

# Claim Form

Before you fill out this Claim Form, please read the information below.



This Claim Form should be submitted within one year of the crime.

*Please include a letter explaining the delay, if more than one year has passed.*

**Attach all itemized statements for services rendered, receipts, and insurance benefit statements.**

\* If you receive additional bills and/or benefits statements for continuing treatment, mail them to VVF at that time.

## You may qualify for payment if:

### THE CRIME

- was committed in Virginia, or a country where Virginia residents are not eligible for compensation
- was the result of a terrorist act
- was reported to a law-enforcement agency within 120 hours, unless there is good reason for the delay

### THE VICTIM

- cooperated with law-enforcement agencies and the courts in the investigation/prosecution
- was not involved in any illegal activity at the time of the crime
- did not provoke or willingly take part in the crime

## Who can apply?

- victims who suffered physical injury as a result of a criminal act
- victims who suffered emotional injury as the result of a felony
- ANYONE who paid or is responsible for paying the victim's funeral bill
- a surviving family member who suffered emotional injury due to the murder of a parent, spouse, sibling, child, or grandchild

## You cannot be paid for:

- pain, suffering, or property loss
- injuries resulting from vehicular accidents except in certain circumstances
- attorney fees
- missed doctors' appointments

## In order to receive payment you must:

- cooperate with all law-enforcement agencies including Commonwealth Attorneys
- bill any relevant insurances, including:
  - medical insurance(s)
  - Medicaid/ Medicare
  - renter's/homeowner's insurance
  - life/burial insurance
  - automobile insurance(s)
- if you are uninsured and went to a hospital, apply for the hospital's financial assistance program
- provide all requested documentation

### **If the victim is a minor or is mentally incompetent:**

- provide proof that you are the person responsible for the victim's welfare (either parent, legal guardian or legal custodian)

## Fax or mail this completed application to:

Virginia Victims Fund  
P.O. Box 26927  
Richmond, VA 23261  
Fax: 804-823-6905

### If you need assistance:

- e-mail [info@virginiavictimsfund.org](mailto:info@virginiavictimsfund.org)
- call 1-800-552-4007 (toll-free)
- contact your local Victim/Witness Assistance Program

While your claim is pending, healthcare providers are prohibited by law from taking collection action against you.

## SECTION A – VICTIM INFORMATION

(Provide all requested information related to the injured person.)



**Victim's Name:** \_\_\_\_\_  
(First Name) (Middle Name) (Last Name) (Suffix – Jr., Sr., I, II, III, etc.)

**Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  None **Gender:**  Male  Female  Unknown

\*Check "None" ONLY if you do not have a SSN.

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of Death:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
\*If claim is related to a homicide.

**Marital Status:**  Divorced  Married  Separated  Unknown  Unmarried  Widowed

### Ethnic Group:

- |   |   |
|---|---|
| <input type="checkbox"/> Hispanic or Latino     | <input type="checkbox"/> Multiple Races                             |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> American Indian/Alaska Native              |
| <input type="checkbox"/> White /Caucasian       | <input type="checkbox"/> Native Hawaiian and Other Pacific Islander |
| <input type="checkbox"/> Asian                  | <input type="checkbox"/> Other                                      |
|   | <input type="checkbox"/> Unknown                                    |

**Address:** \_\_\_\_\_  
(Complete Mailing)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
(County) (Country, if not United States)

**Home/Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Was the victim disabled prior to the crime?**  Yes  No

### How is the victim related to the offender?

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Spouse               | <input type="checkbox"/> Other        |
| <input type="checkbox"/> Parent               | <input type="checkbox"/> Grandparent  |
| <input type="checkbox"/> Sibling              | <input type="checkbox"/> Acquaintance |
| <input type="checkbox"/> Child                | <input type="checkbox"/> Not related  |
| <input type="checkbox"/> Boyfriend/Girlfriend |                                       |

### Who referred you to the Virginia Victims Fund?

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Victim Witness        | <input type="checkbox"/> Funeral Home | <input type="checkbox"/> Other Government Agency |
| <input type="checkbox"/> Police Department     | <input type="checkbox"/> Friend       | <input type="checkbox"/> SAFE Coordinator        |
| <input type="checkbox"/> Commonwealth Attorney | <input type="checkbox"/> Media        | <input type="checkbox"/> Other                   |
| <input type="checkbox"/> Medical Provider      | <input type="checkbox"/> Internet     |  |

## SECTION B – CLAIMANT INFORMATION

(Provide all requested information about the person filing the claim, if different from the victim.)



**Claimant's Name:** \_\_\_\_\_  
(First Name) (Middle Name) (Last Name) (Suffix – Jr., Sr., I, II, III, etc.)

**Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  None **Gender:**  Male  Female  Unknown

\*Check "None" ONLY if you do not have a SSN.

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Marital Status:**  Divorced  Married  Separated  Unknown  Unmarried  Widowed

### Ethnic Group:

- |   |   |
|---|---|
| <input type="checkbox"/> Hispanic or Latino     | <input type="checkbox"/> American Indian/Alaska Native              |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Native Hawaiian and Other Pacific Islander |
| <input type="checkbox"/> White /Caucasian       | <input type="checkbox"/> Other                                      |
| <input type="checkbox"/> Asian                  | <input type="checkbox"/> Unknown                                    |
| <input type="checkbox"/> Multiple Races         |   |

**Address:** \_\_\_\_\_  
(Complete Mailing)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
(County) (Country, if not United States)

**Home/Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

### How are you related to the victim?

- |                                  |   |                                       |
|----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Spouse  | <input type="checkbox"/> Child                | <input type="checkbox"/> Grandparent  |
| <input type="checkbox"/> Parent  | <input type="checkbox"/> Boyfriend/Girlfriend | <input type="checkbox"/> Acquaintance |
| <input type="checkbox"/> Sibling | <input type="checkbox"/> Other                | <input type="checkbox"/> Not related  |

Other \_\_\_\_\_ If applicable, please provide proof of guardianship or Power of Attorney (*attorney or medical Power of Attorney not accepted*)

## SECTION C – CRIME INFORMATION

(You can obtain this information from the responding law-enforcement agency.)

**Crime Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**City/County where the crime occurred:** \_\_\_\_\_

**Street address where the crime occurred:** \_\_\_\_\_

**Crime Type:**

- Abduction
- Arson-Fatal
- Arson-Non-Fatal
- Assault
- Assault-Child Abuse
- Assault-DUI
- Breaking & Entering
- Hit and Run-Assault
- Hit and Run-Homicide
- Homicide
- Homicide-DUI
- Human Trafficking: Sex/Labor
- Other
- Robbery
- Robbery-Carjacking
- Sexual Crime-Adult
- Sexual Crime-Child
- Stalking
- Terrorism-Assault
- Terrorism-Homicide



**Type of Victimization:**

- Bullying
- Domestic and Family Violence
- Elder Abuse
- Hate Crime
- Mass Violence

**SECTION D – REPORTING INFORMATION**

Was the crime reported to law enforcement within 120 hours?  Yes  No

Date the crime was reported to law enforcement: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name of the law-enforcement agency investigating: \_\_\_\_\_

Was a motor vehicle involved in this crime?  Yes  No

Police Report Number, if known: \_\_\_\_\_

***IF WARRANTS WERE OBTAINED AGAINST THE DEFENDANT, PLEASE ATTACH A COPY OF THE WARRANTS.***

**SECTION E – OFFENDER INFORMATION** (Enter all known information)

Offender’s Name: \_\_\_\_\_  
(First Name) (Middle Name) (Last Name) (Suffix – Jr., Sr., I, II, III, etc.)

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Offender’s Name: \_\_\_\_\_  
(First Name) (Middle Name) (Last Name) (Suffix – Jr., Sr., I, II, III, etc.)

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

***PLEASE LIST ADDITIONAL OFFENDERS ON A SEPARATE SHEET AND SUBMIT WITH THIS CLAIM FORM.***

**Court case is being heard in:**

Juvenile & Domestic Relations     General District     Circuit



**Has the court ordered the offender(s) to pay any restitution to you for this crime?**

Yes     No    Amount, if known: \_\_\_\_\_

**CIVIL CASE**

**Has a civil lawsuit been filed against the person responsible for the injury?**     Yes     No

**If yes, please provide the following about your attorney:**

**Name of Attorney:** \_\_\_\_\_

**Address:** \_\_\_\_\_

(Complete Mailing)

\_\_\_\_\_  
(City/County)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**SECTION F – EMPLOYER INFORMATION** (Complete this section if you are requesting lost wages.)

**Are you self-employed?**     Yes     No

**If yes,** send a copy of your most recent Federal Income Tax Return with W2 Wage Statements, 1099s, etc.

**If no,** please provide the following about your employer.

**Name of Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_

(Complete Mailing)

\_\_\_\_\_  
(City/County)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

**Telephone:** \_\_\_\_\_

**PLEASE LIST ANY ADDITIONAL EMPLOYERS ON A SEPARATE SHEET AND SUBMIT WITH THIS CLAIM FORM.**

**Did the crime occur at your place of employment?**     Yes     No

**If yes, have you filed a claim with the Virginia Workers' Compensation Commission?**     Yes     No

*To apply with the Virginia Workers' Compensation Commission, please call 1-877-664-2566 (toll-free).*

## SECTION G – INSURANCE/COLLATERAL RESOURCES



Are the victim's crime-related expenses covered by health insurance?  Yes  No

**IF YES:** Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Private Health Insurance Carrier: \_\_\_\_\_

*Please list any additional insurance on a separate sheet and submit with this Claim Form.*

**Address:** \_\_\_\_\_  
(Complete Mailing)

\_\_\_\_\_  
(City/County) (State) (Zip Code)

### **IF NO:**

If victim does not have health insurance and sought treatment from a hospital, you must contact their financial services department and apply for charity care assistance. VVF *must* be provided with a copy of the decision made on the charity care application *before* payment can be made.

Did the victim apply for hospital charity care?  Yes  No

### **IF YOU ARE APPLYING FOR REIMBURSEMENT OF CRIME SCENE CLEAN-UP EXPENSES:**

Does the victim have homeowner's or renter's insurance?  Yes  No

If yes, please provide the following information about the insurance carrier:

Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_  
(Complete Mailing)

\_\_\_\_\_  
(City/County) (State) (Zip Code)

### **IF AN AUTOMOBILE WAS INVOLVED IN THE CRIME:**

Does the victim have automobile insurance coverage?  Yes  No

Claimant's Auto Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_  
(Complete Mailing)

\_\_\_\_\_  
(City/County) (State) (Zip Code)

Does the offender have automobile insurance coverage?  Yes  No  Unknown

Offender's Auto Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_  
(Complete Mailing)

\_\_\_\_\_  
(City/County) (State) (Zip Code)

**IF YOU ARE APPLYING FOR REIMBURSEMENT OF FUNERAL-RELATED EXPENSES:**



Was the victim covered under any life and/or burial insurance?  Yes  No

If yes, please provide the following: **Name of Beneficiary:** \_\_\_\_\_

**Name of Life/Burial Insurance Carrier:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
(Complete Mailing)

\_\_\_\_\_  
(City/County)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

***Please note that if the funeral bill has been paid or is paid anytime during the processing of your VVF claim, detailed receipts or copies of cancelled checks are required to consider reimbursement to anyone other than the funeral home.***

**SECTION H – EXPENSES** *(caps are based on the policy effective at the time of crime)*

Please check all expenses that you are requesting reimbursement for:

**Medical Expenses**

payment or reimbursement for crime-related expenses with a hospital, physician, dentist, or other medical provider

**Temporary Housing**

housing necessary when a previous dwelling is rendered unsafe by the crime *(30-day maximum; bill must be in victim's name)*

**Mental Health Expenses**

mental health counseling for the **victim** of the crime

**Homicide Loss of Support**

financial support for the care of legal dependents of a homicide victim

**Grief Counseling (up to \$3,500)**

grief counseling for family of homicide victims

**Prosthesis**

reimbursement for replacement of eyeglasses, hearing aids, dentures, false limbs, or other medically necessary aids

**Funeral or Burial Expenses (up to \$10,000)**

payment or reimbursement for the victim's burial, cremation and/or headstone and/or plot

**Home Security (up to \$1,000)**

reimbursement for doors, locks, windows, and purchase and installation of home security system

**Loss of Wages**

replacement of lost wages for the **victim** who could not work because of crime-related injury, as verified by a medical provider

**Prescriptions**

reimbursement for medication that was prescribed as a result of the crime *(please submit pharmacy print-out or "bag tags")*

**Domestic Loss of Support**

compensation for victims of domestic violence or child sexual assault for loss of the offender's wages when the offender is removed from the home *(the offender must have a legal obligation to support the victim)*

**Mileage**

reimbursement of mileage to and from doctors' appointments; *mileage to and from court appearances, if the victim is a minor*

**Crime Scene Clean-Up**

cleaning of items damaged as a result of the crime *(personal property not included)*

**Moving Expenses (up to \$2,000)**

reimbursement for the cost of professional movers, moving equipment rental, temporary storage, rent, and loss of a security deposit *(dated/signed contracts required)*

## SECTION I - MEDICAL PROVIDERS



List the name and addresses of the medical providers who gave crime-related treatment. List additional providers on a separate sheet or attach copies of detailed, itemized billing statements.

**Name of provider:** \_\_\_\_\_

Address: \_\_\_\_\_

**Name of provider:** \_\_\_\_\_

Address: \_\_\_\_\_

**Name of provider:** \_\_\_\_\_

Address: \_\_\_\_\_

**Name of provider:** \_\_\_\_\_

Address: \_\_\_\_\_

**Name of provider:** \_\_\_\_\_

Address: \_\_\_\_\_

**Name of provider:** \_\_\_\_\_

Address: \_\_\_\_\_

**Name of provider:** \_\_\_\_\_

Address: \_\_\_\_\_

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## SECTION J - DEPENDENTS

If a deceased victim had dependents for whom they were legally responsible, the dependents may be eligible for loss of support benefits and/or survivor grief counseling. Please provide the following information for each dependent.

Name	Relationship	Date of birth	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**If you are applying for loss of support benefits for a minor victim, please provide a copy of the statement from Social Security showing the benefits approved. You may submit the VVF Claim Form now and provide Social Security documentation once you receive it.**



# Notarized Agreement

These terms are set forth fully in Virginia Code §§ 19.2-368.1-19.2-368.18. **Your application will not be processed unless this form is signed on the signature line and witnessed by a Notary Public.**



## Collections

I agree that the Criminal Injuries Compensation Fund (Virginia Victims Fund) may pay any award for my benefit directly to the person or entity to which I owe a payment as a result of the crime. I understand VVF will attempt to collect my award from the person responsible for the crime. I further agree that if I later recover money from any other source as a result of the crime, receive restitution, or recover damages through civil litigation, I will immediately repay the VVF award. In the event I fail to repay a VVF award, I agree to be responsible for all collections costs allowed by law.

## Oath

I affirm that I have reviewed this application and understand its contents. I swear it is true and complete to the best of my knowledge. I understand that if any information I submit is false, or if I have not fully cooperated with all law-enforcement agencies, including the criminal prosecution, the claim may be denied or revoked and collected upon.

## Authorization

I authorize any hospital, physician, counselor, funeral director, or other person who attended or examined

\_\_\_\_\_ (*the name of the victim*) and any municipal authority, employer or union, insurance company, social service bureau, Social Security office, or any other person, firm, agency or organization to furnish to the Criminal Injuries Compensation Fund (Virginia Victims Fund), or its representative, any information requested, including tax data and prior police records, required to complete the claimant's or victim's claim for benefits. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization is for the collection of information related only to this claim.

I further authorize the Criminal Injuries Compensation Fund (Virginia Victims Fund) to disclose any and all information in my claim file, except those documents legally protected from dissemination, to the Victim Witness Assistance Program in the locality handling my case.

I HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS ABOVE. I swear or affirm that I am the Claimant; I have reviewed and understand all of the requirements of VVF. The information submitted is true and complete to the best of my knowledge and belief. I understand that submitting false information is a felony under § 19.2-368.16 of the Code of Virginia.

\_\_\_\_\_ **PRINT** Claimant's Name

\_\_\_\_\_ *Claimant's Signature*

City/County of \_\_\_\_\_, Commonwealth/State of \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_ *Signature of Notary Public*

My commission expires the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Notary Public Number: \_\_\_\_\_

Please note that the Criminal Injuries Compensation Fund (Virginia Victims Fund) is a division of the Workers' Compensation Commission, which is exempt from HIPAA, and for HIPAA purposes, the Fund is a "payer" to which disclosures may be made without prior authorization.

