? _____

SECTION XIV. Authorization and Subrogation **THIS PAGE MUST BE SIGNED AND INCLUDED WITH APPLICATION**

VERIFICATION OF APPLICATION: I hereby certify, subject to penalty, fine or imprisonment that the information contained in this application for Crime Victims Compensation is true and correct to the best of my knowledge.

SUBROGATION: In consideration of the payment received from the Crime Victims Compensation Board, in the event I recover damages or compensation from the offender or from any other public or private source as a result of the injuries or death which was the basis of my claim for compensation from the fund, I agree to repay such amount up to the full amount I received from the fund. I understand that compensation from any other public or private source includes, but is not limited to, receipt of insurance, Medicare, Medicaid, Workers Compensation, disability pay, etc. I further agree and understand that no part of recovery due the Crime Victims Compensation Board may be diminished by any collection fees or for any other reason whatsoever.

Should I choose to recover damages or compensation for the injury or death from any sources, I agree to promptly notify the Crime Victims Compensation Board by sending copies of any pleadings, settlement proposals and any other documents relative thereto. I further agree to fully cooperate with the Crime Victims Compensation Board should the Board decide to institute an action against any person or entity for the recovery of all or any part of the compensation I received from the fund.

MEDICAL / PSYCHIATRIC / EMPLOYMENT RELEASE: I hereby authorize any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility, or any other person or firm to release any and all information requested. I understand and acknowledge that my mental health records may contain confidential remarks made by me, information regarding drug or alcohol abuse, HIV status, or other personal data. I further agree and hold blameless any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility or any staff person of any and all liability for the release of these records.

YOUR SIGNATURE: _____ DATE: _____

Attorney's Name: _____ Social Security # or Fed ID:_____

Address: _____ Telephone: _____

Attorney's Signature: _____ Date: _____

You are not required to have an attorney assist in submitting your application; however, if an attorney does assist you, the attorney must sign this application.

EMPLOYMENT VERIFICATION

Complete only if applying for lost wages.

To be completed and signed by employer only. Must be NOTARIZED

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Employee's Name: _____ SS # or other Gov't issued ID #: _____

Date of Crime: _____ Victim was employed at the time of crime: ☐ Yes ☐ No

If yes, complete the following:

Employer's Name: _____ Telephone: _____

Address: _____
Address City State ZIP Code

Victim missed time from work because of injuries related to the crime: ☐ Yes ☐ No

If yes, from _____ to _____.

The items listed below are to be **WEEKLY AMOUNTS:**

Gross Earnings: $ _____ Net Take Home Earning Per Week: $ _____

Federal Tax Withheld: $ _____ State Tax Withheld: $ _____ Social Security Withheld: $ _____

Other Deductions (itemized): $_____ Typical days worked per week: M T W TH F Sat Sun
(please circle)

Victim has returned to work: ☐ Yes ☐ No Victim's wage continued while off work: ☐ Yes ☐ No

If the victim's wage continued while off work, complete the following:

	Deduction	***Amount Per Week***	***From Date***	***To Date***
	Workers Comp	$		
	Unemployment	$		
	Private or Health	$		
	Vacation	$		
	Sick	$		
	Employers Group	$		
	Disability	$		
	Union	$		
	Other, Specify	$		

_____
Employer's Signature and Title

SUBSCRIBED AND SWORN TO BEFORE ME BY _____

THIS _____ DAY OF _____, 20_____

MY COMMISSION EXPIRES: _____

NOTARY PUBLIC: _____
Signature

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PHYSICIAN STATEMENT

To be completed and signed by DOCTOR only.

Complete only if applying for lost wages.

Victim / Patient Name: _____

Type of Injury: _____

Date of Injury: _____ Date(s) victim unable to work: from_____ to _____.

Victim suffered permanent disability: ☐ Yes ☐ No

If yes, please state the victim's percentage of permanent disability to the body as a whole in accordance with the AMA Guidelines:

_____.

COMMENTS:

Name of Attending Physician: _____

Address: _____
Address City State ZIP Code

Telephone: _____ Federal ID Number: _____

_____ _____
Signature Date

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MENTAL HEALTH COUNSELOR'S REPORT

To be completed by COUNSELOR only. Must include an attached Treatment Plan.

Complete only if applying for mental therapy or where applicable for lost wages.

Person receiving services: _____

SS # or other Gov't issued ID #: _____ Crime date: _____

Date(s) victim unable to work: from_____ to _____

The trauma and treatment is a direct result of this crime: ☐ Yes ☐ No

Presenting Complaint: _____

Diagnosis of Record: _____

Description of injury and/or psychological trauma resulting from crime:

_____

_____

_____

_____

HEALTH INSURANCE CARRIER:

_____ _____
Company Name Telephone Number / Extension

_____
Address City State ZIP Code

****PLEASE ATTACH A SEPARATE TREATMENT PLAN****

_____ _____
Authorized Signature of Treating Therapist / Counselor Telephone Number

_____
Licensing Specialty Type

_____
Mailing Address City State ZIP

_____
Professional License No. / Federal ID