

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**

|  |           |  |               |  |     |
|--|-----------|--|---------------|--|-----|
| <b>Name of Family Member Seeking Benefits</b>  |           |  |               | Social Security #  |     |
| Address  |           | City   |               | State  | Zip |
| Date of Birth  | Telephone | Marital Status   | Sex           | <b>Relationship to Primary Victim</b>  |     |
| <b>Name of Primary Victim</b>  |           |  | 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"/><br>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?<br>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:)  |           |  |               | <b>CVCP USE ONLY</b>   |     |
| (If Medicaid/Medicare is checked, please list dates you applied for benefits:)   |           |  |               |  |     |
| <b>YOU MUST USE COLLATERAL SOURCES SUCH AS MEDICAL INSURANCE POLICIES AND GOVERNMENT BENEFITS SUCH AS MEDICAID BEFORE YOU CAN RECEIVE CRIME VICTIMS FUNDS.</b>   |           |  |               |  |     |
| 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.<br><br><b>I declare under penalty of perjury that the foregoing information is true and complete.</b>         |           | _____<br>Signature Date  |               |  |     |
|  |           | _____<br>Signature of legal guardian Date<br>(Required if secondary victim is a minor) |               |  |     |
| <b>CVCP USE ONLY</b>   |           |  |               | <b>CLAIM NUMBER</b>  |     |