ATTORNEY GENERAL OF TEXAS

TEXAS CRIME VICTIMS' COMPENSATION PROGRAM APPLICATION

- **Nota: Si tiene alguna pregunta sobre esta solicitud o si la desea en espanol, favor de llamar al Programa de Compensación para las Victimas de Crimen al (512) 936-1200 o (800) 983-9933.**
- Please read the directions on this page before completing the application. Reading these instructions will help you complete each section correctly.
- Include all the documentation you can. If you have a copy of the police report, protective order with affidavit, hospital or doctor bills, health insurance card, or auto insurance declaration page (if the crime is auto-related), be sure to send them with the application.
- If you require additional space on any section of the application, please attach a separate sheet of paper and include all the required information.
- If you do not have this documentation, do not wait to mail the application. Send the application as soon as you have completed it. Collect all additional information so that you will have it when we contact you.
- Keep this page so that you will have our address and phone number. Mail your completed application to:

  Office of the Attorney General
  Crime Victims' Compensation Program (011)
  P.O. Box 12198
  Austin, Texas 78711-2198

- If your address or phone number changes, it is important that you let us know. The toll-free number for victims, claimants and service providers is (800) 983-9933. Austin callers should use (512) 936-1200. For security reasons, the Crime Victims' Compensation Program does not routinely communicate with victims via email. In some cases where security is not an issue, the CVC Program may use email to inform a victim or claimant of the status of the claim.
- If you need help completing this application, contact your local law enforcement agency's Crime Victim Liaison or your local District Attorney's Victim Assistance Coordinator. The Crime Victims' Compensation staff is also available to help by phone, or you may access our website at www.texasattorneygeneral.gov to find more information on the program.

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GENERAL INFORMATION

What is the Crime Victims' Compensation (CVC) Program?

- The CVC Program may provide financial assistance to victims of violent crime for related expenses that cannot be reimbursed by insurance or other sources.
- The Program is administered by the Office of the Attorney General and is committed to assisting victims and claimants who qualify. The information provided is meant to be generally informative, and the statutory requirements of the Texas Crime Victims' Compensation Act (Texas Code of Criminal Procedure, Chapter 56) and the rules set forth in Title 1 of the Texas Administrative Code, Part 3, Chapter 61, govern the Program.
- Money in the Victims of Crime Compensation Fund comes from fees paid by those convicted of a crime.

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What are the basic eligibility requirements for Crime Victims' Compensation Program benefits?

- The victim must be a resident of Texas, a United States resident who is victimized while in Texas, a Texas resident victimized in another state or country that does not have a crime victim compensation fund, or certain other individuals.
- The crime must be reported to the appropriate state or local public safety/law enforcement agency within a reasonable period of time.
- The victim or claimant must cooperate with law enforcement officials in the investigation and prosecution of the case.

NOTE: If a Medical Forensic Sexual Assault Exam was conducted on or after September 1, 2015, payments for emergency medical care received at the same time as the exam may be available even when a victim does not report the crime or meet certain other eligibility requirements. For more information, please visit the Crime Victims' Compensation web page or call (800) 983-9933. See Section 2a of this application.

Who may be eligible for Crime Victims' Compensation Program benefits?

- Victims of violent crime who suffer physical or mental harm as a direct result of the crime.
- A victim's dependents, family or household members who qualify as claimants under the law.
- Someone authorized by the victim to act on his or her behalf.

Who is not eligible for Crime Victims' Compensation Program benefits?

- The offender, an accomplice of the offender or any person engaged in illegal activity at the time of the crime.
- Anyone injured as a result of a motor vehicle accident, except under certain circumstances provided by law.
- Benefits may be denied or reduced if the victim's or claimant's own behavior contributed to the crime.
- Anyone incarcerated when the crime occurred.
- Any victim or claimant who knowingly or intentionally submits, or causes to be submitted, false or forged information to the Crime Victims' Compensation Program.

What expenses may be covered with Crime Victims' Compensation Program benefits?

- Reasonable and necessary medical and funeral expenses.
- Travel exceeding 20 miles one way for participation and attendance at funeral services, medical appointments and criminal justice appointment.
- Loss of earnings as a result of the disability of the victim.
- Loss of earnings for investigative, judicial or medical appointments.
- Loss of support to dependents of victim's, as a result of the victim's death or if the victim was supporting them at the time of the crime.
- Psychiatric care/counseling.
- Counseling for the victim and eligible claimants.
- Eyeglasses, hearing aids, dentures or prosthetic devices, if damaged during or needed as a result of the crime.
- Crime scene clean-up.
- Replacement of property seized as evidence or rendered unusable by the investigation.
- New expenses for child or adult dependent care as a result of the crime.
- One time rent and relocation expenses for victims of family violence, victims of sexual assault who were assaulted in their home, victims of stalking or victims of human trafficking.
- Reasonable attorney fees for assistance in filing the Crime Victims' Compensation Program application.

What expenses are not covered by Crime Victims' Compensation Program benefits?

- Damage, repair or loss to property or vehicle.
- Pain, suffering or emotional distress damages.
- Any expense which is not the direct result of the crime.

Who is the payor of last resort?

- All other available third party resources (for example, Medicare, Medicaid, personal health insurance, workers' compensation and settlements) must meet their legal obligations to pay crime-related expenses.
- The Crime Victims' Compensation Program must be notified before a civil lawsuit is filed in relation to the crime, if restitution is ordered by the criminal court, or if any party receives the proceeds of a settlement.
- CVC is considered the payor of last resort.

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PLEASE COMPLETE ALL SECTIONS OR A DELAY MAY RESULT IN THE PROCESSING OF YOUR APPLICATION. Information about this claim is confidential and will not be released to another person unless that person is included as a claimant or as otherwise required by law.

What is the language preference of the victim and/or claimant? **English** **Spanish** **Other**_____

SECTION 1-VICTIM INFORMATION: The victim is the person who was injured or died as a result of the crime. If the victim is a minor or deceased, the claimant information in Section 3 MUST be completed. If there is more than one victim, each victim must submit a separate application.

First Name	Middle Name	Last Name	
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Email Address			
Social Security Number: No Yes If yes: _____			
Tax I. D. Number: No Yes If yes: _____			
Gender Male Female	Date of Birth	If victim is deceased, date of death	

SECTION 2 - CRIME INFORMATION: You must complete this section or your application cannot be processed.

Please indicate the type of crimes:

Adult Sexual Assault	Aggravated Assault	Assault (Non-family)	Child Physical Abuse/Neglect
Child Sexual Assault	Child Pornography	DWI/Vehicular Crime	Elder Abuse
Family Violence	Homicide	Human Trafficking	Kidnapping
Robbery	Stalking	Other	

Date of Crime	Law Enforcement Agency (e.g. police, sheriff)	Police Report Number (if known)		
Location of Crime: Street Address	City	State	Zip	County
Alleged Suspect's First Name (if known)	Alleged Suspect's Last Name (if known)	Relationship of suspect to victim (if any)		
Has the suspect been arrested? No Yes Unknown	Have charges been filed? No Yes Unknown	Cause Number (if known)		
Brief Description of Crime				
Brief Description of Injuries (if any)				
If this is a family violence crime, have you obtained a permanent protective order? No Yes				
If this is a family violence crime, are there any prior incidents reported to law enforcement No Yes				

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SECTION 2a-CRIME INFORMATION: FORENSIC MEDICAL EXAM

If this is a sexual assault, was a forensic medical exam performed? **No** **Yes** **Date of forensic medical exam:**

Are you seeking reimbursement ONLY for expenses incurred in connection with emergency medical treatment received at the time of the sexual assault forensic medical exam? **No** **Yes**

If yes, you need only complete SECTION 4 (MEDICAL), SECTION 17 (APPLICATION ASSISTANCE), and the ACKNOWLEDGEMENT AND AUTHORIZATION to finalize this application. By checking "Yes" above, you indicate that you are not applying for additional CVC awards such as counseling expenses, ongoing medical expenses, rent/relocation and loss of earnings. You have three years from the date of the crime to request additional awards.

SECTION 3-CLAIMANT INFORMATION: The claimant is a person, other than the victim, who has out of pocket expenses as a direct result of the crime, is an immediate family member(s) of the victim who requires Psychiatric Care/Counseling as a result of the crime or is someone who has legal authority to act on behalf of the victim. CVC cannot discuss a claim with anyone who is not listed as a claimant. If there are additional claimants, please list them on a separate sheet of paper and include all the required information.

Claimant 1

First Name	**Middle Name**	**Last Name**	
Mailing Address	**City**	**State**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	
Email Address			
Social Security Number: **No** **Yes** **If yes:** _____			
Tax I. D. Number: **No** **Yes** **If yes:** _____			
Gender **Male** **Female**	**Date of Birth**	**Relationship to Victim**	

Claimant 2

First Name	**Middle Name**	**Last Name**	
Mailing Address	**City**	**State**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	
Email Address			
Social Security Number: **No** **Yes** **If yes:** _____			
Tax I. D. Number: **No** **Yes** **If yes:** _____			
Gender **Male** **Female**	**Date of Birth**	**Relationship to Victim**	

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Claimant 3			
First Name	Middle Name	Last Name	
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Email Address			
Social Security Number: No Yes	If yes: _____		
Tax I. D. Number: No Yes	If yes: _____		
Gender Male Female	Date of Birth	Relationship to Victim	

SECTION 4-MEDICAL: Reasonable and necessary health care for the victim as a direct result of the crime. Medical insurance and benefit plan MUST meet their legal obligation to pay crime-related expenses.

VICTIM TREATMENT INFORMATION			
Did the victim require medical treatment at the time of the crime? No Yes			
1. Name of first treating hospital/clinic/doctor:			
Address	City	State	Zip
Phone Number	Fax Number		
Did victim require additional medical treatment upon release from the hospital or clinic or did the victim seek any other medical treatment? No Yes			
2. Name of health care provider who treated crime-related injuries:			
Address	City	State	Zip
Phone Number	Fax Number		
3. Name of health care provider who treated crime-related injuries:			
Address	City	State	Zip
Phone Number	Fax Number		

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VICTIM DISABILITY INFORMATION		
Was the victim a person with disability? No Yes	If yes, date of disability	
Was the disability: Physical Mental Both	If yes, describe	
Does the victim have a new disability due to the crime? No Yes	If yes, describe	

VICTIM INSURANCE INFORMATION		
Did the victim have health insurance or a benefit plan to cover medical expenses at the time of the crime? No Yes		
Does the victim have health insurance or a benefit plan to cover medical expenses on the date of application? No Yes		
Name of Medical Insurance Company/Benefit Plan	Does the victim have Medicare? No Yes	
If Yes, what type of Medicare? A B C D	Has an application been filed with Medicaid or Medicare since the crime? No Yes	
If there are crime-related dental injuries, does the victim have dental insurance? No Yes	If yes, name of victim's Dental Insurance Company	
Was the victim the driver of auto? No Yes Unknown	If yes, does he/she have auto insurance? No Yes Unknown	Name of victim's auto insurance
Did the owner of the auto involved in the crime have auto insurance? No Yes Unknown		If yes, name of owner's auto insurance
Was the suspect the driver of auto? No Yes Unknown	If yes, does he/she have auto insurance? No Yes Unknown	Name of suspect's auto insurance
Is there additional assistance available to victim from: Workers' Compensation Disability Insurance Social Security Assistance Veterans' Benefits Other _____		
Has an insurance claim or any request for additional assistance related to this crime been filed? No Yes		

SECTION 5-PSYCHIATRIC CARE/COUNSELING: Available to victim and/or certain claimants. *Please indicate who has received or will be receiving psychiatric care/counseling because of the crime.*		
Name	Medical/Mental Health Insurance No Yes	If yes, name of Insurance Company
Name	Medical/Mental Health Insurance No Yes	If yes, name of Insurance Company
Name	Medical/Mental Health Insurance No Yes	If yes, name of Insurance Company

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SECTION 6-LOSS OF EARNINGS: Includes reimbursement of earnings lost as a result of medical treatment or participation in, or attendance at, the investigation, prosecutorial and judicial processes. Your employer will be contacted by CVC.

Victim Employment Information

Is the victim seeking loss of earnings? No Yes		**Was the victim employed on the date of crime?** No Yes	
Employer's Name	**Phone**	**Fax**	**Victim's Occupation/Job Title**
Address	**City**	**State**	**Zip**
Was the victim self-employed on the date of the crime? No Yes	**Did the crime occur while the victim was on the job?** No Yes	**Last Date Worked**	**Date Returned to Work**

Claimant Employment Information

Name of claimant seeking loss of earnings. If there are additional claimants, please list them on a separate sheet of paper and include all required information.

Claimant Name:		**Is the claimant self-employed?** No Yes	
Employer's Name	**Phone**	**Fax**	**Claimant's Occupation/Job Title**
Address	**City**	**State**	**Zip**

SECTION 7-LOSS OF SUPPORT: Available to dependents of the victim who have lost support as a result of the crime. All dependents must be listed as claimants in this application.

Name(s)

SECTION 8-RELOCATION: Available to a victim of family violence, a victim of sexual assault who is assaulted in the victim's residence, a victim of stalking or a victim of human trafficking. ***Please indicate adult household members of the victim at the time of the crime.***

List the names of all adult household members:

SECTION 9-FUNERAL: Includes funeral and burial expenses incurred as a result of the crime. ***Please attach a copy of the funeral and burial contract(s), (if available).***

Funeral Home name	**Phone**	**Fax**	**Contact**

SECTION 10-CRIME-RELATED TRAVEL: Includes travel exceeding 20 miles one way for participation and attendance at funeral services, medical appointments including psychiatric care/counseling and criminal justice proceedings. This is applicable to victim or claimant(s). *Please list the victim or claimant(s) requesting travel.*

Name(S)

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SECTION 11-CRIME SCENE CLEAN-UP: Includes professional cleaning services for crime scene clean-up. Does not include repair or replacement of damaged property. *Submit itemized bill from professional cleaning company, (if available).*

Do you have homeowners/renters insurance? No Yes Unknown	If yes, what is the name of the Homeowners/Renters Insurance Company?

SECTION 12-MINOR CHILD OR DEPENDENT CARE: Available for child or dependent care that is a new expense as a result of the crime. Care must be provided by a licensed care provider.

Is child care or dependent care a new expense? No Yes

SECTION 13-REPLACEMENT OF PROPERTY SEIZED: Available for clothing, bedding, or property seized by law enforcement as evidence or rendered unusable by the criminal investigation. *This does NOT cover damaged or stolen property.*

Item:	Value $	Item:	Value $
Item:	Value $	Item:	Value $

SECTION 14-DEPARTMENT OF JUSTICE INFORMATION: The following voluntary information is used for statistical purposes only to comply with the federal regulations.

To which ethnic group does the victim belong?

American Indian/Alaskan Native Asian Black/African American Hispanic/Latino Multliple Races

Native Hawaiian and Other Pacific Islander White Non-Latino/Caucasian Other Race

What is the victim's national origin (country of birth)?

Where did you find out about the Crime Victims' Compensation Program?

Public Service Announcement CVC Staff Advocacy Group Victim Assistance Program Poster

Brochure Hospital Law Enforcement Internet Other

SECTION 15-ATTORNEY INFORMATION: This section refers to representation by an attorney who assisted the victim or claimant in filing for Crime Victims' Compensation or in pursuing a civil legal action for monetary damages. This DOES NOT include attorney representation for child custody, divorce, immigration proceedings or for criminal prosecution (District/County Attorney's Office.)

Has an attorney been hired or retained to: Help the victim/claimant complete this Crime Victims' Compensation application?

No Yes If yes, please attach a letter of representation.

Has an attorney been hired or retained to: Represent the victim's or claimant's interests in pursuing civil legal action against the suspect/offender or in an insurance claim related to this crime?

No Yes If yes, please attach a letter of representation.

Attorney's Last Name	Attorney's First Name	Phone Number	Fax Number
Mailing Address	City	State	Zip

SECTION 16-LAWSUIT OR OTHER SETTLEMENT INFORMATION

Is the victim or claimant a party to a lawsuit or insurance or other type of settlement related to this crime?

No Yes Unknown

Has the victim or claimant received insurance or any other type of third party settlement funds related to this crime?

No Yes Unknown

SECTION 17-APPLICATION ASSISTANCE

Did someone help you complete this application? No Yes

Last Name	First Name	Title	Agency/Organization
Mailing Address	City	State	Zip
E-Mail Address	Phone Number	Fax Number	

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Acknowledgement and Authorization

This authorization is part of your application and <u>must be completed and signed</u> in order to process this application.
BY YOUR SIGNATURE BELOW YOU AGREE TO THE FOLLOWING TERMS.

Authorization for Release of Information. I hereby authorize any financial institution, social service agency, government agency, hospital, physician, mental health facility, counselor, psychologist, psychiatrist, employer, insurer or any other person with information relating to my financial, health or employment status to release information concerning this application for benefits to the employees of the Crime Victims' Compensation Program (CVC) of the Office of the Attorney General, as needed to process this application. This information includes, but is not limited to, criminal, medical, financial and employment information. A copy of this signed release will be considered the same as the original.

Subrogation Agreement. In accordance with Texas Code of Criminal Procedure, Articles 56.51 and 56.52, I agree to notify CVC in writing before I file a lawsuit against another party as a result of this crime. I further agree that I shall not settle or resolve any such action without prior written authorization from CVC. If I recover or anticipate recovery, of any money at any time, by judgment, settlement, restitution, collateral source or any other income as a result of the incident that gave rise to this application, I agree to notify CVC. I acknowledge that I may be responsible for repayment to CVC for any and all amounts that CVC has awarded to me.

Refund Agreement. In accordance with Texas Code of Criminal Procedure, Article 56.47 (c), I understand and agree that the Office of Attorney General may require a refund of an award if the award was obtained by fraud, or mistake or if newly discovered evidence shows the victim or claimant to be ineligible for the award under Texas Code of Criminal Procedure, Articles 56.41 or 56.45.

Authorization. I understand that the Office of the Attorney General or any agent or representative of the office, has the right to review, investigate and verify the information provided. **<u>I understand and agree that if false, misleading or intentionally incomplete information is provided, my application for compensation may be denied and I may be subject to criminal punishment under the Texas Penal Code and the civil and administrative penalties under Ch. 56 of the Texas Code of Criminal Procedure</u>.**

VICTIM	
Printed Name	Date
Signature	Date of Birth

CLAIMANT	
Printed Name	Date
Signature	Date of Birth

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