



MIKE DEWINE

★ OHIO ATTORNEY GENERAL ★

Ohio Victims of Crime Compensation Program

Application for Compensation

*If you or your family members are innocent victims of a violent crime,
financial assistance may be available.*

The Ohio Victims of Crime Compensation Program helps victims with certain out-of-pocket expenses caused when people are physically injured, emotionally harmed or killed by violent criminal acts. Program costs are paid by criminal fines and not by Ohio's taxpayers.

For more information, call:

614-466-5610

Toll-free numbers:

For specific case information:

800-582-2877

For general information:

877-584-2846 (877-5VICTIM)

www.OhioAttorneyGeneral.gov

ELIGIBILITY CHECKLIST

If you answer “yes” to all these questions, you may be eligible for help from this program.

- Was the crime reported and did the victim cooperate with requests of law enforcement?
- Was the victim not committing a criminal act that caused or contributed to the injuries?
- Has the victim incurred expenses that are not fully covered by collateral sources?

WHO MAY BE ELIGIBLE?

- Innocent victims of violent crime
- Someone who legally assumes the financial responsibility on behalf of a victim of violent crime
- For crimes resulting in death, the dependants of that victim or someone assuming the financial responsibility for that victim/family member
- In certain circumstances, family members of the victim may be eligible for compensation

WHO IS NOT ELIGIBLE?

- The offender
- Anyone who engaged in a felony of violence or drug trafficking within 10 years prior to the crime that caused the injury or during the pendency of the claim
- A victim or claimant who has been convicted of a felony within 10 years prior to the crime that caused the injury or during the pendency of the claim
- A claimant who has been convicted of a child endangering or domestic violence offense within 10 years prior to the crime that caused the injury or during the pendency of the claim

WHAT ARE SOME COSTS THAT MAY BE PAID?

- Medical and related expenses
- Counseling for family members of victims for specific crimes (up to \$2,500 each); maximum \$7,500 per claim
- Wages lost as a result of attending a funeral or certain court proceedings, dealing with a medical crisis, or, in certain cases, aiding in the care or recovery of the victim
- Crime scene cleanup/repair for safety (up to \$750)
- Evidence replacement (up to \$750)
- Funeral expenses (up to \$7,500)

ARE THERE LIMITS ON COMPENSATION?

- Yes. Compensation cannot be paid for pain and suffering, or stolen, damaged, or lost property.
- Compensation is not paid for costs payable by other sources (such as insurance or the Bureau of Workers' Compensation).
- The total award must be \$50 or more before payment is made.



Ohio Victims of Crime Compensation Program

Application for Crime Victim Compensation

Please type or print using blue or black ink

After an application has been filed, the law may provide for payment of an emergency award of up to \$2,000 to qualified claimants who, because of the crime, will suffer undue hardship without immediate economic relief and if a final award is likely.

THIS DOCUMENT IS A PUBLIC RECORD. EXCEPT FOR INFORMATION THAT IS PROTECTED BY STATE OR FEDERAL LAW, INFORMATION YOU PROVIDE ON THIS APPLICATION IS SUBJECT TO PUBLIC DISCLOSURE UPON REQUEST.

SECTION 1: VICTIM INFORMATION

Person injured or killed as a result of the crime. If more than one victim is affected, a separate application is required for each.

Victim's name (first/middle initial/last) _____
 Street address _____ City _____ County _____
 State _____ ZIP code _____ Email _____
 Social Security number _____ Date of birth _____
 Victim is/was: a. male female b. single married separated divorced widowed
 Has victim been arrested for, or convicted of, any felony, domestic violence or child endangering offenses within 10 years prior to the injury or since the injury? Yes No
 Has victim lived in any state other than Ohio in the 10 years preceding the crime? Yes No
 If yes, list each state and indicate when the victim lived there. _____

 Home telephone () _____ Work telephone () _____ Cellphone () _____

SECTION 2: CLAIMANT INFORMATION *(if different than the victim) Claimant cannot be a minor or a service provider.*

A "claimant" is a non-victim who paid or is obligated to pay out-of-pocket expenses as a result of this victimization.

Claimant's name (first/middle initial/last) _____
 Street address _____ City _____ County _____
 State _____ ZIP code _____ Email _____
 Social Security number _____ Date of birth _____
 Relationship to victim _____
 Claimant is: a. male female b. single married separated divorced widowed
 Has claimant been arrested for, or convicted of, any felony, domestic violence or child endangering offenses within 10 years prior to the injury or since the injury? Yes No
 Has claimant lived in any state other than Ohio in the 10 years preceding the crime? Yes No
 If yes, list each state and indicate when claimant lived there. _____

 Home telephone () _____ Work telephone () _____ Cellphone () _____

SECTION 3: CRIME INFORMATION

Date of crime _____ Date crime reported _____
 Did crime happen while on the job? Yes No
 Location/address where crime occurred _____ City _____ County _____
 State _____
 Law enforcement agency crime reported to _____
 Suspected offender(s) and address(es). *Use additional sheet if necessary.* _____

 Description of crime: Homicide Assault Robbery Sexual assault Domestic violence Other _____
 What were the victim's injuries? _____
 Did the victim die from crime-related injuries? Yes No Date of death _____
 Did the crime involve any of the following? Bullying Domestic and family violence Elder abuse/neglect Hate crime Mass violence (multiple victims)
 Other _____

SECTION 4: COMPENSATION REQUESTED

Check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Medical and related expenses | <input type="checkbox"/> Items held as evidence by law enforcement | <input type="checkbox"/> Counseling expenses for immediate family members |
| <input type="checkbox"/> Lost wages | <input type="checkbox"/> Counseling expenses for victim | <input type="checkbox"/> Travel/lost wages to attend criminal justice proceedings when a victim is deceased |
| <input type="checkbox"/> Clothing damaged by medical treatment | <input type="checkbox"/> Crime scene cleanup | <input type="checkbox"/> Future loss of support/care for dependents of a deceased victim |
| <input type="checkbox"/> Protection order fees | <input type="checkbox"/> Replacement services (paying someone to do what the victim would typically do such as housecleaning, child care, errands, etc.) | <input type="checkbox"/> Mileage |
| <input type="checkbox"/> Funeral and burial | | |

SECTION 5: VICTIM'S FIRST MEDICAL TREATMENT

Name, address, and date of service for victim's first medical treatment (doctor or hospital, whichever was first)

Doctor/hospital _____
Street address _____ City _____ County _____
State _____ ZIP code _____ Date(s) treated _____

If seeking payment of hospital bills, the following information is needed to determine eligibility for the Hospital Care Assurance Program.

How many are in the household? _____ What was the annual household income at the time of the hospitalization? \$ _____

SECTION 6: INSURANCE AND BENEFIT INFORMATION

All bills must be submitted to insurance or benefit plans before compensation can be considered.

Were there insurance or benefit plans to cover expenses at the time of the crime? Yes No At present? Yes No

If yes, check all boxes that apply and give details in the space provided.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Health insurance plan
<small>(Please send front and back copy of card)</small> | <input type="checkbox"/> Employers/union group | <input type="checkbox"/> Workers' compensation | <input type="checkbox"/> Life Insurance |
| <input type="checkbox"/> Auto insurance | <input type="checkbox"/> Homeowner's insurance | <input type="checkbox"/> Restitution or money from the offender | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private accident health plan | <input type="checkbox"/> Medicare | |

Name of insurance company/benefit plan _____ Member telephone () _____
Street address or P.O. box _____
City _____ State/ZIP _____
Policy holder/beneficiary's name _____ Policy holder/beneficiary's Social Security number _____
Policy no. _____ Group no. _____

SECTION 7: EMPLOYMENT INFORMATION

Complete if filing for loss of earnings. Provide copies of six paychecks prior to crime.

Employed at time of the injury? Yes No Employer email address _____
Employer/business name _____ Telephone () _____
Street address _____ City _____ County _____
State _____ ZIP code _____
Dates absent from work due to crime-related injuries _____
Name of doctor certifying time off from work _____ Doctor's telephone () _____
Street address _____ City _____ County _____
State _____ ZIP code _____

Did you receive (check all that apply):

- Sick pay Workers' compensation Disability Union or fraternal plan benefits Food stamps /cash grant Other (please specify)

SECTION 8: FUNERAL EXPENSES

Complete if filing for funeral expenses. Check all that apply.

Funeral home name and complete address _____

If you have a copy of the death certificate, please include a copy with your application.

SECTION 9: ALL MINOR DEPENDENTS OF DECEASED VICTIMS

Use additional sheets if needed.

Name _____ Date of birth _____ Social Security number _____ Name and address of guardian _____

SECTION 10: ATTORNEY AND/OR VICTIM ASSISTANCE PROGRAM

Has a private attorney represented you in:

Filing this claim? Yes No Suing the offender or a third party? Yes No An insurance claim? Yes No Obtaining a civil protection order? Yes No

VICTIM ASSISTANCE PROGRAM

In some cases there may be a local advocate available to help you. We may contact an advocate to help process your claim.

Name of victim assistance program that helped with this application _____

Street address _____

City/state/ZIP code _____

Telephone () _____

Email _____

ATTORNEY ASSISTANCE

Attorney's name _____

Street address _____

City/state/ZIP code _____

Work telephone () _____ Fax () _____

Cellphone () _____ Email _____

Attorney's signature _____

Attorney's Social Security or tax ID number _____

To submit an application, an attorney is not required. If an attorney does help, he/she must sign the application. An attorney cannot charge an applicant for his/her representation and must submit fees to the Ohio Victims of Crime Program.

SECTION 11: VICTIM STATISTICAL INFORMATION

For statistical purposes only. This is strictly voluntary.

Race: White Black Hispanic American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander Multiple Other

Do you have a disability? Yes No If yes, nature of disability Physical Mental Developmental

SECTION 12: SUBROGATION, AUTHORIZATION, AND SIGNATURE
YOU MUST BE 18 YEARS OF AGE OR OLDER TO SIGN THE APPLICATION.

Have you requested restitution? Yes No Court _____ Result _____

Have you made a claim for any governmental benefits? Yes No From whom _____

Have you contacted an attorney to sue or make claim regarding this incident? Yes No Attorney's name _____

Have you filed a claim with any insurance company regarding this incident? Yes No Insurance claim number _____

Mailing address for insurer _____

I understand that if I get money from any other source to cover the same expenses paid through the Crime Victims Compensation Program, I must reimburse the state of Ohio that amount of money. (Ohio Revised Code Section 2743.72)

I hereby authorize any person (including any physician, medical facility or health care provider), employer organization, the Ohio Department of Job and Family Services, the appropriate county Department of Job and Family Services or Child Support Enforcement Agency (for purposes of child support enforcement), law enforcement agency or government agency, upon request, to release to the Ohio Attorney General, the Court of Claims of Ohio or to my attorney, a copy of any report, document, record, criminal record, or other information (including tax information or returns, or medical information) in any way relating to my claim for an award of reparations under the Ohio Victims of Crime Compensation Program.

I understand that failing to provide my Social Security number may significantly impede the processing of my claim. I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS and AIDS-related conditions.

I understand that disclosure of confidential information from medical records may be protected by state or federal law. If applicable, state law (Ohio Revised Code Section 3701.243) and federal regulations (42 CFR part 2) prohibit the Ohio Attorney General or the Court of Claims of Ohio from making any further disclosure of confidential information without my specific written consent or as otherwise permitted by such regulations. This authorization or a copy hereof shall be valid for a period of two years without any further consent by me.

I understand that the information I have provided is being relied upon as truthful and accurate. By signing below, I swear or solemnly affirm under penalty of law that all information provided by me or on my behalf is true and accurate to the best of my knowledge and belief.

X _____
Signature of person seeking compensation (or signing as the legal guardian of a minor)

Date of signature

This release must be signed and dated for the application to be processed.

AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES

PATIENT'S NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

ADDRESS: _____

VICTIM/CLAIMANT'S NAME: _____

I, _____, authorize the disclosure of information from my/the patient's health record. I authorize the disclosure or use of the patient's **PSYCHOTHERAPY NOTES**.

The information is to be disclosed by any covered entity — including employer(s), physicians, medical facilities, health care providers, mental health care providers, insurance companies, billing departments, health care clearinghouses, health plans, and pharmaceutical entities — and is to be provided to the Ohio Attorney General, the Court of Claims of Ohio or to my attorney. This information is to be used in any way necessary related to my/the patient's claim for an award of reparations from the Ohio Victims of Crime Compensation Program.

I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS and AIDS-related conditions.

I understand that the covered entity from which the Ohio Attorney General seeks to obtain records may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that the Ohio Attorney General is not a covered entity and is not subject to privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization complies with the requirements of 45 CFR 164.508, HIPAA and the HIPAA Privacy Rule.

A photocopy or facsimile copy of this authorization release shall have the same effect as the original.

I understand that I may revoke this authorization in writing submitted at any time to the Ohio Attorney General, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate two years from the date of my signature.

VICTIM'S/CLAIMANT'S SIGNATURE **X** _____ **DATE** _____

CLAIMANT'S RELATIONSHIP TO VICTIM _____

Do not write in this space. For internal use only.
Claim number:

Signature required above.

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

PATIENT'S NAME: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

VICTIM/CLAIMANT'S NAME: _____

I, _____, hereby voluntarily authorize the disclosure of information from the above patient's health record. I authorize the disclosure or use of **THE PATIENT'S ENTIRE RECORD**, excluding psychotherapy notes.

This information is to be disclosed by any covered entity, including any physician, medical facility, health care provider, mental health care provider, insurance company, billing department, health care clearinghouse, health plan or pharmaceutical entity, employer organizations, Ohio Department of Job and Family Services, Child Support, law enforcement or governmental agency, upon request to release and is to be provided to the Ohio Attorney General, the Court of Claims of Ohio, or to my attorney a copy of any report, document, record, criminal record or other information (including tax information or medical information). This information is to be used in any way necessary related to my claim for an award of reparations from the Ohio Victims of Crime Compensation Program.

I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS and AIDS-related conditions.

I understand that the covered entity from which the Ohio Attorney General seeks to obtain records may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that failing to provide my Social Security number may significantly impede the processing of my claim.

I understand that the Ohio Attorney General is not a covered entity and is not subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, I understand that the Ohio Public Records Act (Ohio Revised Code Section 149.43) prohibits the Attorney General or the Court of Claims of Ohio from making any further disclosure of confidential information without my specific written consent or as otherwise permitted by such regulations.

This authorization complies with the requirements of 45 CFR 164.508, HIPAA, and the HIPAA Privacy Rule.

A photocopy or facsimile copy of this authorization release shall have the same effect as the original.

I understand that I may revoke this authorization in writing submitted at any time to the Ohio Attorney General, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate two years from the date of my signature.

VICTIM'S/CLAIMANT'S SIGNATURE **X** _____ **DATE** _____

CLAIMANT'S RELATIONSHIP TO VICTIM _____

Do not write in this space. For internal use only.
Claim number:

Signature required above.