

Crime Victims Compensation
 Idaho Industrial Commission
 P.O. Box 83720
 Boise, ID 83720-0041
 (208) 334-6080

State of Idaho
**CRIME VICTIM'S
 APPLICATION FOR
 COMPENSATION**

**This form is not for the
 primary victim.**

This form is for: parent, spouse, sibling, child, grandchild and grandparent of primary victim.

Print or type -- Then mail to the address above.

FAMILY ASSISTANCE APPLICATION

Name of Family Member Seeking Benefits				Social Security #	
Address		City		State	Zip
Date of Birth	Telephone	Marital Status	Sex	Relationship to Primary Victim	
Name of Primary Victim			Date of Crime	County Where Crime Occurred	
Was a claim filed for Crime Victims benefits on the primary victim? Yes <input type="checkbox"/> No <input type="checkbox"/> Date filed:					
Type of crime: Homicide <input type="checkbox"/> Sexually abused minor <input type="checkbox"/> Sexual assault (adult only) <input type="checkbox"/> Kidnapping <input type="checkbox"/> Physical child abuse <input type="checkbox"/> Domestic violence <input type="checkbox"/>					
Name of your mental health counselor				If none, do you need a referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address of mental health counselor:				Date treatment began:	
Check other sources which may be available to pay for your counseling:					
<input type="checkbox"/> a. Medical Insurance		<input type="checkbox"/> e. Employee Assistance Program			
<input type="checkbox"/> b. Medicare		<input type="checkbox"/> f. Other (Explain)			
<input type="checkbox"/> c. Medicaid		<input type="checkbox"/> g. None			
<input type="checkbox"/> d. Veteran's Benefits					
(If any of the above resources are checked, give company name, address and policy numbers below:)				CVCP USE ONLY	
(If Medicaid/Medicare is checked, please list dates you applied for benefits:)					
YOU MUST USE COLLATERAL SOURCES SUCH AS MEDICAL INSURANCE POLICIES AND GOVERNMENT BENEFITS SUCH AS MEDICAID BEFORE YOU CAN RECEIVE CRIME VICTIMS FUNDS.					
The filing of this claim form is authorization for the release of any medical/counseling records to the Crime Victims Compensation Program from the date of the crime. I declare under penalty of perjury that the foregoing information is true and complete.		_____ Signature Date			
		_____ Signature of legal guardian Date (Required if secondary victim is a minor)			
CVCP USE ONLY				CLAIM NUMBER	