

OFFICE OF THE ATTORNEY GENERAL

Crime Victim Compensation Division
Post Office Box 220
Jackson, Mississippi 39205-0220
1-800-829-6766 or 601-359-6766
601-576-4445 (FAX)
www.ago.state.ms.us (WEB)



For Office Use Only

CLAIM NO. _____

Received Date: _____

VICTIM COMPENSATION APPLICATION

APPLICATION MUST BE COMPLETED, SIGNED AND NOTARIZED. IT IS THE RESPONSIBILITY OF THE VICTIM/CLAIMANT TO NOTIFY THIS DIVISION OF ANY CHANGES TO ADDRESS OR TELEPHONE NUMBERS.

Instructions

Please read the enclosed "General Eligibility Requirements" to see if you may qualify for this program. Fill out this form completely (please print). Attach any required documentation, including all itemized bills, and mail to the above address. If the victim is deceased, include itemized funeral burial expenses.

CHECK THE TYPE OF VICTIM COMPENSATION BENEFITS YOU ARE REQUESTING:

- | | |
|---|---|
| <input type="checkbox"/> Medical Expenses | <input type="checkbox"/> Transportation (funeral) |
| <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Domestic Violence Relocation Assistance |
| <input type="checkbox"/> Mental Health Counseling (victim) | <input type="checkbox"/> Domestic Violence Temporary Housing Assistance |
| <input type="checkbox"/> Mental Health Counseling (family member) | <input type="checkbox"/> Court Related Travel Expenses |
| <input type="checkbox"/> Transportation (Medical/MHC) | <input type="checkbox"/> Crime Scene Cleanup Assistance |
| <input type="checkbox"/> Funeral Expenses | <input type="checkbox"/> Repair/Replacement Expenses |
-
- | | |
|---|--|
| <input type="checkbox"/> Loss of Wages (victim) | <input type="checkbox"/> Loss of Wages (funeral) |
| <input type="checkbox"/> Loss of Wages (claimant) | <input type="checkbox"/> Loss of Support (dependents of deceased victim) |
| <input type="checkbox"/> Loss of Wages (court proceeding) | |

SECTION A – Victim Information

A. Please type or print legibly with ink. B. A separate application must be completed for each victim who received injuries. C. If a person witnessed the crime and is requesting mental health counseling, complete a separate application.

1. Victim's Name _____ 2. Marital Status _____
3. Mailing Address _____ 4. City/State/Zip _____
5. County _____ 6. Home Phone () _____ 7. Work Phone () _____
8. Date of Birth: _____ 9. Age: _____ 10. Social Security #: _____
11. E-mail Address: _____
12. Briefly describe your injuries: _____

13. The following information is used for statistical purposes only and is needed to comply with federal regulations.

- | | | |
|--|---|---|
| A. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male | D. Race: | <input type="checkbox"/> Asian/Pacific Islander |
| B. Handicapped Before Crime <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> African American | <input type="checkbox"/> Caucasian |
| C. Handicapped After Crime <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Hispanic |
| | <input type="checkbox"/> American Indian | <input type="checkbox"/> Other |

SECTION B – Claimant Information

- A. Complete this section if you are filing on behalf of the victim. B. Claimant is the person responsible for the victim if the victim is a minor, deceased or incapable of acting on his/her behalf. C. Claimant can also be the person legally responsible for the dependent(s) of a deceased victim.

1. Claimant's Name _____ 2. Relationship to Victim _____
3. Mailing Address _____ 4. City/State/Zip _____
5. Home Phone () _____ 6. Work Phone () _____
7. Date of Birth: _____ 8. Age: _____ 9. Social Security #: _____
10. E-mail Address: _____

SECTION C – Crime Information

1. Type of Crime (please check one)

- Assault Sexual Assault Child Physical Abuse DUI
 Homicide Child Sexual Abuse Domestic Violence Other (specify): _____

2. Date of Crime: _____ 3. Date Crime Reported: _____
4. Name of Law Enforcement Agency Crime Reported To: _____
5. Police Incident Report # _____ 6. Officer's Name _____
7. Name of Offender(s) _____
8. Did Victim Know Offender(s) Yes No If yes, in what way? _____
9. Location of Crime: Street _____ 10. City/State _____ 11. County _____
12. Were charges filed against the offender? Yes No 13. Has an arrest been made? Yes No Unknown
14. Has the case gone to trial? Yes No Unknown If yes, when? _____
Result? _____
15. Court case or cause # _____ 16. Prosecuting attorney _____
17. Has the court ordered the offender to pay restitution (pay you back)? Yes No Unknown

SECTION D – Employment Information

Complete this section only if:

- A. the victim was employed at the time of the crime and has had a loss of wages due to the crime related injuries; or
B. the claimant missed work and had a loss of wages in order to assist the victim during the victim's recovery from injuries; or
C. the claimant missed work and had a loss of wages in order to make arrangements for or to attend the victim's funeral.

Request for lost wages is for Victim Claimant

Note: Victim and claimant may both receive compensation for lost wages. Both awards cannot exceed the maximum of \$600 per week.

1. Dates absent from work due to crime: From _____ To _____
2. Employer: _____ 3. Employer Phone # _____
4. Employer Address: _____ 5. City/State/Zip _____
6. Job Title: _____ 7. Supervisor's Name _____
8. Are you self-employed? Yes No If you are self-employed, attach a copy of your latest federal income tax form.

SECTION E – Loss of Support for Dependent(s)

Complete this information only if the victim financially supported dependent(s) at the time of death.

1. Did victim contribute financial support to any dependent at the time of death?
 Yes No If yes, list dependents (Attach additional sheet if necessary)

Name	Address – if different from claimant's address	Social Security #	Relationship to Victim	Date of Birth Month/Day/Year

2. Attach a copy of the victim's latest income tax form and proof of dependency. (You may be asked for more information to determine dependency and actual loss of support.)

SECTION F – Insurance and Other Collateral Source Information

By law, the Crime Victim Compensation Division is payer of last resort and must verify all sources available for payment of expenses. This section must be completed. Please check each source that applies.

1. Source	YES	NO	APPLIED FOR	N/A
Health Insurance.....				
Automobile Insurance				
Social Security: SSI.....				
Social Security: Disability.....				
Social Security: Death Benefits.....				
Workers' Compensation.....				
Medicaid.....				
Medicare.....				
Veteran's Administration.....				
Unemployment Compensation.....				
Disability Pay.....				
Life Insurance.....				
Amount of Policy _____				
Beneficiary _____				
Relationship to Victim _____				
Burial Insurance				
Amount of Policy _____				
Donations for Funeral Expenses				
Amount _____				
Other (specify) _____				

2. Please list name, address and telephone number for each insurance company indicated above.

Insurance Company	Address	Telephone Number

3. If a car was involved in the crime, list the name and address of the offender's automobile insurance company.

SECTION G – Attorney Information

1. Have you filed or are you considering filing a civil action against the offender or some other third party for expenses as a result of the crime? Yes No If yes, please complete the following:

A. Attorney's Name _____ B. Telephone # _____

C. Mailing Address _____

SECTION H – Referral Information

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Children Services | <input type="checkbox"/> Funeral Home | <input type="checkbox"/> Mental Health Counselor | <input type="checkbox"/> Sexual Assault Crisis Center |
| <input type="checkbox"/> City/County Agency | <input type="checkbox"/> Hospital/Doctor | <input type="checkbox"/> Mothers Against Drunk Driving | <input type="checkbox"/> Survivor of Homicide Agency |
| <input type="checkbox"/> District Attorney | <input type="checkbox"/> Law Enforcement Agency | <input type="checkbox"/> Other Social Service Agency | <input type="checkbox"/> Victim Assistance Coordinator |
| <input type="checkbox"/> Domestic Violence Shelter | <input type="checkbox"/> Media (TV, Radio, Newspaper) | <input type="checkbox"/> Poster/Brochure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Elderly Services | | | |

SECTION I – Authorization, Consent and Subrogation

CERTIFICATION OF APPLICATION: I hereby certify, subject to the penalty of fine and imprisonment, that the information contained in the application for crime victim compensation is true and correct to the best of my knowledge.

CONSENT: I acknowledge and agree that all or any part of the compensation award may be paid directly, at the discretion of the Crime Victim Compensation Division, to the person(s) to whom payment is owed.

SUBROGATION: I agree to immediately repay any award(s) to the Crime Victim Compensation Division, if I later recover the money through legal action or otherwise. Furthermore, I agree to notify the Crime Victim Compensation Division in writing prior to filing a civil lawsuit resulting from the criminal action. In consideration of any award made by the Crime Victim Compensation Division, I agree to subrogate to the Crime Victim Compensation Division, or its representatives, any information requested, including tax data and prior police records, needed to perfect my claim for compensation.

AUTHORIZATION: I hereby authorize, in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 45 C.F.R. § 164.508) any hospital, physician, health care provider, mental health care provider; any funeral director or other person who rendered related services; any employer of the victim or claimant; any law enforcement or governmental agency, including state or federal taxing authorities; any insurance company; or any other individual, company, agency or organization having relevant knowledge, to furnish to the Crime Victim Compensation Division, any and all information in their possession with respect to the incident that is the basis for this claim.

NOTICE:

•The individual signing this Authorization may request the entity provide them with both a copy of the Authorization and a copy of the Protected Health Information (PHI) to be disclosed.

•The individual signing this Authorization has the right to revoke this Authorization at any time, provided the revocation is in writing, except to the extent that the entity has already relied upon this Authorization to disclose PHI.

A photocopy of this Authorization shall be considered as effective and valid as the original.

This Authorization will expire in 3 years from the date the victim/claimant signed below or when this claim is resolved.

I certify that I have read and/or understand, and agree to the above statements.

Victim/Claimant Signature

Date

Sworn to and subscribed before me the undersigned Notary on this the _____ day of _____, _____.

Notary Public: _____ My Commission Expires: _____.