TEXAS CRIME VICTIMS' COMPENSATION PROGRAM APPLICATION

CVC Official use only – VC# _____ Application Received _____

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 ☐ Child Sexual Assault ☐ DWI/Vehicular Crime ☐ Elder Abuse ☐ Family Violence ☐ Homicide ☐ Human Trafficking ☐ Kidnapping ☐ Robbery ☐ Stalking ☐ Other

Date of Crime	Law Enforcement Agency (e.g. police, sheriff) ☐ None	Police Report Number (if known)	
Location of crime: Street address	City	State/Zip	County
Alleged Suspect's Name (if known)	Relationship of the suspect to the victim (if any)		
Has 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			

Return this page to the Office of the Attorney General.

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	

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

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	Fax

3. Name of health care provider who treated crime-related injuries:

Address	City	State	Zip

Phone	Fax

VICTIM DISABILITY INFORMATION

Was the victim a person with a 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

Did the victim have insurance or a benefit plan to cover medical expenses at the time of the crime? ☐ No ☐ Yes

Does the victim have insurance or a benefit plan to cover medical expenses on the date of application? ☐ No ☐ Yes

Name of Medical Insurance Company/Benefit Plan	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
Did the crime involve an auto? ☐ No ☐ Yes	If yes, name of Auto Insurance
Was the victim the driver of auto? ☐ No ☐ Yes ☐ Unknown If yes, does he/she have auto insurance?	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

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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

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 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 seperate sheet of paper and include all required information.

Employer's Name	Phone	Fax	Claimant's Occupation/Job Title
Address	City	State	Zip

Is the claimant self-employed? ☐ No ☐ Yes

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 or a victim of sexual assault who is assaulted in the victim's residence. *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

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 compan, (if available).*

Do you plan to seek compensation from an insurance company? ☐ 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 dependant 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	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 or Alaskan Native ☐ Black ☐ Hispanic ☐ White ☐ Asian or Pacific Islander ☐ Other _____

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 or 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 First Name		Attorney Last Name	
Mailing address	City	State	Zip
Phone		Fax	

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 If yes, please attach a statement of the settlement disbursement.

SECTION 17-APPLICATION ASSISTANCE

Did someone help you complete this application? ☐ No ☐ Yes

Name	Title
Agency/Organization	
City	State/Zip
Phone	Email

Return this page to the Office of the Attorney General.

IMPORTANT AFFIDAVIT

This authorization is part of your application and must be completed and signed 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. **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.**

VICTIM	
Printed Name	Date
Signature	Date of Birth

CLAIMANT	
Printed Name	Date
Signature	Date of Birth

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