georgia crime victims compensation program application

YOU SHOULD APPLY IF:

- You are an innocent victim of a violent crime and suffered personal injury and/or serious mental or emotional trauma as a result
- You went to the aid of another and suffered personal injury and/or serious mental or emotional trauma as a result
- You witnessed or were threatened with a crime and suffered serious mental or emotional trauma as a result
- You are the parent or legal guardian of a minor victim
- You are the parent or legal guardian of a minor victim and you lost wages or support due to the victimization
- You are the surviving spouse, parent, grandparent, sibling or child of a homicide victim
- You were legally dependent on support from a deceased crime victim
- You are a domestic violence victim who is dependent on support from your abuser
- You are not the victim, but you have been paying bills related to the crime

YOU SHOULD NOT APPLY IF:

- You were committing a crime or you were incarcerated when the crime occurred
- You participated in or were involved in the events leading to the crime
- You were on probation or parole for a felony conviction when the crime occurred
- You are filing the application more than 3 years from the date of the crime

The Crime Victims Compensation Program (CVCP) was established for two primary purposes, to assist victims with debt incurred as a result of violent crime, and to encourage victims to participate in the criminal justice system. Eligible program applicants can receive compensation for up to $25,000 to help with medical and dental care, mental health counseling, economic support, crime scene clean-up, and funeral expenses when the costs are not covered by other sources (see category caps below).

Categorical Caps (For covered expenses)

- ✓ Medical and Dental Expenses - up to $15,000
- ✓ Mental Health Counseling Expenses - up to$3,000
- ✓ Funeral Expenses - up to $3,000
- ✓ Economic Support - up to $10,000
- ✓ Crime Scene Clean-Up - up to $1,500

*Benefits received are based on actual eligible expenses.

General Instructions

- ✓ Please print clearly and remember to sign your application (an original signature is required to process your application).
- ✓ Provide at least two telephone numbers where you can be reached, or where we can leave a message, during business hours.
- ✓ Provide the completed and signed application, one itemized bill, and a copy of the police report, incident report, TPO, or warrant when you submit your application.
- ✓ If you would like assistance filing your claim, or if you have questions, please call the Criminal Justice Coordinating Council at 404-657-2222 or 800-547-0060.
- ✓ Please send your completed application to:
  Georgia Crime Victims Compensation Program
  104 Marietta Street NW, Suite 440
  Atlanta, GA 30303

Please Note

- ✓ You may submit an application even if there is no known offender. Prosecution is not a program requirement.
- ✓ It is important that you inform the Program if you change your address or telephone number. Also, be sure to provide a secondary contact who has an address or telephone number that we can send information about your claim, or leave messages for you regarding your claim.
- ✓ CVCP is the payor of last resort, this means your benefits will be reduced by the monies you receive from any other source as a result of the crime, such as insurance, restitution, and civil suit settlements.
- ✓ CVCP is not an entitlement program; we only award compensation to those who meet all of the programs eligibility requirements.

GEORGIA CRIME VICTIMS COMPENSATION PROGRAM APPLICATION

104 Marietta Street, Suite 440 – Atlanta, GA 30303
Office (404) 657-2222 Fax (404) 463-7652 Toll Free (800) 547-0060 TTY (404) 463-7650
Web Site: http://cjcc.ga.gov/

SECTION 1. VICTIM / WITNESS INFORMATION

Please provide information on the individual who witnessed a violent crime, or was injured or killed as result of a violent crime.

Name of Victim / Witness (Last, First, M.I.)	Date of Birth (MM/DD/YY) / /	**Social Security Number**
Gender ☐ Male ☐ Female	Race (optional) ☐ Asian/Pacific Island ☐ White ☐ Black ☐ Hispanic ☐ Other _____	

Street Address (including apartment #)	City	State	Zip Code
Best Contact Phone Number	Alternate Phone Number	E-Mail Address (Check box if you want all program correspondence sent via email ☐)	

Please check all that apply:

☐ Victim/Witness gainfully employed at the time of the crime ☐Victim/Witness disabled before the crime ☐ Victim/Witness was unable to work due to crime

Please provide the date(s) victim/witness was out of work, due to crime:

SECTION 2. SECONDARY CONTACT INFORMATION

This contact should be a person with an address or telephone number that we can send information about your claim or leave information for you regarding your claim.

Name (Last, First, M.I.)	Best Contact Phone Number	Alternate Phone Number	
Street Address (including apartment #)	City	State	Zip Code

SECTION 3. BENEFITS REQUESTED

Please complete this section by checking all the benefits you are applying for. The program may request additional information once the application is received.

☐ **Medical** Include your itemized bills with your application.	☐ **Lost Wages** Include paystubs for at least 60 days prior to the crime.	☐ **Loss of Support** Include paystubs for at least 60 days prior to crime and proof of support.	☐ **Counseling** Include your itemized bills with your application.	☐ **Funeral/Burial** Include your itemized bills and death certificate with your application.	☐ **Crime Scene Clean-Up** Include your itemized bills with your application.

If applying for lost wages, you cannot be reimbursed if you were paid sick leave, vacation, disability, or workers compensation while you were out due to crime related circumstances. If eligible, you can only be reimbursed when you missed work and were not paid.

Please check if you have requested/filed: ☐ Restitution ☐ Civil Action

SECTION 4. CLAIMANT INFORMATION

Complete this section if you are filing on behalf of the deceased victim, minor victim, an incapacitated adult victim, or if you are not the victim but are paying the bills.

Claimant's Name (Last, First, M.I.)	Date of Birth (MM/DD/YY) / /	**Social Security Number**	
Street Address (including apartment #)	City	State	Zip Code

Relationship to Victim / Witness	Best Contact Telephone Number	Alternate Telephone Number

SECTION 5. CRIME INFORMATION

Include with this application, a copy of the report from law enforcement, child protective services, the courts, medical authorities or any other official government authority.

Location of Crime	County of Crime	Date of Crime	Date Crime Reported
Type of Crime Reported	Agency Crime Reported To	Name of Officer/Detective	

Offender's Name	Law Enforcement Case Number

SECTION 6. INSURANCE INFORMATION	Please provide information on any insurance, Medicaid, or Medicare benefits that you have available to you. If you have insurance, please send a copy of your card with your application.		
Please check if you have applied for: ☐ Workers Compensation ☐ Social Security Benefits ☐ Other_____			
Name of Primary Insurance Company	Policy Number	Policy Number	
Address	City	State	Zip Code
Name of Secondary Insurance Company	Policy Number	Policy Number	
Address	City	State	Zip Code

SECTION 7. REFERRAL INFORMATION	Please tell us who referred you to the crime victim compensation program.
Name of Referring Agency or Office	Name of Contact Person from Referring Agency or Office

SUBROGATION AGREEMENT ACKNOWLDGEMENT

Please read carefully, a copy of this signed release shall be considered the same as the original.

I hereby agree that if I am awarded any money by the Georgia Crime Victims Compensation Board, in consideration of such award, I assign, transfer and subrogate to the Board, all rights, claims, interests, and rights of action, to the extent of the Board's award, that I may have against other parties or entities that may be obligated to compensate me for the injuries or damages which form the basis for this application. I also hereby certify that, to date, I have not received any compensation except as noted on this form.

_____ _____

Victim/Witness/Claimant Signature (Original Signature Required) **Date**

MEDICAL AND CRIMINAL HISTORY RELEASE ACKOWLEDGEMENT

Please read carefully, a copy of this signed release shall be considered the same as the original.

A Criminal History will be completed on all victims/witnesses and claimants 18 years of age and older. I hereby authorize and understand that a criminal history report will be analyzed to determine eligibility for the Georgia Crime Victims Compensation Program. I authorize any hospital, physician, medical facility, insurer or any other person or law enforcement agency that has knowledge relative to my claim to furnish information to the Georgia Crime Victims Compensation Board. If psychiatric assistance is requested, a separate authorization form may be required.

_____ _____

Victim/Witness/Claimant Signature (Original Signature Required) **Date**

ACKNOLEDGEMENT OF UNDERSTANDING

Please read carefully, a copy of this acknowledgement shall be considered the same as the original.

I hereby acknowledge that the Georgia Crime Victims Compensation Program will only award compensation if **all** of the programs eligibility requirements are met; I also acknowledge that the Georgia Crime Victims Compensation Program is **not** an entitlement program, and is the payor of last resort, this means my benefits will be reduced by the monies I receive from any other source as a result of the crime, such as insurance, restitution, and civil suit settlements.

_____ _____

Victim/Witness/Claimant Signature (Original Signature Required) **Date**

Form CV-1 Revised January 2011