

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

**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 using blue ink or type information.
- **A copy of the police report must be attached.**
- Along with original application and documentation, please include one copy of each.
- Mail this completed form, along with all required documentation, to the address above.

**ADDITIONAL INFORMATION**

- 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, or 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 have paid or owe expenses related to the crime.
- Incident must be reported to law enforcement within 48 hours; 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 required to prosecute the alleged offender).
- If crime occurred before July 15, 1998 you have one year to file a claim; after July 15, 1998 you have five years to file a claim.
- CVCB does not pay for any property loss, except corrective lenses 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 other expenses resulting from the crime.

**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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**FOR OFFICE USE ONLY**

CLAIM NO: \_\_\_\_\_

INVESTIGATOR: \_\_\_\_\_

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

Victim's Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

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 Information** (to be filled out by person filing on behalf of a victim)

Claimant's name: \_\_\_\_\_ Relationship to victim: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Month Day Year

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ (work) \_\_\_\_\_ (cell): \_\_\_\_\_

E-mail: \_\_\_\_\_

**SECTION III Crime Information** (YOU MUST 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)*

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**SECTION V.** Describe the injuries.

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**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 *(You MUST attach documentation)*

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   
  Veterans Benefits  
 Homeowner's Insurance   
  Auto Insurance   
 Auto Insurance   
 Other \_\_\_\_\_

**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, attach the Employment Verification Form, which **MUST** be filled out by the **EMPLOYER** and **NOTORIZED**.

If yes, attach the Physician Statement and/or the Mental Health Counselor Report, 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 cover period of crime.

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

Total monthly income prior to incident \_\_\_\_\_ Paid out per month \_\_\_\_\_

Total current monthly income \_\_\_\_\_ Pay 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 contribution or donations.**

Life Insurance: \$ \_\_\_\_\_ Workers Comp: \$ \_\_\_\_\_ Burial Insurance: \$ \_\_\_\_\_

Social Security: \$ \_\_\_\_\_ Estate: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

Name of Funeral Home: \_\_\_\_\_

Address: \_\_\_\_\_  
Address City State ZIP Code

Telephone No. \_\_\_\_\_ Relationship to victim: \_\_\_\_\_

**SECTION XI. Loss of Support** (*Fill out this section if you are the surviving spouse of the victim and/or had dependent children at time of crime*)

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 **NOTORIZED**.*

List income you now receiving 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
- Black

- U.S. Citizen
- Handicap

- Federal Crime
- Kentucky Resident

Who referred you to the compensation program?

- Law Enforcement
- Victim Advocate
- Judge
- Hospital
- Prosecutor
- Other \_\_\_\_\_

**SECTION XIII. Restitution and Civil Lawsuit (Enter information regarding about any payments the court has ordered to be paid to you by the offender or any settlement you reached 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**

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 I agree to repay the full amount I received from the fund 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 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 source, 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.

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.**

Attorney's Name: \_\_\_\_\_ Social Security # or Fed ID \_\_\_\_\_

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

Attorney's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EMPLOYMENT VERIFICATION**  
***To be completed and signed by employer only.***  
***Must be NOTARIZED.***

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Employee's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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 continue while off work:  Yes  No

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

<i>Deduction</i>	<i>Amount Per Week</i>	<i>From Date</i>	<i>To Date</i>
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

\_\_\_\_\_



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.**

Person receiving services: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Crime date: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ 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

