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Application For Victim Compensation: October 1, 2017 Las Vegas Attack

Section 1: Tell Us About the Claimant

A separate application must be filed for each person seeking assistance.
Section 1 must be completed for all applications. The claimant is the person who has expenses or is seeking assistance as a result of a crime. If you are filing this application on behalf of someone else, put his/her information in Section 3.

Preferred Spoken Language

Preferred Written Language

First Name | Middle Name | Last Name | Gender

Relationship to Victim | Social Security Number (SSN) | No SSN | Date of Birth

Mailing Address

Street Number and Name or PO Box

From the date of the crime to now, has the **claimant** been in prison, on probation, on parole or post-release community supervision because of a felony?

Is the **claimant** required to register as a sex offender?

Address 2 (Apartment or Unit #) | City | State (CA) | Zip

Best Contact Number | Extension | E-mail | E-mail Type

☐ **Check this box if you are a parent/guardian applying on behalf of a minor witness to violent crime.** Minor witnesses are eligible for mental health treatment only. Claimant is under age 18, a witness in close proximity to a violent crime, but is neither the crime victim nor related to the victim. Provide available victim, crime or other information in remaining sections.

If you are an adult victim and the expenses are for you, skip to Section 4.

If not, continue to Section 2.

Section 2: Tell Us About the Victim

The crime victim is the person who was injured, threatened with injury, or killed due to the crime.

First Name | Middle Name | Last Name | Gender

Social Security Number (SSN) | No SSN | Date of Birth | If victim is deceased, date of death

Mailing Address

Street Number and Name or PO Box

From the date of the crime to now, has the **victim** been in prison, on probation, on parole or post-release community supervision because of a felony?

Is the **victim** required to register as a sex offender?

Address 2 (Apartment or Unit #) | City | State (CA) | Zip

Best Contact Number | Extension | E-mail | E-mail Type

If you are completing this application on behalf of a minor or an incapacitated adult, continue to Section 3.
If not, skip to Section 4.

CALIFORNIA CalVCB VICTIM COMPENSATION BOARD

Section 3: If You are Applying for the Victim, Tell Us About You

This section is for parents or guardians of minors or incapacitated adults in Section 1.

Please indicate your relationship to the person listed in Section 1:

Preferred Spoken Language

Preferred Written Language

First Name | Middle Name | Last Name | Date of Birth | Gender | Social Security Number (SSN) | No SSN

Mailing Address

Street Number and Name or PO Box

From the date of the crime to now, have **you** been in prison, on probation, on parole or post-release community supervision because of a felony?

Are **you** required to register as a sex offender?

Address 2 (Apartment or Unit #) | City | State (CA) | Zip

Best Contact Number | Extension | E-mail | E-mail Type (Personal)

Continue to Section 4.

Section 4: Information About Your Expenses

For the victim of the crime, the following benefits may be available. Please check the crime-related expenses you are requesting. Please attach copies, or a list, of any crime-related bills.

- ☐ Medical and/or dental expenses
- ☐ Mental health treatment
- ☐ Income loss (if you missed work because of the crime)
- ☐ Moving or relocation expenses
- ☐ Home security improvements
- ☐ Home or vehicle modifications (for a victim disabled because of the crime)
- ☐ Job retraining (for a victim disabled because of the crime)
- ☐ Crime scene clean-up
- ☐ Mileage reimbursement or transportation costs

Other crime-related expenses

For someone other than the victim of the crime, the benefits below may be available. Please check the crime-related expenses you are requesting. Please attach copies, or a list, of any crime-related bills.

For minor witnesses to violent crime, only mental health benefits are available. Proceed to Section 5.

- ☐ Mental health treatment
- ☐ Wage loss (up to 30 days if a minor dies or is hospitalized)
- ☐ Loss of support (for dependents of a deceased or disabled victim)
- ☐ Funeral and/or burial expenses
- ☐ Crime scene clean-up
- ☐ Home security improvements
- ☐ Medical expenses for a deceased victim

If you already have an application number from the State of Nevada Victims of Crime Program, list it here.

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Section 5: Crime Information

Please tell us where you were when the attack occurred.

If you sustained injuries, please describe them.

Section 6: Representative Information (A representative is not required to apply for compensation.)

This section is for representatives only. Victim Witness Assistance Center Advocates need only provide phone, name, center #, sign and date. All other representatives, please fill out this section completely.

Please indicate your relationship to the person listed in Section 1:

If other, please indicate:

First Name | Middle Name | Last Name | Telephone | Extension

Organization Name

Mailing Address

Street Number and Name or PO Box | Address 2 (Suite #)

For Victim Assistance Center Staff Only

JP/VWC Number

City | State (CA) | Zip

For Attorneys Only

☐ I am requesting payment pursuant to Government Code Section 13957.7(g).

Tax ID | State Bar Number

Telephone | E-mail

Signature and Date Required for all Representatives

Representative's Signature	Date

CALIFORNIA CalVCB VICTIM COMPENSATION BOARD

Section 7: Federal Reporting Information

The following **voluntary** information is for the person receiving compensation and is used for statistical purposes only to comply with federal regulations.

Ethnicity

- ☐ American Indian/ Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian and Other Pacific Islander
- ☐ White Non-Latino/ Caucasian
- ☐ Other Race
- ☐ Multiple Races
- ☐ Decline to State
- ☐ Other

Is the victim disabled? ☐ Was the victim disabled prior to the crime? ☐

Section 8: Insurance Information

Please list the victim's insurance information below. The California Victim Compensation Board (CalVCB) is the payer of last resort. We may contact your insurance company as a potential reimbursement source.

☐ I have no insurance of any kind.

Health Insurance

Medi-Cal Benefits Identification Card Number | Issue Date

Health Insurance Company Name | Policy Number | Group Number | Telephone | Ext.

Mailing Address

Street Number and Name or PO Box | Address 2 (Suite #) | City | State | Zip

State: CA

Name of Insured

First Name | Middle Name | Last Name | Have you filed an insurance claim related to this crime?

If you have more than one insurance provider, please list on a separate piece of paper and mail with your application.

Section 9: Employer Information (Complete only if you are requesting income or support loss.)

Please list the victim's employer. If you are a parent/guardian seeking wage loss benefits because a minor victim was hospitalized or is deceased, list your employer.

Contact Person

Employer's Business Name | First Name | Last Name | Telephone | Ext. | OK to contact employer?

Mailing Address

Street Number and Name or PO Box | Address 2 (Suite #) | City | State | Zip

State: CA

Is or was the victim self-employed? ☐

Did the victim miss work as a result of crime-related injuries? ☐

Did the crime occur while the victim was on the job or at the workplace? ☐

If you have more than one employer, please list on a separate piece of paper and mail with your application.

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This page **must** be signed and dated.

Section 10: Information Release

I give permission to any healthcare provider; any medical biller, any funeral director or similar persons, any employer, any police or other government agency, including the Department of Justice, the Social Security Administration, the State Franchise Tax Board, and the Federal Internal Revenue Service; any insurance company; or any other person or agency, to provide information relating to this application, including medical (including, but not limited to history or physical records, consultation reports, pathology reports, discharge summaries, operative reports, X ray and other radiology reports, laboratory reports, chart notes, narrative reports, and billing records), mental health, and felony conviction records, to the California Victim Compensation Board (CalVCB) or its representatives, for the purpose of determining eligibility for CalVCB benefits. This permission also applies to all sources of recovery for the claimed losses, including but not limited to, health or medical benefits, unemployment or disability benefits, Social Security benefits (Social Security disability, Supplemental Security income, and/or retirement, including the supporting medical and/or mental health records), and Veteran benefits. I also give permission for the release of federal and state tax information, including tax returns, for the purpose of verifying income. I hereby waive all legal privileges to any of this information required by CalVCB regarding my claim.

I agree that a photocopy or fax of this signed form is as valid as the original, and my signature gives permission for the release of all specified information.

I agree that CalVCB or its representatives may pursue restitution from the convicted offender in this matter to recover monies paid to me by CalVCB and that by filing this application I have authorized use of information in this application and subsequent claim files to pursue restitution from the convicted offender.

In order to verify or process this application, I agree that CalVCB or its representatives may provide information about this application, and the information contained in this application, to any representative named on this application, government agency, or health care provider or other provider of services, and may pay the provider directly if payment of these services is approved.

I agree that I may revoke this authorization at any time. The revocation must be in writing. The revocation will take effect when CalVCB receives it, but I may be deemed ineligible for CalVCB benefits once the revocation is received by CalVCB. However, no healthcare provider may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I am entitled to a copy of this authorization except in limited circumstances. I agree that information disclosed under this authorization may be redisclosed by the recipient as required by law and this redisclosure may no longer be protected by federal or state law.

I agree that the authorizations and agreements herein will expire ten (10) years after the date of my signing this form.

Signed	Date

(Parent or guardian must sign if victim is a minor or incapacitated.)

Section 11: My Agreement to the California Victim Compensation Board

As required by California law, I will contact and repay the California Victim Compensation Board (CalVCB) if I, or anyone on my behalf, receives any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private entity, for losses suffered as a direct result of the crime that was the basis for receipt of benefits from CalVCB, in the amount of the total benefits granted by CalVCB. I understand I may be responsible for repaying CalVCB any amount for which it is later determined that I was not eligible. I will notify CalVCB if I hire an attorney to represent me in any action related to this crime or if I pursue any action on my own.

Any monies I receive from CalVCB for moving/relocation expenses, improving home security, or for modifying a home or vehicle for a disabled victim will be used only for those purposes. If I am a victim of domestic violence receiving moving/relocation expenses, I will not tell the offender my home address nor allow the offender on the premises at any time, or I will seek a restraining order against the offender.

In the event that I am compensated for any pecuniary loss by CalVCB and the State of California subsequently receives compensation for the same loss on my behalf from the perpetrator (including any monies received through a restitution order) or from any other source, I hereby assign to the Victim Compensation Board any and all rights to such duplicate compensation.

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct and completed to the best of my knowledge and belief. I understand that I may be found to be ineligible for benefits, and that action may be taken to recover benefits I receive if I provide information that is false, intentionally incomplete, or misleading.

Signed	Date

(Parent or guardian must sign if victim is a minor or incapacitated. County social workers, see section 11a.)

Printed Name

Section 11a: For County Social Workers Only

As required by California law, I will contact and inform the California Victim Compensation Board (CalVCB) if I learn the claimant receives any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private entity, for losses suffered as a direct result of the crime that was the basis for receipt of benefits from CalVCB.

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true, correct and completed to the best of my knowledge and belief. I understand that the claimant may be found to be ineligible for benefits, and that action may be taken to recover benefits the claimant receives if the claimant provides information that is false, intentionally incomplete, or misleading.

Signed	Date
Printed Name	

Send completed application to:
California Victim Compensation Board
PO Box 3036, Sacramento, CA 95812-3036
Fax: (833) CALVCB-0 *(225-8220)*
or
deliver to your local Victim Witness Assistance Center

For more information call:

1-800-777-9229

Hearing impaired, please call the
California Relay Service (711)

***victims.ca.gov** Helping California Crime Victims Since 1965*

Application For Victim Compensation: October 1, 2017 Las Vegas Attack
State of Nevada Application

The California Victim Compensation Board (CalVCB) will submit an application to the State of Nevada Victims of Crime Program on behalf of each victim who applies to the Board. Submission of an application to both California and Nevada programs assists in determining eligibility for all available benefits.

Authorization for Release of Information, Certification and Acknowledgements

Victim Name	Victim DOB	VOCP Claim #

I have filed an application with the Nevada Victims of Crime Compensation Program (VOCP). In order to assist the VOCP determine my eligibility I hereby consent to, and authorize the release of information to the VOCP. I hereby release and hold harmless anyone providing information to the VOCP from any liability for any such release.

Law Enforcement Reports: I hereby authorize any police, law enforcement agency, child protective agency, or Coroner's office to release any police, investigative, incident report, or coroner's report related to my application to the VOCP as required by: NRS 217.110 (2)(d), NRS 217.180, NRS 217.210 (1) and NRS 217.220 (1) and (2). I understand that all such reports will remain confidential as provided by State and Federal law and NRS 217.105.

Medical Information : I hereby authorize any hospital, medical clinic, physician, dentist, mental health provider, pharmacist, or any other medical provider to release any and all information including medical reports, histories, prognosis, treatment plans, billing information and any other information relating to my medical treatment for my crime related injuries or condition, to the VOCP as required by NRS 217.100. This Medical Authorization shall automatically expire without express revocation one year from the date below. This release is in compliance with all HIPAA regulations.

VOCP Release of Information: I hereby authorize the VOCP to release information to police agencies, medical or other service providers, my advocate, attorney, or others concerning my application or claim only as necessary to administer the VOCP or my claim. No information will be released where prohibited by law. NRS 217.110 and 217.105.

Certificate of Financial Eligibility: I hereby certify that I do not have Savings or Investments exceeding the amount of my Annual Income, and that it would be a financial hardship if I were to receive no assistance from the VOCP. I hereby authorize any Insurer, Financial Institution, Government Agency, or any other person with information about me to release such information to the VOCP. NRS 217.220 (4).

My Promise to Repay the VOCP: I hereby acknowledge my legal obligation to repay the VOCP any money paid to me, or paid on my behalf, by the VOCP, if I receive any money, from any source, as a result of the crime. I hereby agree to notify the VOCP if I retain an Attorney to pursue a lawsuit or claim, or if I receive any court ordered restitution or other recovery including, but not limited to, insurance payments, settlements or other benefit payments. NRS 217.240.

Penalties for Providing False Information:

I understand that I may be imprisoned or fined for providing false or misleading, or intentionally incomplete information to the VOCP. I declare under Penalty of Perjury and pursuant to Nevada law that all the information I have provided is true, correct and complete to the best of my information and belief. NRS 217.270.

Print Full Name of Person Signing Application:	

Signature of Victim/Applicant (must be signed by an adult)	Date:

Privacy Notice on Collection

1. CalVCB collects this information based on California Government Code sections 13952 et seq. and 13954.
2. All information collected from this site is subject to, but not limited to, the Information Practices Act. See http://victims.ca.gov/media/pra.aspx.
3. This information is collected for the purpose of determining eligibility for compensation.
4. CalVCB may disclose your personal information to another requestor, only if required to do so by law or in good faith that such action is necessary to:
   a. Conform to the edicts of the law or comply with legal process served on CalVCB or the site;
   b. Protect and defend the rights or property of CalVCB; and,
   c. Act under exigent circumstances to protect the personal safety of users of CalVCB, or the public.
5. Individuals are to provide only the information requested.
6. The information provided is mandatory.
7. The consequences of not providing the requested information could result in the denial of your application.
8. You have the right to access the records containing the personal information that you provided.
9. The information collected is used by the California Victim Compensation Board.
10. Any questions regarding the information collected, please write to the following address: PO Box 48, Sacramento, CA 95812, email info@victims.ca.gov, call (800) 777-9229, or contact the CalVCB Privacy Coordinator at InfoSecurityandPrivacy@victims.ca.gov.
11. For additional information regarding privacy, please see CalVCB's Privacy Notice. See http://victims.ca.gov/privacy.aspx.
12. For information regarding consumer information on security, please visit https://oag.ca.gov/privacy/online-privacy.