

Application For Crime Victim Compensation

(Please print legibly and fill out both sides)

VC # _____

I. Victim Information

Victim's name _____ Female _____ Male _____
Mailing address _____ Home telephone (____) _____
City/State _____ Zip _____ Work telephone (____) _____
Date of birth _____ Age at time of incident _____ SSN ____-____-_____

II. Applicant Information

(If victim is applicant, write "same"; if under 18, application must be completed by parent or guardian)

Applicant's name _____ Female _____ Male _____
Mailing address _____ Home telephone (____) _____
City/State _____ Zip _____ Work telephone (____) _____
Date of birth _____ Relationship to victim _____ SSN ____-____-_____
If filing on behalf of minor dependent(s) of homicide victim, relationship to minor dependent(s) _____

III. Crime Information

Type of Crime:

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> homicide | <input type="checkbox"/> assault (non-familial) | <input type="checkbox"/> drunk driving | <input type="checkbox"/> robbery |
| <input type="checkbox"/> domestic violence | <input type="checkbox"/> sexual assault | <input type="checkbox"/> other vehicular crimes | <input type="checkbox"/> arson |
| <input type="checkbox"/> stalking | <input type="checkbox"/> child physical or sexual assault | <input type="checkbox"/> kidnapping | <input type="checkbox"/> other _____ |

Exact location of crime _____ City/State _____

Date of crime _____ Date crime reported _____

(If NOT reported within 5 days, please explain why in attached statement)

Name of Police Department _____ Investigating Officer _____

Name(s) of person(s) who committed crime (if known) _____

If you have been assisted by a victim advocate in the court/district attorney's office, provide name and telephone number of advcate _____

Briefly describe the crime and any injuries which resulted _____

IV. Expenses

Check types of expenses for which you seek compensation:

- | | | |
|---|--|---|
| <input type="checkbox"/> medical services* | <input type="checkbox"/> lost wages (for victim only) | <input type="checkbox"/> counseling for victim* |
| <input type="checkbox"/> medical supplies/pharmacy* | <input type="checkbox"/> loss of financial support
(for dependents of homicide victims) | <input type="checkbox"/> counseling for family members
of homicide victim* |
| <input type="checkbox"/> dental services* | <input type="checkbox"/> funeral/burial* | <input type="checkbox"/> counseling for children who witness
violence against a family member* |
| <input type="checkbox"/> homemaker expenses* | | |

***attach copies of bills and/or receipts**

Name/address of Funeral Home: _____

V. Lost Income

(complete if seeking lost wages or loss of support)

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Victim's employer _____ Contact person _____ Telephone _____

Address _____ City/State _____ Zip _____

If victim has or will return to work, estimated period of disability _____

If requesting financial support for dependent(s) of a homicide victim, provide the following information:

Name(s) of dependent(s)	Date of birth	SSN	Relationship to victim
_____	_____	____-____-____	_____
_____	_____	____-____-____	_____
_____	_____	____-____-____	_____
_____	_____	____-____-____	_____

IV. Other Sources of Financial Assistance

Check all potential sources of full or partial payment of expenses:

- | | | |
|--|---|--|
| <input type="checkbox"/> health insurance | <input type="checkbox"/> hospital-based "free care" | <input type="checkbox"/> workers compensation |
| <input type="checkbox"/> life/accident insurance | <input type="checkbox"/> unemployment benefits | <input type="checkbox"/> public benefits (welfare, medicare, medicaid, SSDI) |
| <input type="checkbox"/> automobile insurance | <input type="checkbox"/> disability benefits | <input type="checkbox"/> restitution |
| | <input type="checkbox"/> other (please specify) _____ | |

Names and addresses of applicable insurance companies: _____

Have you filed or do you intend to file a civil lawsuit? Yes _____ No _____ Not Sure _____

If yes: Attorney's name _____ Telephone _____

Address _____ City/State _____ Zip _____

VI. Optional Information

(For statistical purposes only)

Race/ethnicity of victim: White Black Hispanic Native American
 Asian/Pacific Islander Other I decline to answer this question

Who referred you to Victim Compensation? _____

Acknowledgement and Information Release

I understand that the Victim Compensation Fund is a fund of last resort. I agree to inform the Division of any funds I may receive from any source for losses for which I have requested compensation, and to promptly reimburse the Commonwealth for any such funds I may receive.

I give permission to any hospital, medical facility, doctor, mental health provider, insurance company, employer, person or agency to give needed information to the Victim Compensation Division. I understand that the information will be used to determine my claim for victim compensation benefits. I do not authorize the use or release of this information to any person or entity for any other purpose whatsoever. A photocopy of this signed release is as valid as the original. This authorization shall expire upon final determination of all requirements under G.L. c. 258C and 940 CMR 14.00.

I certify, under the pains and penalties of perjury, that all information and supporting documentation contained in this application is true and accurate to the best of my knowledge and belief.

X _____ Date _____
Applicant signature (parent or guardian if victim is a minor)

Return completed application to: **Office of the Attorney General, Victim Compensation & Assistance Division
One Ashburton Place, 19th floor, Boston, MA 02108-1698. (617) 727-2200**