CRIME VICTIM COMPENSATION PROGRAM APPLICATION INFORMATION

An application may be filed by, or on behalf of, a person who was injured or died as a result of the crime. The Program may help with certain expenses such as medical or mental health bills or other losses directly related to the crime. **Personal property losses including cash and "pain and suffering" cannot be reimbursed by the Program.**

WHAT TO DO

- **PLEASE PRINT CLEARLY.** Separate applications must be completed for each injured victim.
- Enclose ***itemized*** copies of crime-related medical bills. Send copies of other itemized crime-related medical bills as they are received. This Program requires that the bills be itemized.
- Crime-related medical bills must first be sent to all other payment sources available, i.e. health insurance, Medical Assistance, Badger Care or another payment source. You must use a medical provider that accepts your insurance plan. Otherwise, this Program may not be able to reimburse for those expenses.
- This Program may pay expenses incurred within 4 years of the date of the crime or until the claim reaches $40,000 maximum, whichever comes first.
- Send the completed application to the Crime Victim Compensation Program as soon as possible. Do **not** wait until court is over or treatment is completed.
- Return the completed application to the address listed on the bottom of this page. The applicant will receive a letter or, if specified, an email from the Crime Victim Compensation Program acknowledging receipt of the application. Notify the Program of any change in address, email or phone number. If you have any questions, call the Office of Crime Victim Services at 608-264-9497 or 1-800-446-6564. **Keep this information sheet for your reference.**

ELIGIBILITY REQUIREMENTS

Eligibility for Crime Victim Compensation:

- The crime must be reported to law enforcement within 5 days of the date of the crime or within 5 days of the time when a report could reasonably be made.
- The application must be filed within 1 year of the crime date.
- These requirements may be waived in the interest of justice. If the crime was not reported within 5 days or the application was not filed within 1 year, include a brief but detailed written reason for the delay.
- The victim must cooperate with the investigation and prosecution of the case.
- A restitution request must be made to the District Attorney's Office if the criminal case is being prosecuted. Provide all restitution information promptly to the District Attorney's Office as they request it.
- Parents of victims who are under the age of 18 may be eligible for lost wages and counseling expenses incurred due to the crime. Limits apply and itemized bills or documents are required.
- Adults victimized as children can apply for benefits. The program can pay eligible expenses for four years or $40,000 maximum. Other eligibility requirements still apply.

NOTE: If a claim is approved, the Program may be able to assist certain family/household members of the deceased victim with losses due to emotional/physical reactions to the death. More information can be obtained by calling the Crime Victim Compensation Program.

- Any money received from other sources such as restitution, lawsuits, insurance settlement, etc. **must be repaid** to the Crime Victim Compensation Program for crime related expenses paid by the Program.

Wisconsin Department of Justice
Crime Victim Compensation Program
Post Office Box 7951
Madison, WI 53707-7951
(608) 264-9497 or 1-800-446-6564 (Toll-free)
www.doj.state.wi.us/ocvs

All information will be verified by the Crime Victim Compensation Program.
Section 949.17 of the Wisconsin Statutes provides penalties for persons who submit fraudulent applications.

CRIME VICTIM COMPENSATION APPLICATION

Post Office Box 7951
Madison, WI 53707-7951
(608) 264-9497 or 1-800-446-6564 (Toll-free)
WI Statutes Chapter 949

CLAIM NO: ____________

DATE RECEIVED:

(For Office Use Only)

PLEASE BE SURE TO SIGN THE APPLICATION ON THE LAST PAGE

THE APPLICATION MUST BE FILED WITHIN 1 YEAR OF THE DATE OF THE CRIME

SECTION 1: VICTIM/DECEASED VICTIM INFORMATION

1. Victim's First Name | Victim's Last Name | 2. ☐ Female ☐ Male | 3. Date of Birth / /

Age at time of the crime: ☐ 0-12 ☐ 13-17 ☐ 18-24 ☐ 25-59 ☐ 60 and older

4. Social Security Number | 5. Mailing Address

6. City | 7. State | 8. Zip Code | 9. County

10. Home Telephone ( ) | 11. Cell Phone ( ) | 12. Work Telephone ( ) | 13. E-mail

I prefer to be contacted by e-mail. ☐ Yes ☐ No

14. Is the victim/applicant represented by an attorney due to this crime:

In filing this application? ☐ Yes ☐ No
In a civil lawsuit? ☐ Yes ☐ No
In an insurance action? ☐ Yes ☐ No

15. Name of Attorney | Telephone ( )
Street Address | E-mail
City | State | Zip Code

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

A. Disabled

Before Crime: ☐ Yes ☐ No
After Crime: ☐ Yes ☐ No

B. Race/Ethnicity:

☐ White/Caucasian ☐ Asian
☐ Black/African American ☐ Hispanic/Latino
☐ American Indian/Alaskan Native ☐ Multiracial
☐ Hawaiian/Other Pacific Islander ☐ Other

Do you need a Spanish interpreter? ☐ Yes ☐ No

If you need interpretation services in another language, please identify the language: ____________

C. How did you learn about the Compensation Program? (Check all that apply)

☐ Law Enforcement ☐ Attorney ☐ Probation or Parole ☐ Friend ☐ Poster or Brochure
☐ District Attorney ☐ Sexual Assault Program ☐ Newspaper ☐ Relative ☐ Public Service Announcement
☐ Victim/Witness Program ☐ Domestic Abuse Program ☐ Funeral Director ☐ Hospital ☐ Other

SECTION 2A: PERSON FILLING OUT THE APPLICATION IF VICTIM IS A MINOR, HAS A GUARDIAN, OR IF VICTIM IS DECEASED

1. Person's Name | 2. Relationship to Victim

3. Mailing Address | 4. City | 5. State | 6. Zip Code

7. Home Telephone ( ) | 8. Cell Phone ( ) | 9. Work Telephone ( ) | 10. E-mail

SECTION 2B: THIS SECTION IS FOR VICTIM ADVOCATES OR VICTIM WITNESS STAFF WHO ARE PROVIDING ASSISTANCE

1. Name | 2. Organization/Title | 3. Work Phone ( )

4. Address | 5. E-mail | 6. Preferred/Alternate Contact for Victim

SECTION 3: CRIME INFORMATION

1. Type of Crime (Check all that apply)

☐ Homicide ☐ Domestic Violence ☐ Hit and Run of Pedestrian, Bicycle or Buggy ☐ Drunk Driving / DUI
☐ Attempted Homicide ☐ Child Physical Abuse ☐ Sexual Assault ☐ Other ______
☐ Assault/Battery ☐ Child Sexual Abuse ☐ Robbery

Did the crime involve? ☐ Domestic or Family Violence ☐ Bullying ☐ Elder Abuse ☐ Hate Crime ☐ Mass Violence

2. Location of Crime: Street Address	3. City	4. State	5. County

6. Date of Crime / /	7. Date Crime Reported / /	8. Law Enforcement Agency to which crime was reported	Officer's Name

If crime date is approximate, provide details.

9. Offender(s) Name(s):

10. Did victim know offender(s)? ☐Yes ☐No If yes, in what way?

Description of crime (optional):

SECTION 4: MEDICAL/MENTAL HEALTH EXPENSE INFORMATION

1. Name and address of medical facility where victim was **first treated:**	2. Date of Treatment: / /

3. Mental Health Treatment received, or to be received? By victim? ☐ Yes ☐ No ☐ Unknown By parent? ☐ Yes ☐ No ☐ Unknown

SECTION 5: MISCELLANEOUS EXPENSES

Caretaker Services $ ______ Documented Crime Scene Cleanup $ ______
Securing a Crime Scene $ ______ Modifications to home to accommodate a disability $ ______
Clothing/bedding/telephone/electronic devices held as evidence and the reasonable replacement value of each:

______ $______ ______ $______
______ $______ ______ $______

SECTION 6: INSURANCE AND BENEFIT INFORMATION

1. Was there insurance or other source of payment to cover expenses at the time of the crime? ☐ Yes ☐ No
   Please attach copies of any crime-related itemized bills and explanations of benefits.

2. Check all that apply:

☐ Employers/Union Group ☐ Workers' Compensation ☐ Medical Assistance/Title 19 ☐ Homeowners Insurance
☐Veterans' Benefits ☐ County Assistance ☐ Victim/Spouse/Parent Insurance ☐ Badger Care
☐ Lawsuit ☐Disability ☐ Medicare ☐ Other (describe) ______

SECTION 7: CRIMES INVOLVING MOTOR VEHICLES

Did the victim have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company and policy limits:
Did the driver have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company and policy limits:
Did the offender have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company and policy limits:

SECTION 8: EMPLOYMENT INFORMATION

Complete the section **ONLY** if the victim/parent was employed at the time of injury.

1a. Did victim miss time from work immediately following the crime?
☐ Yes ☐ No ☐ Unknown

1b. Did parent of a minor victim miss work immediately following the crime?
☐ Yes ☐ No ☐ Unknown

2a. Is the victim/parent self-employed?
☐ Yes ☐ No

2b. May we contact your employer?
☐ Yes ☐ No

3. Dates absent from work due to crime related injuries: From ______ To ______

4. Name of Employer	5. Employer Telephone ( )

6. Employer Mailing Address	7. City	8. State	9. Zip Code

FOR CRIME RESULTING IN DEATH

SECTION 9: FUNERAL/BURIAL EXPENSES

1. Funeral Home Name		2. Mailing Address	
3. City	4. State	5. Zip Code	6. Telephone ( )

7. Life Insurance ☐ Yes ☐ No ☐ Unknown Amount: $ ____________ Beneficiary ______________________________

SECTION 10: DEPENDENTS FINANCIALLY SUPPORTED BY VICTIM AT TIME OF DEATH

First Name	Last Name	Date of Birth Month / Day / Year	Relationship to Victim
		/ /	
		/ /	
		/ /	

AGREEMENT

- My signature below means that I certify that information on this application is true and correct.
- I agree that payments for bills may be paid directly to whom the payment is owed.
- I understand that the Crime Victim Compensation Program reimburses for costs not covered by any other source.
- I agree to notify the Crime Victim Compensation Program if a lawsuit is filed.
- I agree to repay the Crime Victim Compensation Program for all payments made if I receive money from any other source.
- I agree to refund the Crime Victim Compensation Program for all money paid by the Program if this claim is determined to be false or fraudulent.

AUTHORIZATION

I authorize and request any person having information needed by the Crime Victim Compensation Program to process my claim to release that information to the Wisconsin Department of Justice. That includes, but is not limited to, all past law enforcement records or child support agency records concerning me; private and governmental physicians and hospitals; all billing information; local, state and federal law enforcement and prosecutors office and federal court personnel; any employer, unemployment compensation insurance program, workers compensation program; and any private company or governmental agency that is providing or may provide medical or monetary benefits. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I authorize the Crime Victim Compensation Program to release copies of crime-related medical bills and wage information to the Office of the District Attorney for determination and documentation of restitution. I certify that I understand and agree to the above statements.

____ ______________________

Signature of Victim or Authorized Applicant (see below) Date

The **victim** must sign and date the application form. If the victim is under the age of 18, the **parent** or **guardian** must sign and date the application form. If the victim is deceased or an incapacitated adult victim, the **applicant** or **legal representative** must sign and date the application form.

RETURN COMPLETED APPLICATION TO:

Wisconsin Department of Justice
Crime Victim Compensation Program
Post Office Box 7951
Madison, WI 53707-7951
FAX (608) 264-6368

FOR ASSISTANCE CALL: In Madison (608) 264-9497
Toll Free 1-800-446-6564