Office of the Attorney General

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VICTIM COMPENSATION CLAIM FORM

This document is available in alternate format upon request.
For assistance, please call the toll-free Victim Services Information and Referral Line at 1-800-226-6667.
TDD users may call through Florida Relay Service at 1-800-955-8771.

Instructions

Please read the "Eligibility Requirements" on the back page to see if you qualify for this program. Fill out this form completely (please print), attach any required documentation, and mail to the above address. If you move or change your address, please notify this office. A criminal history record check will be made on each victim and claimant seeking victim compensation assistance.

CHECK THE TYPE OF VICTIM COMPENSATION BENEFITS YOU ARE REQUESTING:

- ☐ DISABILITY—compensation for the victim who suffered a permanent disability. (Attach a written statement from doctor certifying your disability.)
- ☐ WAGE LOSS—compensation for the victim who lost wages because of the crime. (Attach documentation from employer.)
- ☐ LOSS OF SUPPORT—compensation for the dependents of a deceased victim who was employed at the time of the crime.
- ☐ EXPENSES—payment or reimbursement on behalf of the victim for crime-related expenses, including funeral/burial, medical/dental and mental health counseling, as well as prescriptions, eyeglasses, dentures, or a prosthetic device lost, damaged, or required because of the crime. (Attach itemized bills and receipts.)
  - ☐ FUNERAL /BURIAL ☐ MEDICAL / DENTAL TREATMENT ☐ MENTAL HEALTH COUNSELING
- ☐ EMERGENCY ASSISTANCE—reimbursement for documented wage loss and out-of-pocket expenses related to the crime. (Attach receipts.)
- ☐ PROPERTY LOSS— for elderly adults (60 years of age or older) and disabled adults who suffered a loss of tangible personal property as a result of a criminal or delinquent act. Attach a receipt or a written estimate from a vendor or merchant.
- ☐ DOMESTIC VIOLENCE RELOCATION ASSISTANCE— for victims of domestic violence seeking assistance to relocate to a safe environment. Shelter certification form must accompany the claim.

Section 1. Victim Information (please print)

VICTIM'S NAME (last, first, middle) | DATE OF BIRTH ___/___/___

ADDRESS | E-MAIL ADDRESS

CITY | STATE | ZIP | SOCIAL SECURITY #

WORK, CELL PHONE OR OTHER NUMBER WHERE YOU CAN BE REACHED DURING THE DAY ( ) | HOME TELEPHONE NUMBER ( )

THIS VICTIM INFORMATION IS REQUESTED FOR FEDERAL REPORTING PURPOSES AND IS OPTIONAL.

RACE: ☐ CAUCASIAN ☐ AFRICAN AMERICAN ☐ HISPANIC ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN OR PACIFIC ISLANDER ☐ OTHER, IDENTIFY: _____

GENDER: ☐ MALE ☐ FEMALE | WAS VICTIM DISABLED BEFORE THE CRIME OCCURRED? ☐ YES ☐ NO

CLAIMANT, IF VICTIM IS (check one) ☐ DECEASED ☐ INJURED MINOR ☐ MINOR WITNESS—NOT INJURED ☐ INCOMPETENT ☐ ELDERLY OR DISABLED ADULT

CLAIMANT NAME (last, first, middle) | DATE OF BIRTH ___/___/___

ADDRESS | E-MAIL ADDRESS

CITY | STATE | ZIP | SOCIAL SECURITY #

WORK, CELL PHONE OR OTHER NUMBER WHERE YOU CAN BE REACHED DURING THE DAY ( ) | HOME TELEPHONE NUMBER ( ) | RELATIONSHIP TO VICTIM

Section 2. Referral Source Information

If someone helped you fill out this application, provide the following information.

NAME OF PERSON HELPING WITH APPLICATION (last, first, middle initial) | E-MAIL ADDRESS

NAME OF AGENCY/ORGANIZATION WHERE PERSON WORKS

AGENCY'S ADDRESS (address, city, state, zip) | TELEPHONE NUMBER

FOR BUREAU USE ONLY

Section 3. Disability or Lost Wages Information

Attach a copy of your pay stub or earnings statement that shows your earnings at the time of the crime. If you are self-employed, attach a copy of your latest income tax return, including Schedule C. If more than five (5) work days were missed as a result of the crime, attach a doctor's letter verifying this absence. For disability, attach a doctor's letter stating disability rating.

SUPERVISOR'S NAME	TELEPHONE NUMBER

NAME OF COMPANY/BUSINESS (if more than one [1] employer, please attach additional sheet)

COMPANY ADDRESS (address, city, state, zip)

IS WAGE LOSS COVERED BY INSURANCE? ☐ YES ☐ NO

IS VICTIM DISABLED AS A RESULT OF THE CRIME? ☐ YES ☐ NO

IS WAGE LOSS COVERED BY WORKER'S COMPENSATION? ☐ YES ☐ NO

Section 4. Loss of Support Information

Indicate below the name(s) and date(s) of birth of the deceased victim's surviving dependent spouse, parent, sibling, or child. Also attach a copy of deceased victim's latest income tax return or other proof of dependency.

DEPENDENT'S NAME	DATE OF BIRTH	RELATIONSHIP TO VICTIM

Section 5. Expense Information

Attach itemized bills from doctors, hospitals, and mental health counselors where victim was treated and medical expenses were incurred. If victim is deceased, attach a copy of the bill from the funeral home which provided burial services.

Section 6. Property Loss Information

This benefit is available only to persons who are disabled adults or 60 years of age or older. Attach a receipt or written estimate from a merchant or vendor for replacement of property that was lost or damaged as a result of the crime. Compensable items must be identified in the law enforcement report.

Section 7. Domestic Violence Relocation Information. Complete section 2 in its entirety.

This benefit is available only if the application is processed through a certified domestic violence center and the application is filed within 30 days after the crime incident.

Section 8. Insurance Information

IS INSURANCE OR MEDICAID AVAILABLE TO ASSIST WITH THESE EXPENSES? ☐ YES ☐ NO MEDICAID NUMBER _____

If yes, provide the following for all insurance policies, including Medicaid, Medicare, life, homeowner's, automobile, or major medical. Attach all related insurance Explanation of Benefits statement(s).

1. COMPANY NAME		POLICY NUMBER	TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP
2. COMPANY NAME		POLICY NUMBER	TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP

Section 9. Attorney Information

HAVE YOU FILED OR DO YOU PLAN TO FILE A CIVIL SUIT AS A RESULT OF THIS CRIME? ☐ YES ☐ NO

ATTORNEY'S NAME		TELEPHONE NUMBER ( )
ADDRESS		E-MAIL ADDRESS
CITY	STATE	ZIP

Section 10. Crime Information

Complete the following and attach a copy of the law enforcement report if available.

WAS CRIME REPORTED TO LAW ENFORCEMENT WITHIN 72 HOURS? ☐ YES ☐ NO IF NO, EXPLAIN _____

DATE OF CRIME	DATE REPORTED TO LAW ENFORCEMENT	REPORTED TO (law enforcement agency)

LOCATION OF CRIME (address, city, county)

TYPE OF CRIME	POLICE REPORT NUMBER

NAME OF LAW ENFORCEMENT OFFICER

NAME OF OFFENDER (if known)

HAS OFFENDER BEEN ARRESTED? ☐ YES ☐ NO	HAS CASE GONE TO TRIAL? ☐ YES ☐ NO	IF YES, DATE
NAME OF ASSISTANT STATE ATTORNEY HANDLING THE CASE		COURT CASE NUMBER

IF CLAIM WAS NOT FILED WITHIN ONE YEAR AFTER THE CRIME OCCURRED, PLEASE EXPLAIN THE DELAY IN FILING: _____

PLEASE READ CAREFULLY AND SIGN THE FOLLOWING CERTIFICATIONS

Section 11.

CONFIDENTIALITY: If you are the victim of a sexual battery, aggravated child abuse, aggravated stalking, harassment, aggravated battery, or domestic violence, you have the right to have information about your home address and telephone number, employment address and telephone number, and your personal assets, kept confidential for a period of five years. If you are the victim of any of these crimes, please mark one of the following statements. Your response will not affect the processing of your claim.

☐ **I want the information to be confidential.** ☐ **I do not want the information to be confidential.**

SERIOUS FINANCIAL HARDSHIP: I certify that I have a serious financial hardship because of crime-related expenses that cannot be paid by any other source.

PROPERTY LOSS CERTIFICATION: I certify that the property in question belonged to the victim; that this loss adversely affects the victim's quality of life; that there is no other source of reimbursement for this loss; and that replacement of the property would cause the claimant a serious financial hardship.

RELEASE OF INFORMATION: I give permission to any hospital, doctor, dentist, mental health counselor, or other treatment provider, banking institution, social service agency, law enforcement agency, corrections agency, state attorney's office, insurance carrier, attorney or employer to give out information that is requested concerning any treatment rendered, employment, insurance, third-party payer, or law enforcement investigative information to the Department of Legal Affairs for use in processing my claim. I give permission to the Department to release information about the status of my claim to any treatment provider, law enforcement agency, or state attorney's office.

REPAYMENT REQUIREMENT: I understand that payment by the victim compensation program is a payment of last resort and that I must repay the Crimes Compensation Trust Fund if I receive a victim compensation award and also receive payment as a result of the same criminal incident from another source. Other sources include, but are not limited to, any payment from the offender, an insurance policy, a settlement, a judgment or an award in a third party lawsuit. I further understand that I must repay any emergency award from the Crimes Compensation Trust Fund, if my claim is determined ineligible. I also understand that if my eligibility is withdrawn, I must repay any amount received from the Crimes Compensation Trust Fund.

The information I have provided is true and correct to the best of my knowledge.

Signature of Claimant _____ Date _____

(must be signed by person 18 or over)

FLORIDA BUREAU OF VICTIM COMPENSATION
Eligibility Requirements

- Victim or claimant must cooperate fully with law enforcement officials, state attorney's office, and the Attorney General's Office.
- Crime incident must be reported to law enforcement within three days after it happened, unless there is good reason for reporting it later.
- Claim must be filed within one year after the date of the crime, but the filing time can be extended to two years when there is a good reason for not filing within one year. Exceptions are made for victims who are minors.
- Victim must not have contributed to the circumstances that caused the crime injury or death.
- **Victim Compensation:** Victim must have suffered a physical, psychiatric, or psychological injury or death as a result of the crime.
- **Property Loss:** Victim who is an elderly person 60 years of age or older or a disabled adult who suffers a loss of tangible personal property as a result of a criminal or delinquent act may receive property loss reimbursement.
- **Domestic Violence Relocation Assistance:** Victims who need immediate assistance to escape from a domestic violence environment may receive financial assistance to relocate. Application must be filed within 30 days after the crime incident; requires certification by a certified domestic violence center.
- Criminal history record check will be performed through the Florida Crime Information Center for all victims and claimants. Persons who have been adjudicated as an habitual felony offender, habitual violent offender, or violent career criminal, and persons who have been adjudicated guilty of a forcible felony offense are not eligible to receive benefits.

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NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 663 TALLAHASSEE, FL

POSTAGE WILL BE PAID BY ADDRESSEE

OFFICE OF THE ATTORNEY GENERAL
DIVISION OF VICTIM SERVICES
THE CAPITOL, PL-01
TALLAHASSEE FL 32399-9914

(Fold here and seal)

Compensation Benefits

- The Victim Compensation Program may provide financial assistance for eligible persons, but only after all other sources of payment have been exhausted.
- Payments accepted by in-state providers on behalf of victims are payment-in-full per Florida Statute.
- Claimants who are determined eligible for the Victim Compensation Program may be exempt from the insurance deductible and co-payment provisions of their insurance policy(ies).
- Total victim compensation benefits cannot exceed the maximum award amount of $25,000 ($50,000 for catastrophic injury) per claim. Limits below the maximum may apply to specific benefits, which may be reduced without prior notice to the award recipient based on availability of funding.