Violent Crimes Compensation Board

Application for Crime Victim Compensation

Include any documentation you may have available such as a copy of the police report, bills, receipts or other crime-related information. If you do not have any of this documentation, you do not need to wait to mail the application. Information can be provided to our office as it becomes available.

If you require additional space on any section of the application, please attach a separate sheet of paper.

If your address or phone number changes, it is important to update your information with our office.

For assistance in completing the application, you may call our office at 1-800-764-3040. Victim advocates, social workers, victim-witness paralegals in the prosecutor's office, and victim-witness coordinators at local police departments may also be available to assist you.

Submit the completed application by mail, email or fax.

VCCB
PO Box 110230
Juneau, AK 99811

Fax: 907.465.2379

Email: doa.vccb@alaska.gov

Application for Crime Victim Compensation

Section 1 Claimant

An application must be completed for each person seeking assistance, per incident. The claimant is the person who incurred expenses or is seeking assistance as a result of a crime. If you are filing on behalf of a minor child, incapacitated or deceased victim, enter your information in Section 1 and the victim's information in Section 2.

Your Name:_____ Sex ☐ M ☐ F

Mailing Address_____ City/State/Zip_____

Residential Address_____ City/State/Zip_____

SSN_____ Date of Birth _____

Home Telephone_____Cell phone_____ Other _____

Email address_____

If you are not the victim, please identify your relationship to the victim

☐ Child ☐Parent ☐Sibling ☐Spouse/Domestic Partner ☐Stepchild/Adopted Child ☐Other: _____

Section 2 Victim Information

The victim is the person who was injured, threatened with injury, or killed.

Name:_____ Sex ☐ M ☐ F

Mailing Address_____ City/State/Zip_____

Residential Address_____ City/State/Zip_____

SSN_____ Date of Birth _____

Home Telephone_____Cell phone_____ Other _____

Email address_____

Section 3 Crime Information

Date of Crime _____ Date Reported _____

Crime Location _____ Did the crime occur on the job? ☐ Yes ☐ No

Law Enforcement Agency _____ Report Number _____

Prosecution Case Number (if offender is being charged with the crime) _____

Name of Person who Committed Crime _____

Relationship to victim, if any _____ Is the offender a juvenile? ☐ Yes ☐ No ☐ Unknown

Type of Crime

☐Arson I ☐Assault ☐Child Physical Abuse ☐Child Sexual Abuse ☐Domestic Assault ☐DUI ☐Homicide

☐Kidnapping ☐Robbery ☐Sexual Assault ☐Threats to Harm ☐Vehicular Assault ☐Other: _____

Section 4 Expenses

Select the type of expenses you are requesting. Please attach any receipts, bills, or invoices.

☐Bedding and/or clothing taken for evidence ☐Childcare

☐Counseling ☐Crime Scene Cleanup

☐Dental ☐Funeral or Burial

☐Lost wages ☐Lost support for dependent of deceased victim

☐Medical ☐Relocation

☐Security Measures ☐Transportation

☐Trial or Sentencing Attendance ☐Other: _____

EMERGENCY AWARD:

Do you wish to request an emergency award (subject to eligibility)?

☐Counseling ☐Funeral ☐Lost Wages ☐Relocation ☐Security

What is the nature of the emergency? _____

_____

Section 5 Medical Providers and Insurance Information

Complete this section if you are requesting compensation for medical, dental or mental health treatment. Provide insurance information and list any providers seen in relation to the crime. If the victim is a minor and covered by someone else's insurance, provide the insurance information on behalf of the primary insured party.

Insurance Information

Insurance Company Name ____

Telephone Number ____ Policy Number_________________________

Name of Insured ____Relationship to victim ___________________

Please check if you have any of the following:

☐Denali KidCare ☐Indian Health Services ☐ Medicaid ☐ Medicare ☐ Social Security Disability
☐Veteran Affairs ☐Other:

Auto Insurance (for crimes involving DUI, hit and run or vehicular assault)

Insurance Company Name ____

Policy Number_______________________________________Name of Insured ________________________________

Have you filed an insurance claim related to this crime: ☐ Y ☐ N

Provider Information

Facility or Provider Name	Telephone Number	Date of Service	☐Counseling ☐Dental ☐Medical ☐Other:_________
Facility or Provider Name	Telephone Number	Date of Service	☐Counseling ☐Dental ☐Medical ☐Other:_________
Facility or Provider Name	Telephone Number	Date of Service	☐Counseling ☐Dental ☐Medical ☐Other:_________
Facility or Provider Name	Telephone Number	Date of Service	☐Counseling ☐Dental ☐Medical ☐Other:_________
Facility or Provider Name	Telephone Number	Date of Service	☐Counseling ☐Dental ☐Medical ☐Other:_________
Facility or Provider Name	Telephone Number	Date of Service	☐Counseling ☐Dental ☐Medical ☐Other:_________
Facility or Provider Name	Telephone Number	Date of Service	☐Counseling ☐Dental ☐Medical ☐Other:_________

Section 6 Employer Information

Complete this section if lost wages are being requested.

Employer _____ Contact Person _____

Employer Address _____

Telephone Number_____

Would you like us to contact your employer on your behalf to obtain lost wage information? ☐Yes ☐ No

Section 7 Representative Information

Complete this section if an advocate or attorney assisted you with completing the application.

Please specify if a person or agency assisted you with the application.

☐Advocate ☐Attorney ☐Other: _____

Name: _____ Organization _____

Section 8 Federal Reporting Information

The following information is used for statistical purposes only and is required to comply with Federal Regulations. Please identify the victim's race/ethnicity and any disability.

☐Alaska Native ☐ American Indian ☐Asian ☐Black/African American

☐Hispanic or Latino ☐Native Hawaiian/Other Pacific Islander ☐Two or more races ☐White

Disability: ☐Yes ☐No Type of disability ☐Mental ☐ Physical

Was the disability caused by the crime? ☐Yes ☐No

Section 9 How Did You Learn About This Program?

☐Child Advocacy Center ☐ Counselor ☐Family/Friend ☐Funeral Home

☐Hospital/Medical Provider ☐Law Enforcement ☐Paralegal/Prosecutor ☐Poster/Brochure

☐Victim Assistance Program ☐Website ☐Other: _____

Section 10 Civil Suit Information

Have you filed or do you plan to file a civil suit related to this crime? ☐ Yes ☐ No

Attorney's Name and Law Firm _____

Section 11 Information Release

Note: Not valid unless signed by victim or legal guardian of the victim

I voluntarily give permission to any hospital, clinic, doctor, mental health treatment provider, social worker, rehabilitation counselor, employer, law enforcement authority, prosecution authority, government agency, insurance company, funeral director or similar persons, or any other person or agency to provide information relating to this application, including medical (including but not limited to history or physical records, consultation reports, pathology reports, discharge summaries, operative reports, x ray and other radiology reports, laboratory reports, chart notes, narrative reports, billing records, and records relating to drug abuse, alcoholism or other substance abuse and sexually transmitted diseases), mental health, and felony conviction records to the Violent Crimes Compensation Board (VCCB) or its representatives, for the purpose of determining eligibility for VCCB benefits. This permission also applies to all sources of recovery for the claimed losses, including, but not limited to, health or medical benefits, unemployment or disability benefits, Social Security benefits and Veteran benefits. I also give permission for the release of federal tax information, including tax returns, for the purpose of verifying income. I hereby waive all legal privileges to any of this information required by the VCCB regarding my claim.

In order to verify or process this application, I agree that the VCCB or its representatives may provide information about this application, and the information contained in this application, to any representative named on this application, government agency, or health care provider or other provider of services, and may pay the provider directly if payment of these services is approved. I agree that a photocopy or fax of this signed form is as valid as the original, and my signature gives permission for the release of all specified information. I agree that this information release is valid two (2) years from the date of my signature and that I can cancel this release by writing to the VCCB at any time, save that if any information has already been received and used, it is not subject to cancellation. I understand that all information necessary for use in law enforcement, prosecution, or the collection of restitution may be released to parole, probation, and law enforcement or prosecution authorities.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure and may not be protected by HIPAA or other confidentiality rules any longer. If research-related PHI is used or disclosed for continued research purposes, an expiration date or event does not apply. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization. I understand the information will be used to determine compensation benefits, and that only the information needed to make a decision about compensation benefits will be requested by the compensation program.

_____

Print Name **Signature** **Date**

Section 12 Repayment Agreement

I understand that Alaska law requires me to contact the Violent Crimes Compensation Board if I receive payments from the offender, a civil lawsuit, an insurance program, or any other government or private agency for losses suffered as a direct result of the crime that was the basis for receipt of benefits from the VCCB and that I may be required to refund either the amount of the collateral sum received from the offender, a civil lawsuit, an insurance program, or any other government or private agency, or the amount of compensation paid by the VCCB, whichever is less. I also understand that I may be required to repay any amount received from the VCCB for which it is later determined I was not in fact eligible. I will notify the VCCB if I hire an attorney to represent me in any action related to this crime.

I declare under penalty of perjury that all the information I have provided is true, correct, and completed to the best of my knowledge and belief. I understand that my signature says I agree to all statements in this agreement.

_____

Print Name **Signature** **Date**

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 (“HIPAA”); 45 CFR Parts 160 and 164 and Alaska Statute 18.67.

For Office Use Only: RECORDS TO BE DISCLOSED

Name:	
SSN:	Date of Birth:
Authorization to:	