Agency Use Only
CV # _____

Incident # _____

IDAHO CRIME VICTIMS COMPENSATION PROGRAM
MASS CASUALTY APPLICATION

DATE OF INCIDENT: 10/25/2021 **LOCATION:** Boise Town Square Mall

LAW ENFORCEMENT AGENCY: **Boise Police Department** **VICTIM ADVOCATE:** _____

VICTIM INFORMATION:

VICTIM'S FULL NAME: _____ DOB: _____

ADDRESS, CITY, ZIP CODE: _____

MALE: _____ FEMALE: _____ SSN: _____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER: _____

EMAIL ADDRESS: _____

LOCATION DURING INCIDENT: ☐ INSIDE MALL ☐ PARKING LOT ☐ OTHER (SPECIFY): _____

_____

IF MINOR, PARENT OR GUARDIAN INFORMATION:

PARENT/GUARDIAN FULL NAME: _____ DOB: _____

ADDRESS: _____

MALE: _____ FEMALE: _____ SSN: _____

RELATIONSHIP TO VICTIM: _____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER: _____

EMAIL ADDRESS: _____

INSURANCE/THIRD PARTY PAYMENT SOURCES: ☐ HEALTH INSURANCE ☐ MEDICAID ☐ MEDICARE

INSURANCE COMPANY NAME: _____ POLICY NUMBER: _____

EACH OF THE FOLLOWING SECTIONS MUST BE AGREED TO AND SIGNED TO RECEIVE COMPENSATION

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INFORMATION RELEASE

I give permission to release to and receive from any hospital, clinic, doctor, insurance company, employer, mental health provider, treatment center, person, agency or any other entity any needed information to the IDAHO CRIME VICTIMS COMPENSATION PROGRAM, for _____ (name of victim). I also give permission to the Program to release copies of any of my medical or mental health records necessary to the prosecuting attorney to secure restitution from the alleged offender in order to reimburse the fund.

I understand the information will be used to determine compensation benefits, and that only information needed to make a decision about the application or any claim for compensation benefits or otherwise deemed necessary by the Program to achieve its statutory mandate will be requested from other entities or released by the Program. With these exceptions, all information provided will be kept strictly confidential.

I understand this information release is valid until my claim is closed, as provided in Idaho Code § 72-1014, and that I can cancel this release by writing to the Program at any time, but that such cancellation will result in my claim not being processed further.

I understand a photocopy or facsimile of this signed form is as valid as the original, and that my signature gives permission for the release of all information specified in this permission form.

Federal law specifically requires that any disclosure or redisclosure of mental health, drug/alcohol or AIDS related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CRF Part 2). The Federal rules prohibit you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any drug/alcohol abuse patient.

XXX_____DATE _____
Applicant signature (parent or guardian must sign if victim is a minor)
Printed Name of Applicant _____relationship to victim _____

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REPAYMENT AND SUBROGATION AGREEMENT

I understand that Idaho law requires me to contact and repay the Program if I have already received or receive in the future any payments from the offender, a civil lawsuit, an insurance program, any other government or private agency or any other source resulting from the criminal offense upon which this application was made. I also acknowledge that the Program has a first lien against any money payable to me from any of such sources.

I understand and agree to the terms of this Repayment And Subrogation Agreement.

XXX_____DATE _____
Applicant signature (parent or guardian must sign if victim is a minor)
Printed Name of Applicant _____relationship to victim _____

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APPLICATION CERTIFICATION

I certify that the information in this application is true and correct to the best of my knowledge. I understand that I must use all financial resources available to me including but not limited to, medical/health insurance, workers compensation, disability insurance, VA benefits, Medicaid/Medicare, Social Security, auto insurance and sick leave prior to the Program paying any benefits. I understand by signing below I agree to all of the provisions in this Application for Compensation. If the victim is deceased, I certify that I have authority to file this application on behalf of all surviving dependents, including minor children, entitled to apply for benefits under the Program, unless a separate application has been filed for that dependent.

XXX_____DATE _____
Applicant signature (parent or guardian must sign if victim is a minor)
Printed Name of Applicant _____relationship to victim _____