

### ASSOCIATED APPLICATION ID:

Enter if known

# **Application For Crime Victim Compensation**

Section 1 must be completed for all applications. If you are filing this application on behalf of someone else, put their information in Section 1 and your information in Section 3. Please print clearly and complete all sections that apply.

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 all sections.

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Example:										
F	FIRS	ST NA	AME:							
	F	i	r	S	†					
L	LAST NAME:									
	L	а	S	†						

Section 1 Claimant				
SECTION 1 MUST BE COMPLETED FOR ALL APPLICATIONS	Preferred spoken language:			
A separate application must be filed for each person				
seeking assistance.	Preferred written language:			
The claimant is the person who has expenses or is seeking assistance as a result of a crime.				
FIRST NAME:	MIDDLE NAME:			
LAST NAME:	SOCIAL SECURITY NUMBER:			
DATE OF BIRTH (MM/DD/YYYY):	Does the claimant have a Social Security number?			
GENDER: M F	Social Security Humber?			
Relationship to victim: Self Other If other, describe:				
From the date of the crime to the present, has the <u>claimant</u> been in prison, on probation, on parole, or post-release community supervision because of a felony?	Is the <u>claimant</u> required to register as a sex offender?			
Mailing Address:	No			
STREET NUMBER AND NAME OR P.O. BOX:	Address 2 (Apartment or Unit #):			
CITY:	STATE: ZIP:			
HOME TELEPHONE: WORK TELEPHONE:	Ext.			
WORK TELETHONE.	LAL.			
CELL PHONE:				

If you are an adult victim and the expenses are for you, skip to Section 4. If not, continue to Section 2

E-MAIL:

E For more information call: **1.800.777.9229** 

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

www.victims.ca.gov

Mail completed application to:

California Victim Compensation Board PO Box 3036, Sacramento, CA 95812-3036

or deliver to your local

**Victim Witness Assistance Center** 

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FIRST NAME:			MIDDLE NAME:	
AST NAME:			SOCIAL SECURITY N	NUMBER.
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DATE OF BIRTH (MM/DD/YYYY):	From the date of the cri		Does the victim have	
	present, has the victim prison, on probation, on	parole, or Yes	Social Security numb	per?
GENDER: M F	<ul> <li>post-release community supervision because of</li> </ul>		Is the victim required register as a sex offer	
GENDER: M F	Supervision beduce of	a lololly.	register as a sex one	, Index:
Mailing Address:	IF VICT	IM IS DECEASED, DATE OF	DEATH:     /	
STREET NUMBER AND NAME OR P.O. BO	X:		Address 2 (Apartment or	r Unit #):
CITY:			STATE:	ZIP:
HOME TELEPHONE:		WORK TELEPHONE:		Ext.
CELL PHONE:		E MANU.		
		E-MAIL:		
	If	you are completing		
	If		apacitated adult, c	ontinue to Section 3
		an inc	apacitated adult, c	ontinue to Section 3
Section 3 Parent or Gu	If Iardian (Applican	an inc	apacitated adult, c	ontinue to Section 3
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Section 4 Information About Your Expenses	
For the victim of the crime, the following benefits may be avrequesting. Please attach copies, or a list, of any crime-related by	
Medical and/or dental expenses	Home or vehicle modifications (for a victim disabled because of the crime)
Mental health treatment	Job retraining (for a victim disabled because of the crime)
Income loss (if you missed work because of the crime)	Crime scene clean-up
Moving or relocation expenses	
Home security improvements	Other:
For someone other than the victim of the crime, the benefits expenses you are requesting. Please attach copies, or a list, of a	
For minor witnesses to violent crime, only mental health be	าefits are available. Proceed to Section 5.
Mental health treatment	Crime scene clean-up
Wage loss (up to 30 days if a minor dies or is hospitalized)	Home security improvements
Loss of support (for dependents of a deceased or disabled victim)	Medical expenses for a deceased victim
Funeral and/or burial expenses	
	Continue to remaining sections
EMERGENCY AWARD REQUEST:	•
Emergency awards may be requested in certain situations. An ein cases where you will suffer serious financial hardship if crime hardship means you would not have any money left for necessit Qualifying emergency awards are generally paid within 30 caler	-related expenses are not immediately paid. Substantial ties like food or rent after you paid for crime-related bills.
Section 5 Crime Information	Do you need to request an emergency award? Yes
Law Enforcement Agency Name:  IF REPORTED TO LAW ENFORCEMENT, NAME OF THE LAW ENFORCEMEN (Includes Child Protective Services)	NT AGENCY:
Date(s) crime occurred	
FROM: (If on one day only, enter date here)  TO:	DATE CRIME WAS REPORTED:
TYPE OF CRIME:	
DESCRIBE INJURIES:	
LOCATION OF CRIME: (if known) Address, Intersection, Area, etc:	
CRIME REPORT NUMBER:	COUNTY WHERE CRIME OCCURRED:
Person who committed the crime (suspect), if known: FIRST NAME:	MIDDLE NAME:
LAST NAME:	
LAST NAME:	Suspect Unknown



#### Section 6 Representative Information (A representative is not needed to apply for victim 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. FIRST NAME: MIDDLE NAME: LAST NAME: TELEPHONE: PLEASE INDICATE YOUR RELATIONSHIP TO THE PERSON LISTED IN SECTION 1: Attorney Victim Witness Advocate Community-based Advocate Spouse Parent Family Member Friend Other: **Mailing Address:** STREET NUMBER AND NAME OR P.O. BOX: Address 2 (Suite #): ZIP: CITY: STATE: Date: Representative's signature: ORGANIZATION NAME: VICTIM WITNESS ASSISTANCE CENTER NAME: JP/VWC #: For Attorneys Only: Yes Are you requesting payment pursuant to State Bar Number: Federal Tax ID: Government Code Section 13957.7(g)? No Telephone: E-mail: How Did You Find Out About the Board? Section 7 Child Protective Services Mental Health Provider Law Enforcement District Attorney Adult Protective Services Victim Witness Assistance Center Medical Provider Media (TV, Radio, Newspaper, etc.) Billboard or Poster Card or Booklet Other: Federal Reporting Information Section 8 The following voluntary information is for the person receiving compensation and is used for statistical purposes only to comply with federal regulations. African American Asian, Pacific Islander Hispanic Ethnicity: Caucasian Native American Other: Is the victim disabled? Was the victim disabled prior to the crime?

STATE OF CALIFORNIA CALIFORNIA VICTIM COMPENSATION BOARD

No

Yes

No

Yes

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#### Section 9 **Insurance Information** Please check all available sources that could be applied to your claim. The California Victim Compensation Board (CalVCB) is the payer of last resort. We may contact your insurance company as a potential reimbursement source. List insurance contact information below or on an additional sheet and attach. Health Medi-Cal Medicare Auto/ Workers' Compensation Homeowners/Renters None Other: Vehicle **Health Insurance** MEDI-CAL BENEFITS IDENTIFICATION CARD NUMBER: ISSUE DATE: INSURANCE COMPANY NAME: TELEPHONE: **Mailing Address:** STREET NUMBER AND NAME OR P.O. BOX: Address 2 (Suite #): CITY: STATE: ZIP: Name of Insured: FIRST NAME: MIDDLE NAME: LAST NAME: **GROUP NUMBER:** POLICY NUMBER: Have you filed an insurance claim related to this crime? Undecided Yes No Auto/Vehicle Insurance (Includes car, truck, motorcycle, motorhome, boat, jet ski, airplane, etc.) Complete if the crime involves a vehicle, including pedestrians hit by a vehicle. INSURANCE COMPANY NAME: TELEPHONE: **Mailing Address:** STREET NUMBER AND NAME OR P.O. BOX: Address 2 (Suite #): CITY: STATE: ZIP: Name of Insured: FIRST NAME: MIDDLE NAME: LAST NAME: GROUP NUMBER: Have you filed an insurance claim related to this crime? POLICY NUMBER: Yes No Undecided



Section 10 Employer Information	
Please list the victim's employer. If you are a parent/guardian seeking wage loss hospitalized or is deceased, list your employer.	benefits because a minor victim was
EMPLOYER'S BUSINESS NAME:	
Contact Person: FIRST NAME:	
INSTINANC.	OK to contact employer?
	Yes No
LAST NAME:	TELEPHONE:
Mailing Address:	
STREET NUMBER AND NAME OR P.O. BOX:	Address 2 (Apartment or Suite#):
CITY:	STATE: ZIP:
s or was the victim Yes No 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?
Section 11 Civil Suit Information	
Have you filed, or do you plan to file, a civil suit related to this crime?	No
Note: If you decide to file a civil suit, by law, you are required to notify CalVCB within 30 da	ays of filing the action.
Attorney's Name:	
FIRST NAME:	MIDDLE NAME:
LAST NAME:	TELEPHONE:
Mailing Address:	
waliliy Auuless.	
STREET NUMBER AND NAME OR P.O. BOX:	Address 2 (Suite #):
	Address 2 (Suite #):
	Address 2 (Suite #):  STATE: ZIP:
STREET NUMBER AND NAME OR P.O. BOX:	

### Your application for crime victim compensation is almost complete

- Print the application and then enter all available information.
- Attach copies of any documentation that supports your application for crime victim compensation, including copies of crime-related bills, insurance, or anything relating to the crime. Save original documents for your records.
- Please read the next page carefully, sign and date, and send to the address indicated or deliver to your local Victim Witness Assistance Center.
- CalVCB will send you a letter acknowledging that your application has been received. The acknowledgment letter will include additional information about the benefits requested on your application.
- A CalVCB representative may contact you for additional information if you were not able to provide it with your application.
- For any questions about victim compensation, you can contact your local Victim Witness Assistance Center or call CalVCB at 1-800-777-9229.



### This page MUST be signed and dated

#### 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 CaIVCB or its representatives may pursue restitution from the convicted offender authorized use of information in this application and subsequent claim files to pursue restitution.	in this matter to recover monies paid to me by CalVCB and that by filing this application I have on from the convicted offender.
	rovide information about this application, and the information contained in this application, to any provider of services, and may pay the provider directly if payment of these services is approved.
benefits once the revocation is received by CalVCB. However, no healthcare provider may co	e revocation will take effect when CalVCB receives it, but I may be deemed ineligible for CalVCB endition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I lation disclosed under this authorization may be redisclosed by the recipient as required by law and
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 13 My Agreement to the California	Victim Compensation Board
insurance policy, or any other government or private entity, for losses suffered as a direct resu	ard (CaIVCB) if I, or anyone on my behalf, receives any payments from the offender, a civil lawsuit, an all tof the crime that was the basis for receipt of benefits from CaIVCB, in the amount of the total mount for which it is later determined that I was not eligible. I will notify CaIVCB if I hire an attorney to
	or for modifying a home or vehicle for a disabled victim will be used only for those purposes. If I am a y home address nor allow the offender on the premises at any time, or I will seek a restraining order
	tion Board and the State of California subsequently receives compensation for the same loss on my any other source, I hereby assign to the Victim Compensation Board any and all rights to such
I declare under penalty of perjury under the laws of the State of California that all the informati understand that I may be found to be ineligible for benefits, and that action may be taken to re	ion I have provided is true, correct and completed to the best of my knowledge and belief. I ecover 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 o	r incapacitated. County social workers, see section 13a.)
Printed Name:	
Section 12a For County Social Workers Or	
Section 13a For County Social Workers Or	шу
As required by California law, I will contact and inform the California Victim Compensation Boa insurance policy, or any other government or private entity, for losses suffered as a direct resu	ard (CaIVCB) if I learn the claimant receives any payments from the offender, a civil lawsuit, an ult of the crime that was the basis for receipt of benefits from CaIVCB.
I declare under penalty of perjury under the laws of the State of California that all the informati understand that the claimant may be found to be ineligible for benefits, and that action may be intentionally incomplete, or misleading.	ion I have provided is true, correct and completed to the best of my knowledge and belief. I taken to recover benefits the claimant receives if the claimant provides information that is false,
Signed:	Date:
Printed Name:	
Timed Name.	
Mail completed application to:	For more information call:

**Victim Compensation Board** PO Box 3036, Sacramento, CA 95812-3036

deliver to your local Victim Witness Assistance Center

1-800-777-9229

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

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

## **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 <a href="http://victims.ca.gov/media/pra.aspx">http://victims.ca.gov/media/pra.aspx</a>.
- 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 <u>info@victims.ca.gov</u>, call (800) 777-9229, or contact the CalVCB Privacy Coordinator at <u>InfoSecurityandPrivacy@victims.ca.gov</u>.
- 11. For additional information regarding privacy, please see CalVCB's Privacy Notice. See <a href="http://victims.ca.gov/privacy.aspx">http://victims.ca.gov/privacy.aspx</a>.
- 12. For information regarding consumer information on security, please visit <a href="https://oag.ca.gov/privacy/online-privacy">https://oag.ca.gov/privacy/online-privacy</a>.