

You must fill out every section completely to have your claim processed. You must include all necessary attachments.

DO NOT WRITE IN THIS SPACE
CLAIM # _____
DATE RECEIVED _____

ALABAMA CRIME VICTIMS COMPENSATION COMMISSION

P.O. BOX 1548 • Montgomery, Alabama 36102-1548
(334) 290-4420
1-800-541-9388 (Victims only)
FAX (334) 290-4455

TYPE OR PRINT

HOW DID YOU FIRST LEARN ABOUT THE ALABAMA CRIME VICTIM COMPENSATION COMMISSION?

- Police Department
- Sheriff's Department
- District Attorney's Office
- Lawyer
- Hospital
- Media (TV, Radio, Newspaper, etc.)
- Other _____

SECTION 1. CLAIMANT INFORMATION (If someone other than victim is filing claim)

Your Name	Social Security Number	Date of Birth
Address	City	State
		Phone Work: Home:
Relationship to Victim		

SECTION 2. VICTIM

Victim's Name			
Address	City	State	Phone Work: Home:
Social Security Number	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Date of Birth _____ month/day/year
Spouse's Name			
Dependent's names, relationships, and ages:			

The following information is used for statistical purposes only. It is voluntary and applies only to the victim:

Handicapped Prior to Crime: <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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(For purposes of this application, a handicapped person is one who; 1) has a physical or mental impairment which limits the capacity to work; 2) has a record of such impairment; 3) is perceived as having such an impairment.)

SECTION 3. ELIGIBILITY CRITERIA

1. Did the victim report this crime to law enforcement within 72 hours? Yes No If no, explain: _____
2. Did you file this claim within one (1) year of the crime? Yes No If no, explain why not: _____
3. Did the victim have any criminal charges pending against him/her? Yes No _____
4. Was the victim under the influence of alcohol or illegal drugs at the time of the crime? Yes No _____

Victims must notify ACVCC of any address change. **CLAIMS MAY BE CLOSED WHEN THERE IS NO RESPONSE TO CORRESPONDENCE.**

SECTION 4. CRIME, INJURIES, AND RELATED INFORMATION

Date of injury to victim: _____ Date of death of victim: _____ Location where crime occurred: _____
Month / Day / Year Month / Day / Year City County State
Type of Crime: Assault Sexual Offense Vehicular Murder Other _____
Brief description of crime (In your own words tell what happened.): _____ (Specify)

Name of Offender(s): _____
Name, address, and telephone number of witness(es): _____

Name of law enforcement agency to whom crime was reported: _____ Phone No.: _____ Date and time reported: _____

Name of investigating Officer(s): _____

Has arrest been made? Yes No
Did you sign a warrant? Yes No If no, explain why not: _____

Yes No Did victim know the offender? If yes, in what way?
 Yes No Was the victim related to offender? If yes, in what way?
 Yes No Was victim living in same house as offender **at the time of the crime**?
 Yes No If **yes**, is victim still living in same house as offender?

SECTION 5. MEDICAL/PSYCHIATRIC

Copies of all bills must be included if available. (You must send the bills and insurance statements.)

Describe injuries _____

Medical/psychiatric, dentists, ambulance, doctors, hospitals, counselor(s), and other related medical bills	Charge	Insurance Paid	Claimant/Victim Paid	Balance
1. Name: _____ Phone: _____ Address: _____				
2. Name: _____ Phone: _____ Address: _____				
3. Name: _____ Phone: _____ Address: _____				

Date victim released to work: _____ Full Duty Light Duty If Light Duty, how long? _____

SECTION 6. EMPLOYMENT INFORMATION See instruction sheet for eligibility criteria. (This section must be completed if lost wages are requested)

We must contact your employer to verify lost wages. Do you want them to be contacted? Yes No
Was victim or claimant employed at the time of crime? Yes No If yes, state work title: _____
Name of employer: _____ Phone: _____ FAX: _____
Complete mailing address: _____ City _____ State _____ Zip _____

If victim was self-employed, submit most recent income tax returns and other proof such as statements from those for whom victim worked showing amount(s) paid and date(s) for a period of at least 60 days prior to injury.

Victim's net (take home) earning or income at time of crime (Attach a doctor's excuse.) if time loss or loss of support benefits are claimed (include tips and bonuses): \$ _____ per week.

Date left work due to crime: _____ month / day / year Date returned to work: _____ month / day / year

Number of days or hours missed due to crime: _____ Rate per hour/day: \$ _____ Per _____
Estimated total earnings/support (take home): \$ _____

SECTION 7. INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION

Was the victim covered by any type of insurance policy? Yes No

Type of Insurance: Life Burial Medical Auto

Name of Company: _____

Phone No: _____

Policy No: _____

Name of Agent: _____

Do (Did) you receive income from any of the following sources? Yes No If yes, please indicate below:

	Amount Per Month		Amount Per Month
Social Security:	\$ _____	Social Security Disability:	\$ _____
Welfare:	\$ _____	Workmans Compensation:	\$ _____
Aid to Dependent Children:	\$ _____	Other, specify:	\$ _____

SECTION 8. FUNERAL EXPENSES (Attach Copy of Funeral Bills)

Were funeral expenses paid by any of the following: Yes No If yes, amount paid: \$ _____

Social Security	Burial Insurance	Life Insurance	Veterans Insurance	Other (describe):
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Name of funeral home: _____

Address: _____

Phone: _____

Amount of funeral and burial expenses: _____

Have burial expenses been paid? Yes No Partial (\$ _____)

Name, address, phone number of person who paid: _____

Address: _____

Phone: _____

Relationship to victim: _____

SECTION 9. OTHER EXPENSES

(Note: See Instructions for further details on what may be claimed. All expenses are subject to approval by Commission.)

Future economic loss: Will the victim or victim's dependents have future additional losses as a result of the crime? If yes, please list what you think those losses might include and your estimate of the cost of those losses: _____

Moving Expenses: In order to qualify for an award pursuant to this category, staying in your home must place you in direct danger or cause you to reasonably believe that you are in direct danger. What is the cost of the move? _____

Replacement services: Has the victim's family had financial losses which they would not have had if the crime had not occurred? If so, please list the service and the costs of replacement: _____

Please use the following space for any further information you may wish to bring to the attention of the Crime Victims Compensation Commission: _____

Property loss: Yes No Did the victim have property taken by law enforcement or damaged during victimization? If so, please list property and include values: _____

SECTION 10. EMERGENCY AWARD

Are emergency funds requested? Yes No _____

In order to receive emergency funds, you MUST attach an explanation why you feel you qualify for emergency funds.

SECTION 11. LAWSUIT RECOVERY (Must Be Completed)

Has the victim/claimant filed a civil lawsuit in connection with this case? (Other than the criminal case.) Yes No Please include your attorney's name, complete mailing address and telephone number. If no, please remember to notify us in writing if you file a lawsuit later. Alabama law requires that you give the Commission written notice within 15 days of initiating any legal proceeding to recover restitution or damages. ALA. CODE § 15-23-14(c).

Patient Authorization for Use and Disclosure of Protected Health Information

Name: _____ Social Security No.: _____ DOB: _____

1. I hereby authorize the Alabama Crime Victims Compensation Commission (ACVCC) to obtain and use my health, medical, psychiatric and billing information for the purpose of processing my compensation claim.
2. I authorize any and all service providers, including physicians, hospitals, clinics, laboratories, psychologists, psychiatrists, nurses, physician assistants and counselors, to release my health, medical, psychiatric and billing information, which includes discharge summary, laboratory reports, history and physical, operative procedure, pathology reports and billing information to the ACVCC and its agents and employees who are acting within the scope of their employment.
3. I understand that this authorization is for any and all health, medical, psychiatric and billing information related to my victimization, which occurred on _____.
4. I understand that such medical records may contain information concerning psychological, drug, and/or alcohol conditions, and/or diagnosis, treatment and care of sexually transmitted disease or complications related to the same, including but not limited to HIV testing and results. I understand that the health, medical, psychiatric and billing information to be released may be subject to re-disclosure by the recipient of the health, medical and billing information and no longer be protected by the Federal Privacy Rules.
5. I understand that this authorization is voluntary. I also understand that I may revoke this authorization at any time by notifying the ACVCC in writing, but if I do, it will not have any effect on uses and disclosures made before the receipt of the revocation.
6. In the event that this authorization is being signed by a personal representative of the patient, a description of such individual's authority to do so must be attached to this document along with proper documentation of this authority.
7. This authorization shall be valid for the entire duration of the processing of my compensation claim at the ACVCC and shall terminate at such time the ACVCC has rendered a final decision for my compensation claim.

Patient Signature

Date

Personal Representative (if applicable)

Date

AUTHORIZATION

Subrogation Agreement: I hereby agree to give the ACVCC written notice within 15 days of initiating any legal proceeding to recover restitution or damages that is related to my victimization. I agree to repay the ACVCC the amount of compensation that I have received in the event that my economic loss is recouped from any collateral source. I understand that failure to comply with this agreement may result in legal action being taken against me.

Financial Release: I hereby authorize any financial institution, any social service agency, any medical or mental health service provider or any state or federal governmental agency to release information concerning my financial status to the ACVCC. I hereby authorize my employer or former employer to release my employment information to the ACVCC.

Service Provider Information Release: I hereby give permission to the ACVCC to release information or records about my application for assistance to service providers and their authorized representatives who represent information about the status of my pending claim. I understand that this release is for the limited purpose of helping service providers determine the status of the claim in order to receive payment for services rendered.

Therefore, I HEREBY AND FOREVER HOLD HARMLESS, the ACVCC and its authorized representatives and agents from any and all legal responsibility/liability which may arise from the release of any of the above information. The undersigned swears or affirms that the information contained herein is true to his or her best knowledge. This signature authorizes the ACVCC to obtain all necessary information. I understand that the filing of a false claim is a Class C Felony offense in the state of Alabama.

BY SIGNING THIS DOCUMENT, I CERTIFY THAT I HAVE READ THE ENTIRE APPLICATION AND AGREE TO COMPLY WITH ITS TERMS.

VICTIM/CLAIMANT _____ DATE _____
Claimant may sign only if victim is deceased, incapacitated, or is a minor. Claimant must be the person legally authorized to act on behalf of the victim. (Documentation **MUST** be provided)

RELATIONSHIP TO VICTIM _____

LIST ANY FRIENDS/FAMILY AUTHORIZED TO DISCUSS YOUR CLAIM.

NAME _____ PHONE _____ RELATIONSHIP _____

NAME _____ PHONE _____ RELATIONSHIP _____

Check here and sign below if you DO NOT authorize release of status information to service providers.

VICTIM/CLAIMANT _____ DATE _____

⌘ PLEASE NOTE: ACVCC MUST RECEIVE THE SIGNED AND DATED ORIGINAL IN ORDER TO PROCESS YOUR CLAIM. ⌘

INSTRUCTIONS

1. Please type or print with ink and answer all questions on the form.
2. Attach all bills, receipts, insurance or benefit statements with the application. Also, you should send copies of additional bills as treatment continues. Only send medical bills and expenses related to the victimization. Your claim cannot be processed until necessary documentation is received.
3. Your claim cannot be processed without a police report. If you have a copy of the police report, please send it in with your application. Doing so can shorten the processing time for your claim.
4. Promptly mail the application and all documents to the address on the form. There is a one-year deadline from the date of the crime for filing your claim.
5. If you need help with the form, please contact your local District Attorney's office or our office.
6. If we ask you for additional information, you should send it to us immediately. If it is not received within forty-five (45) days, that portion of your claim may be declared ineligible.

EMERGENCY AWARDS

Emergency awards are for cases of dire economic need that result from violent crime victimization. These awards are usually granted for loss of income or moving expenses. If you are requesting an emergency award for loss of income, please attach a statement from your employer stating the time lost from work and your net (take-home) weekly pay. If you are requesting an emergency award for moving expenses, you must attach estimates or receipts for the requested items.

Emergency awards are not usually considered for medical bills unless a service provider has refused treatment pending payment. Please have the service provider write a letter noting this, and provide a copy of the estimate.

If you do not include these requested items, it will take longer to process your emergency award. There is a maximum of \$1,000 available for emergency award funds.

SUPPLEMENTAL AWARDS

In order to qualify for a supplemental award, the expense must be related to the original injury and must be supported by appropriate documentation.

THE COMMISSION DOES NOT PROVIDE COMPENSATION FOR PROPERTY CRIMES, ACCIDENTS, IDENTITY THEFT, PAIN & SUFFERING OR ATTORNEY'S FEES.

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www.acvcc.state.al.us

If you have limited English proficiency, you have the right to language assistance and this language assistance will be provided to you free of charge.

Si usted ha limitado la pericia inglesa, usted tiene el derecho a la ayuda del idioma y esta ayuda del idioma será proporcionado a usted libre de la carga.

APPLICATION INSTRUCTIONS

Before completing the attached application for compensation, please carefully read these instructions. You do not have to be represented by an attorney. If you need help, please contact your local District Attorney's office or our office.

YOU MAY QUALIFY FOR COMPENSATION IF:

- A) The crime was reported to law enforcement within **72 hours** (unless good cause can be shown for not doing so). Good cause must be submitted in writing.
- B) The claim is filed within **one (1) year** of the date of the incident (unless good cause can be shown for not doing so). Good cause must be submitted in writing.
- C) The victim suffered serious personal injury or death as a result of a criminal act.
- D) The victim cooperated with law enforcement officials, the prosecutor's office, the courts and the Commission.
- E) The victim was not engaged in illegal activity (example: drug activity) or was not in an illegal place of business (example: shot house) at the time of the incident.
- F) The victim did not provoke, incite or willingly take part in the incident.
- G) The victim was not convicted of a felony or criminally injurious conduct after applying for compensation.
- H) The victim was not on probation, parole, work release or any type of custodial or non-custodial release for a violent felony conviction, at the time of his/her victimization.
- I) The victim did not contribute to the victimization in any way.
- J) The victim's presence in the United States of America was lawful. (Claimants/victims who are certified by federal authorities as victims of human trafficking shall be eligible for compensation benefits.)

COMPENSATION CAN BE AWARDED FOR:

- A) **Medical expenses**—including doctor and hospital care, dental expenses, prescriptions, medical supplies, inpatient psychiatric care, etc. This does not include expenses covered by insurance. ACVCC can only pay for 50% of eligible, outstanding medical bills. Victims may be eligible to receive 100% reimbursement for medical expenses he/she has paid for out-of-pocket.
- B) **Rehabilitation expenses**—including vocational or physical therapy, if not covered by another source.
- C) **Counseling expenses**—includes counselor, psychologist and/or psychiatrist fees for counseling services that are related to the victimization. Mental health providers must be properly licensed by the appropriate regulatory body in order for the Commission to consider their services for payment. Counseling is usually limited to 50 sessions per claim unless exigent circumstances arise. Reimbursement for single counseling sessions is limited to the following: \$80 per hour for licensed counselors and social workers; \$100 per hour for psychologists and licensed therapist; \$125 per hour for psychiatrists; and \$60 per hour for group therapy.
- D) **Work loss**—including the victim or claimant's net (take-home) weekly pay for a reasonable length of absence from work. There is a maximum of **\$400** per week for work loss for a maximum of 26 weeks.
- E) **Funeral expenses**—including funeral home expenses, cremation, burial expenses including monument. The total amount allowable for funeral costs is **\$5,000**.
- F) **Property expenses**—Compensation may be awarded for property that is taken by law enforcement for evidence and/or property that was damaged during victimization. Automobiles, automobile repairs, insurance deductibles, appliances and money are **not** eligible for reimbursement. Alarm systems, fences and burglar bars that are installed after victimization may be considered for compensation for the victim's real property. There is a \$1000 maximum allowance for property expenses per claim.
- G) **Moving expenses**—including security deposits, utility deposits and the costs to move. It does not include rent payments. There is a **\$1,000 maximum** allowance for moving expenses. This is only considered in extreme circumstances in which the victim is in imminent physical danger and when the offense occurred at home.
- H) **Future economic loss**—future or additional expenses or loss to victim or victim's dependents. Must be justified with explanation of how losses were calculated. There is a maximum of \$5000.
- I) **Replacement services loss**—expenses claimant would not have suffered had the victim lived. There is a maximum of \$1500.