



Kentucky Claims Commission - Crime Victims Compensation
130 Brighton Park Blvd., Frankfort, KY 40601
Office 502-782-8255 Fax 502-573-4817

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 in ink or type information. SIGN ON PAGE 5, SECTION XIV.
- A copy of a police report or other documentation will be required. If you cannot obtain a copy, state this on your application and CVC staff will contact law enforcement.
- Mail this completed form, along with all required documentation, to the address above.
- The victim must have been an innocent victim of a crime or some type of conduct that could be charged as a crime (a conviction is not required).
- The Claimant that is 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, the parent of a minor child, or a surviving spouse, parent, or child of a victim of criminally injurious conduct who died as a direct result of such conduct who has paid or owes expenses related to the crime.
- Only qualifying expenses for which the victim/Claimant has no other source of payment can be considered.
- The incident must have been reported to law enforcement officials within 48 hours. If the incident was not reported within the required timeframe, a justifiable reason must be provided.
- The victim/Claimant must cooperate with law enforcement officials and the prosecution (i.e. testify and/or provide whatever truthful information is required to prosecute the alleged offender).
- The deadline for filing a claim with Crime Victims Compensation is five years from the date of the crime unless good cause can be shown for the delay in filing.
- State law does not allow for payment for any property loss or damage, except for corrective lenses and dentures destroyed or lost as a result of the crime.
- CVC awards are capped at \$5,000.00 for funeral/burial expenses and \$25,000.00 total for all expenses resulting from the crime.
- The Employment Verification Form and Physician Statement must be completed if the victim/Claimant is applying for lost wages.
- The Mental Health Counselor's Report must be completed if the victim/Claimant is applying for mental health counseling or where applicable for lost wages (if the victim/Claimant lost time from work due to psychological trauma due to the crime).
- Applications without a government-issued ID number for the victim and/or Claimant may be dismissed.

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| <p style="text-align: center;">FOR OFFICE USE ONLY</p> <p style="text-align: center;">CLAIM #:</p> <hr style="width: 80%; margin: 5px auto;"/> <p style="text-align: center;">INVESTIGATOR:</p> <hr style="width: 80%; margin: 5px auto;"/> | <p>Kentucky Claims Commission Crime Victims Compensation 130 Brighton Park Blvd. Frankfort, KY 40601 Office 502-782-8255 Fax 502-573-4817</p> | <p style="text-align: center;">FOR OFFICE USE ONLY (DATE STAMP)</p> |
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Section I: Victim Information *(to be completed by victim or Claimant)*

Victim's Name: _____ SSN or Gov't ID #: _____

Date of Birth: _____ Age: _____ at time of crime Male _____ Female _____

Address: _____
City
State
Zip Code

Telephone #: (Home) _____ (Work) _____ (Cell) _____

E-Mail: _____

Section II: Claimant Information *(to be completed by the person filing on behalf of a victim)*

Claimant's Name: _____ Relationship to Victim _____

SSN or Gov't ID #: _____ Date of Birth: _____ Male _____ Female _____

Address: _____
City
State
Zip Code

Telephone #: (Home) _____ (Work) _____ (Cell) _____

E-Mail: _____

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| <p>Section III: Crime Information <i>(Attach a copy of the police report)</i></p> <p>Location of Crime: _____ Address City County</p> <p>Date of Crime: _____ Date Reported: _____</p> <p>Crime Reported To: _____ Law Enforcement Agency</p> <p>Reported within 48 hours of discovery? _____ Yes _____ No If no, please explain why: _____</p> <p>Name of Offender(s): _____</p> <p>Offender(s) charged with a crime? _____ Yes _____ No If yes, what charge(s)? _____</p> <p>What Court? District: _____ Circuit: _____ Juvenile: _____</p> | <p>Type of Crime (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arson <input type="checkbox"/> Assault <input type="checkbox"/> Burglary <input type="checkbox"/> Child Physical Abuse / Neglect <input type="checkbox"/> Child Pornography <input type="checkbox"/> Domestic Assault <input type="checkbox"/> DUI / DWI <input type="checkbox"/> Fraud/ Financial Crimes <input type="checkbox"/> Homicide (Murder) <input type="checkbox"/> Human Trafficking <input type="checkbox"/> Kidnapping <input type="checkbox"/> Other Vehicular Crimes <input type="checkbox"/> Robbery <input type="checkbox"/> Sexual Assault Adult <input type="checkbox"/> Sexual Assault Child <input type="checkbox"/> Stalking <input type="checkbox"/> Terrorism <input type="checkbox"/> Other |
|---|--|

Section IV: Describe what happened (If known, please explain the reason for the crime. If you need additional space, feel free to attach a separate sheet of paper).

Section V: Describe any injuries (If you need additional space, feel free to attach a separate sheet of paper).

Section VI: Medical/Dental 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 an itemized billing statement attached, including date, type, and charge for service. If you need additional space, feel free to attach a separate sheet of paper).

| Provider Name | Total Amount Charged | Amount Insurance Covered | Claimant/Victim Out of Pocket | Current Balance |
|---------------|----------------------|--------------------------|-------------------------------|-----------------|
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Section VII: Mental Health 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 an itemized billing statement attached, including date, type, and charge for service. If you need additional space, feel free to attach a separate sheet of paper).

| Provider Name | Total Amount Charged | Amount Insurance Covered | Claimant/Victim Out of Pocket | Current Balance |
|---------------|----------------------|--------------------------|-------------------------------|-----------------|
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Section VIII: Funeral/Burial Expenses (This section is to be filled out only if the victim is deceased. A signed funeral service contract 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 contributions or donations).

Life Insurance:\$ _____ Workers Comp: \$ _____ Funeral/Burial Insurance:: _____

Social Security:\$ _____ Estate: _____ Other: _____

Donations (including crowd funding websites) _____

Name of Funeral Home : _____

Address: _____ Telephone No. _____
 Street City State Zip

Total of Funeral Expenses: \$ _____ Have they been paid? () Yes () No

If yes, by whom: _____ Relationship to the victim: _____

Section IX: Other sources of payment (Please check all sources of payment that the victim/Claimant had at the time of the crime or received due to the crime. Documentation will be required).

- () Medicaid () Medicare () Worker's Compensation () Health Insurance () Auto Insurance
- () Health Insurance () Veteran's Benefits () Other (please specify) _____

Section X: Lost Wages

What was the victim/Claimant's employment status at the time of the crime? () Employed () Unemployed

If employed, did the victim/Claimant lose time from work due to the crime? () Yes () No

If employed, is the victim/Claimant applying for lost wages? () Yes () No

If the victim/Claimant is applying for lost wages:

- the Employment Verification Form must be submitted. **The form must be completed by the EMPLOYER and must be NOTARIZED.**
- The Physician Statement and/or Mental Health Counselor's Report must be completed and **signed by the Physician or Licensed Therapist.**

If the victim/Claimant was self-employed at the time of the crime, copies of both State and Federal tax returns for the two year period prior to the crime must be submitted.

Section XI: Loss of Support (Fill out this section if you are financially dependent on the victim or filing for someone who is financially dependent on the victim).

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 **NOTARIZED.**

List income you now receive 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)

If the victim was self-employed at the time of the crime, copies of both State and Federal tax returns for the two year period prior to the crime must be submitted.

Section XII: Federal Government Information (optional/for statistical use only)

Ethnic Group (Victim/Claimant)

- () Caucasian
- () African American
- () American Indian or Alaskan Native
- () Hispanic / Latino
- () Multiracial
- () Asian
- () Native Hawaiian / Other Pacific Islander
- () Other

Are you? (please check all that apply)

- () U.S. Citizen () Handicap () Kentucky Resident

Who referred you to the compensation program?

- () Law Enforcement () Hospital () Victim Advocate
- () Prosecutor () Judge () Other _____

Is this a Federal Crime? () Yes () No

Section XIII: Restitution and Civil Lawsuit (Enter information regarding any payments the court has ordered to be paid by the offender or any settlement you have received or will receive as the result of a lawsuit).

Has the victim and/or Claimant filed or plan to file a civil suit against anyone relating to the injury received as a result of the crime? () Yes () No

If yes, name of attorney: _____ Telephone: _____

Address: _____
Street City State Zip

Was the offender ordered by the court to pay restitution? () Yes () No If yes, amount: \$ _____

Section XIV: Authorization and Subrogation (THIS PAGE MUST BE SIGNED AND INCLUDED WITH YOUR APPLICATION).

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 Kentucky Claims Commission, 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 agree to repay such amount up to the full amount I received 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 Kentucky Claims Commission 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 sources, I agree to promptly notify the Kentucky Claims Commission by sending copies of any pleadings, settlement proposals and any other documents relative thereto. I further agree to fully cooperate with the Kentucky Claims Commission should the Commission 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 by the Kentucky Claims Commission. 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.

YOUR SIGNATURE: _____ **DATE:** _____

Attorney's Name: _____ Social Security or Fed ID #: _____

Address: _____ Telephone: _____

Attorney's 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 the application as well.

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EMPLOYMENT VERIFICATION FORM
Complete only if applying for lost wages/loss of support
To be completed and signed by employer only. This form must be NOTARIZED.

Employee's Name: _____ Social Security #: _____

Date of Crime: _____ Was the employee employed at the time of crime? () Yes () No

If the employee was employed at the time of the crime, please complete the following:

Employer's Name: _____ Telephone: _____

Employer's Address: _____
City State Zip Code

Did the employee miss time from work because of injuries related to the crime: () Yes () No

If yes, please provide the dates missed. 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)

Has the employee returned to work: () Yes () No Did the employee's wages continue while off work: () Yes () No

If the employee's wages continued while off work, please complete the following:

| Deductions | Amount Per Week | Starting Date | Ending Date |
|--------------------|-----------------|---------------|-------------|
| Workers Comp | \$ | | |
| Unemployment | \$ | | |
| Insurance – Health | \$ | | |
| Insurance – Other | \$ | | |
| Vacation | \$ | | |
| Sick | \$ | | |
| Employers Group | \$ | | |
| Disability | \$ | | |
| Union | \$ | | |
| Other | \$ | | |

 Employer's Name and Title *(please print)*

 Employer's Signature

The following must be completed by a Notary Public:

The foregoing was SUBSCRIBED AND SWORN TO BEFORE ME BY _____ on this _____ day of _____, 20____. My commission expires _____.

Signature: _____

Affix stamp or seal here

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PHYSICIAN STATEMENT
To be completed and signed by PHYSICIAN only.
Complete only if applying for lost wages.

Patient Name: _____

Type of Injury: _____

Date of Injury: _____ Date(s) patient unable to work: _____ to _____

Did the patient suffer permanent disability due to the crime? ()Yes ()No

If yes, please state the victim's percentage of permanent disability to the body as a whole in accordance with the AMA Guidelines:

Please describe the injury/trauma sustained by the patient due to the crime and any comments you may like to add:

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Name of Physician: _____

Office Address: _____
Address City State Zip Code

Telephone: _____ State License Number: _____

Physician's Signature

Date

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MENTAL HEALTH COUNSELOR'S REPORT

To be completed by COUNSELOR only. Must include an attached Treatment Plan.
Complete only if applying for mental health counseling or where applicable for lost wages.

Name of client receiving treatment: _____

Crime Date: _____ Date(s) client was unable to work: _____ to _____

Was the trauma and treatment received a direct result of this crime? ()Yes ()No

Presenting Complaint(s): _____

Diagnosis(es) of Record: _____

Please provide a brief description of the psychological trauma that resulted from the crime:

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Health Insurance: _____
Company Name Phone Number/ Extension

_____ Address City State Zip Code

****A PATIENT TREATMENT PLAN MUST BE ATTACHED****

Name of Physician/Therapist/Counselor: _____ Specialty: _____

Office Address: _____
Address City State Zip Code

Telephone: _____ State License Number: _____

Physician/Therapist/Counselor Signature

Date