# APPLICATION FOR VERMONT VICTIMS COMPENSATION

We realize that this is a difficult time for you. If you need help filling out this form, call the Victims Compensation Program at the numbers listed below. You can also visit our website listed below for more information.

**The Victims Compensation Program** provides limited financial assistance to victims of crime who have experienced a financial loss as the direct result of the crime, as long as the loss is not reimbursable through other sources, such as insurance.


## Victims Compensation Program

58 South Main Street, Suite One

Waterbury, Vermont 05676-1599

**1-800-750-1213 (Voice – VT only)**

**1-802-241-1250 (Voice)**

**1-802-241-1253 (fax)**

**www.ccvs.vermont.gov**


VERMONT

VERMONT CENTER FOR CRIME VICTIM SERVICES

## Eligibility Requirements

- The crime has been reported to a law enforcement officer, who must conclude that a crime was committed.
- The victim has suffered physical injury or emotional harm as a direct result of a crime.
- The crime was committed in Vermont, or was committed against a Vermont resident in a country that does not have a Compensation Program.
- The crime was committed after July 1, 1987.
- The victim did not violate a criminal law of this state which caused or contributed to his or her injuries or death.
- Family members of a homicide victim are also eligible.

Where appropriate, money is available to pay for the following expenses, as long as they have not already been paid by other sources:

- Medical and dental care
- Counseling for victims and family members
- Funeral expenses
- Lost wages due to time missed from work
- Other expenses such as prescriptions, eyeglasses, and limited transportation costs
- If death occurs as a result of the crime, legal dependents may receive temporary living expenses
- Limited relocation assistance
- Pet care/injury/death

*Property losses are generally not covered.*

## Application Instructions

**You must complete all of this application. Make sure that you:**

1. Sign and date after the "certification statement."
2. Sign and date the "Authorization to Obtain Information" section of the application. You may provide an alternative expiration date if desired.
3. Sign and date the "Repayment, Restitution, and Subrogation" section of the application.
4. After you fill out this application, please tape or staple all sides to seal before mailing.

If you would prefer to mail your application to us in a separate envelope and do not have a stamp, please contact the Victims Compensation Program and we will send you a postage paid envelope to mail your application and/or bills.

If you receive more crime-related bills in the future, please make sure that you send them to us at the address on the first page of this application.

## I. Victim Information

Victim's Name:_____

Mailing Address:_____

City or Town:_____

State:_____ Zip:_____

Home phone:_____ Work phone:_____

Cell phone:_____ Email Address:_____

If you do not want us to contact you at the above address, please provide another mailing address and phone number:

_____

_____

**If the victim is a minor:**

❑ Parent or ❑ Legal Guardian's name:

_____

Parent/Guardian date of birth:_____

Home phone:_____ Work phone:_____

Cell phone:_____ Email address:_____

If address is different from victim's address:

_____

_____

If in DCF (Dept. of Children & Families) custody, case worker's name:

_____

**If the victim is deceased:**

Survivor's name:_____

Survivor's Date of birth:_____

Relationship to victim:_____

Mailing Address:_____

City or town:_____

State:_____ Zip:_____

Home phone: _____ Work phone: _____

Cell phone: _____ Email Address:_____

## II. Information about the Crime

Please complete as much of the following information as you can. If you do not have this information, leave the space blank, and we will try to obtain the documentation from the police or your Victim Advocate.

Date of Crime:_____ Date reported:_____

Name(s) of suspect(s):_____

Date of birth of suspect(s):_____

Town where crime occurred:_____

Police department reported to:_____

Name of police officer:_____

Incident number:_____

**Type of crime: (check all that apply)**

- ❑ Arson
- ❑ Assault
- ❑ Burglary
- ❑ Child physical abuse/neglect
- ❑ Child pornography
- ❑ Child Sexual abuse
- ❑ Domestic violence
- ❑ DUI (Driving under influence of intoxicating liquor or other substance)
- ❑ Fraud/financial crimes
- ❑ Homicide
- ❑ Human Trafficking
- ❑ Kidnapping
- ❑ Other vehicular crimes
- ❑ Robbery
- ❑ Sexual assault
- ❑ Stalking
- ❑ Terrorism
- ❑ Other_____

Are you represented by a private attorney in a civil lawsuit or insurance action regarding this crime? ❑ Yes ❑ No

Attorney's name:_____

Email:_____ Phone:_____

## III. Requests for Compensation

Please complete as much of the following information as you can. If you do not have this information, leave the space blank.

I am requesting compensation for the following crime-related losses:

- ❑ Child Care
- ❑ Counseling
- ❑ Crime Scene Clean-up
- ❑ Dental
- ❑ Eyeglasses, hearing aids, dentures, or any prosthetic device taken, lost, destroyed during the crime
- ❑ Funeral Costs
- ❑ Loss of Support

- ❑ Lost Wages (time missed from work)
- ❑ Medical
- ❑ Mileage/Gas
- ❑ Payment of bills for pets that are injured or killed during the crime
- ❑ Boarding of pets
- ❑ Rent/relocation
- ❑ Safety/Security
- ❑ Temporary living expenses
- ❑ Travel Expenses/transportation costs
- ❑ Other:_____

➔ **Please send any crime-related bills that you receive to the Victims Compensation Program. Please indicate the name and phone number of the provider(s) that you are seeing for crime related treatment below:**

Dentist: _____ Phone: _____

Doctor: _____ Phone: _____

Hospital: _____ Phone: _____

Counselor: _____ Phone: _____

Funeral Home: _____ Phone: _____

**Insurance Information:**

Does the victim have health insurance? ❑ Yes ❑ No

If yes, name of insurance company:

❑Medicaid ❑ Medicare ❑ MVP ❑ Blue Cross/Blue Shield ❑ Cigna

❑Other:_____ Insurance Identification #:_____

Does the parent, guardian or survivor have health insurance? ❑ Yes ❑ No

If yes, name of insurance company:

❑Medicaid ❑ Medicare ❑ MVP ❑ Blue Cross/Blue Shield ❑ Cigna

❑Other:_____ Insurance Identification #:_____

**Employer Name**:

Address: _____

City/Town:_____ State:_____ Zip:_____

Phone:_____ Employer Email:_____

Name of contact person at work:_____

Due to the crime, I have missed work for the following:

Date(s) Missed: Reason:

1. _____ 1. _____

2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____

**PLEASE BE ADVISED: IF YOU ARE ASKING FOR COMPENSATION FOR LOST WAGES (TIME MISSED FROM WORK), WE WILL CONTACT YOUR EMPLOYER.**

Were you paid for time missed from work? ❑Yes ❑No

➔ **If you miss work in the future due to crime-related reasons, please contact us with the additional dates.**

## IV. Optional Information

**Where did you hear about the Victims Compensation Program?**

- ❑ Counselor
- ❑ Department of Children and Families
- ❑ Victim Advocate
- ❑ Hospital
- ❑ Police
- ❑ TV
- ❑ Internet
- ❑ Radio
- ❑ Organization serving person with a disability
- ❑ Other, please specify: _____

**The following information is optional and requested to comply with federal regulations, and is for statistical purposes only.**

Race/Ethnicity: (self reported)

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White-Non-Latino or Caucasian
- ❑ Another Race
- ❑ Multiple Races

Gender: (self reported) ❑Male ❑Female ❑Self Identify:_____

**In order to better assist you, do you need accommodations for any of the following:**

(Optional)

- ❑ Visual Disability
- ❑ Deaf or Hard of Hearing
- ❑ Physical Disability
- ❑ Mental Health Diagnosis
- ❑ Intellectual Disability

Please identify disability if not listed above:_____

**Please let us know what accommodation(s) you would like us to provide:**

- ❑ American Sign Language Interpretation
- ❑ Language Interpretation
- ❑ Large Printed Materials
  Specify language_____
- ❑ Communication Assistance (Please specify):_____

Other Please specify: _____

Each county has a Victim Advocate located in the State's Attorney's Office. We encourage you to call your Advocate with any questions you may have about the court process. For information on how to contact your Advocate, call the Victims Compensation Program at

1-800-750-1213 (Voice–VT only)

or 1-802-241-1250 (Voice)

**You must sign and date in the three (3) places that follow to be eligible for victims compensation.**

## AUTHORIZATION TO OBTAIN INFORMATION

I hereby voluntarily authorize, in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 42USC § 132d et seq.) any hospital, clinic, physician, health care provider or other person who attended or examined the victim named below; any funeral director, insurance company, counselor, attorney or other person who rendered related services; any employer of the victim or claimant; any police or governmental agency, including state or federal revenue services; or any organization having relevant knowledge, to furnish the Vermont Victims Compensation Program with any and all information in their possession with respect to the incident that is the basis for this claim. A photocopy of this authorization is as effective and valid as the original unless otherwise required by law. Further release of this information is prohibited. I understand that this authorization will expire one year from the date of this authorization unless I otherwise specify.

I further understand that I may revoke this authorization at any time by notifying the Victims Compensation Program in writing, except to the extent it has already been relied upon.

Alternative expiration date if desired:_____

Victim's name:_____ Date of birth:_____

Signature of victim or survivor:_____

Signature of parent or guardian, if victim is under 18:_____

Date: _____

## REPAYMENT, RESTITUTION, AND SUBROGATION AGREEMENT

I understand, on behalf of myself, assignee, heir, or dependent, that Vermont law requires me to contact and repay the Victims Compensation Program if I receive payments from the offender, a civil action, or an insurance company, and that the Victims Compensation Program has a lien against any monies I may recover as a result of this crime. I also understand that I must notify the Program if I hire a lawyer to represent me in any action related to this crime. I understand that my signature indicates that I agree with all statements specified in this agreement.

Victim's name: _____Date of birth: _____

Signature of victim or survivor: _____

Signature of parent or guardian, if victim is under 18:_____

Date:_____

## CERTIFICATION

I certify that the information in this application is true and correct to the best of my knowledge.

Signature of victim or survivor:_____

Signature of parent or guardian, if victim is under 18:_____

Date:_____