for Crime Victim Compensation

South Carolina has a Crime Victim Compensation Fund to help citizens with costs related to injuries received as a result of the crime. To find out more, read the instructions below or call the Department of Crime Victim Compensation (DCVC) at 1.800.220.5370 (Victims Only) or 803.734.1900 in Columbia, South Carolina or contact your local Victim Advocate.

# Assistance from the Department of Crime Victim Compensation

If you qualify for services, DCVC may consider the costs of medical care, counseling, lost wages/support, for you as the victim, or for a victim you are financially responsible for. You may also be reimbursed for money you spent on the funeral/burial of a deceased victim. The law limits the amount of these payments so call DCVC for information. The most that can be paid on behalf of a victim for all expenses combined is \$15,000. DCVC can pay for either up to 40 counseling sessions or 180 days of counseling sessions, whichever is greater.

# **DCVC Eligibility Criteria**

If you are a victim or claimant (person filing for a victim), please note that:

- Crime must occur in South Carolina
- Victim must sustain direct injury (Physical or Psychological)
- South Carolina law requires DCVC to consider contributory or illegal behavior when making eligibility determinations
- Victim must cooperate with DCVC and Law Enforcement
- Crime must be reported within 48 hours (May be Waived)
- Claims must be filed within 180 days (May be Waived)
- Claim must be filed within 4 years of the incident
- DCVC is considered the payer of last resort.

# What losses are not covered?

- Property damage or loss Expenses related to going to court (lawyer, travel, etc.)
- Crime scene cleanup
- "Pain and suffering"

# Who can qualify for financial assistance?

Injured crime victims, immediate family members of crime victims, or someone who is paying bills or taking care of a crime victim may apply. There are some exceptions so call DCVC for information.

# How can I get help with this application?

Law enforcement agencies, solicitors' offices and victim assistance organizations in your area have victim advocates to help you with this application. If unable to reach an agency or don't know who to call, the Department of Crime Victim Compensation (DCVC) is available to assist you. Please call DCVC at 1.800.220.5370 (Victims Only) or 803.734.1900 between 8:30 am and 5:00 pm.

#### Do I have to fill out this entire packet?

No. Only part of this packet is the application for compensation benefits. Supplemental forms are included for you to give to your counselor, doctor, or employer to complete if applicable.

#### If I want to apply now, what should I do?

Read the instructions and fill out the attached application. Also include as much related information (i.e. itemized receipts, bills, insurance statements, and incident report) as possible. You must submit the application within 180 days of the crime, so do not wait to collect all of your bills. You can send additional itemized bills later as you receive them. You will be notified as your claim is processed through the system.

If you have not received a letter after four weeks, please call DCVC or your local victim advocate. If you move, or if your phone number changes, please let DCVC know immediately.

For assistance with claims for anonymous reporting, contact DCVC for details.





South Carolina Attorney General's Office Department of Crime Victim Compensation

# If you are...

- Filing for *yourself as an adult victim*, then you are the "Victim", and the "Claimant".
- ◆ Filing for a *minor, or an incapacitated or incompetent victim,* then you are the "Claimant", and the crime victim should be named as the "Victim" and the "Person Receiving Services".
- Filing for the medical and/or funeral/burial bills *for a deceased victim*, then you are the "Claimant". The "Person Receiving Services" and the deceased crime victim should be named as the "Victim".
- ♦ Filing for *counseling for yourself because an immediate family member has been injured or killed*, then you are the "Claimant" and the "Person Receiving Services". The injured or deceased family member is the "Victim".
- Filing for *counseling for a minor because his/her immediate family has been injured or killed*, then you are the "Claimant". The minor is the "Person Receiving Services", and the injured or deceased family member is the "Victim".

*Please call your local victim advocate or DCVC for assistance in completing this application.* (Supplemental forms can be found online or in the application packet)

#### Print neatly and use a separate application for each applicant.

SECTION 1 "Person Receiving Services"	Print the name of the person who is getting medical attention, counseling or other services as a result of the crime. The "Person Receiving Services" is the "Victim" and/or the "Claimant," or the immediate family member of the person injured or killed. In homicide cases, the deceased Victim's name should appear here.			
SECTION 2 "Victim"	The crime victim is the person who was injured, threatened with injury or is deceased as a result of the crime This will be the same person listed as the "Victim" on the law enforcement incident report.			
SECTION 3 "Claimant"	If the "Person Receiving Services" is an adult responsible for his/her own bills, please list his/her name as the "Claimant". If the "Person Receiving Services" is under 18, incapacitated or incompetent, the financially responsible person (e.g. parent, guardian, spouse) should be named in this section. If the "Victim is deceased as a result of the crime, then the adult legally responsible for the medical and/or funeral/burial bills and expenses is the "Claimant".			
SECTION 4 "Crime"	<b>Be specific in describing injuries.</b> Attach a copy of the incident report. If you don't have one, you can obtain a free copy from the law enforcement agency that you reported the crime to. <b>The law enforcement incident report is required to determine eligibility and process the claim.</b>			
SECTION 5 "Expense"	List the names of doctors, hospitals, and others that have provided services. If you already have itemized bills, please send copies with your application(s). You must send the application within 180 days of the crime, so do not wait to collect all of your bills.			
SECTION 6 "Insurance"	If you have insurance that may cover some of your crime-related bills, list your insurance information in this section.			
SECTION 7 "Employment"	List your job information if you have not been able to work for at least two weeks in a row because of crime-related injuries or to take care of someone with crime related injuries. Your employer will be required to complete the Employer's Report; the doctor treating the "Victim" will be required to complete the Physician's Report.			
SECTION 8 "Civil Action"	Complete if you have hired a lawyer to settle an insurance claim or file a lawsuit related to this crime.			
SECTION 9 "Referral"	Provide the information of the victim advocate or other professional who assisted you with this application.			
SECTION 10 "Authorization"	Important: This application is a legal document which must be read and signed by the adult "Claimant" (must be 18 or older). Person(s) representing an agency cannot sign the application on behalf of the victim.			

# **DCVC:** Crime Victims' Compensation Application

Department of Crime Victim Compensation, Edgar A. Brown Bldg., 1205 Pendleton St., Rm. 401, Columbia, SC 29201 . 1.800.220.5370 or 803.734.1900 Use a separate application for each person. Incomplete or unsigned applications will not be accepted.

SECTION 1 <i>Person Receiving Services</i> Victim or family member requesting assistance.							
Check one: Mr. Mrs. Ms. Full Legal Name of Individual Receiving Services/Benefits							
Social Security # (last 5 digits) - Date of Birth Sex: Male Female							
The Person Receiving Services is the Victim (as identified on the incident report upon which this claim is based)							
OR the Victim's Spouse Parent Sibling Child Other							
Check services requested: Medical Counseling Lost Wages / Support Burial Other							
Please call a local victim advocate or DCVC if you need help with completing this form.							
SECTION 2 Victim Information The Victim is the same person listed as a victim on the law enforcement incident report.							
Check one: Mr. Mrs. Ms. Name as it appears on the incident report							
Social Security # (last 5 digits)     -     Date of Birth     Victim is:     Deceased     Incompetent       Under 18     Disabled							
Home Mailing Address (City, State, Zip)							
E-Mail Address Contact #(s) (i.e. work, cell, fax							
(For statistical purposes only and is optional) Sex: Female Male							
Race: Caucasian African American Hispanic Native American Asian or Pacific Islander Other							
SECTION 3 <i>Claimant Information</i> Complete only if: The Claimant is the adult assuming responsibility for the crime-related bills and/or the adult that has abvaired and/or the adult that has advanted as a sum of the second seco							
bills and/or the adult that has physical custody of a minor.       Check one:     Mr.       Mrs.     Full Legal Name							
Relationship to Victim Social Security # (last 5 digits) - Date of Birth							
Home Mailing Address (City, State, Zip)							
E-Mail Address Contact #(s) (i.e. work, cell, fax							
SECTION 4 Crime Information							
If law enforcement was not contacted, an incident report was not							
written within 48 hours of the crime, <u>or</u> if you are not filing this claim with DCVC within 180 days of the crime, please explain why:							
Date of Crime Date Reported Law Enforcement Agency							
Address of Crime City State							
Incident Name(s) of Offender(s)							
Was suspect arrested? Yes No Type of Crime and Injury Sustained:							
Relationship of Offender(s) to Victim     Warrant #(s)     Has the case gone to court?       Image: Construction of the second							
Please indicate the type of court: Magistrate Municipal General Sessions PTI Family Court							
How much restitution was ordered: None S Amount Ordered S Amount Paid to Date							

SECTION 5 Crime Related	Expense Information*	Attach copies of iter	mized bills (detailed bi	lls, UB92 or HCFA 1500).			
Name of Doctor/Hospital	Services Provided fr	om (date) to (date)	Phone #	Fax#			
Counselor	Services Provided fr	om (date) to (date)	Phone #	Fax#			
	Services I forlade II	on (dute) to (dute)	Those #	I UAII			
Funeral Home	Services Provided fr	om (date) to (date)	Phone #	Fax#			
SECTION 6 Health Insural	nce / Benefits Informatio	Does the viction	n have public/private l	Health Insurance? Yes No			
Please provide Health Insuranc							
Private Insurance: Policy Name			olicy Number				
Medicaid: Policy Number							
Medicare: Policy Number							
SECTION 7 Lost Wages /			east two consecutive we				
qualify for compensation for your I Report and the Physician's Disabil from the IRS, the Self-Employmen See Supplemental Forms at (http:// Employer's Information If injured on the job, does your en Have you, or will you, file for Soc	lity Report. If you were self- emp tt Verification Form, and the Phy /devc.scag.gov) to request Lost V	loyed, you must submissician's Disability Repo Vages/Support.	t your most recent Tax l				
Are you missing work to care for		Yes	No				
SECTION 8 Civil Action Info			with insurance or file a				
If yes, please provide: Name of L Mailing Address	Lawyer		Phone #				
SECTION 9 Referral Source	e Information Solici	tor LEVA H	lospital/Dr. Coun	selor Other			
Name/Title of Professional Assisting with Application							
Phone #	Fax #	Agency/Office					
Mailing Address							
County Referral's Email Address							
SECTION 10 Legal Author	ization & Signature						
I understand that I am responsible f this application does not entitle me information or records to determine further understand that there is a pot at any point I so desire. I agree to re may receive from the offender, any including settlement disbursements,	for all bills and the compensation period to benefits. I authorize the Deparent to benefits. I authorize the Deparent to benefits. I authorize the Deparent to be benefits of my claim or to be benefit for me to no longer be protected by DCVC if I receive money from insurance policy or settlements, ju, negotiated medical bills, and all of benefits and the best of th	program is designated to artment of Crime Victim obtain restitution for a p ted by the Privacy Rule, om another source, up to adgments, or civil law su ther records related to su <b>numbers, to maintain</b> <b>f my knowledge under</b>	a Compensation (DCVC) period not to exceed the and that I have the right to be the amount paid on my uits. I authorize DCVC to brogation from myself or accuracy in the process penalty of law (§16-3-1	vered by another source. Submitting to request, obtain, and release any full processing of this application. I prevoke this authorization in writing behalf. This includes any payment I request and obtain any information representatives acting on my behalf. sing of this claim. Incomplete or			
Print Name of Above Victim/Claimant							
The nume of Above vicinit/Cu							