IDAHO
CRIME VICTIMS
COMPENSATION PROGRAM

Application for Compensation

VICTIM INFORMATION

VICTIM'S LEGAL NAME [REQUIRED]: _____

VICTIM'S EMAIL ADDRESS [Needed to Ensure Timely Communication]: _____

VICTIM'S SOCIAL SECURITY NUMBER [Needed to Request Medical Records]: _____

VICTIM'S DATE OF BIRTH [Needed to Request Medical Records]: _____

VICTIM'S MAILING ADDRESS: _____

CITY/STATE: _____ ZIP: _____ PHONE :_____

GENDER: MALE_____ FEMALE_____ RESIDENT OF IDAHO: YES_____ NO_____

RACE/ETHNICITY (VOLUNTARY - CHECK WHICH APPLIES):

AMERICAN INDIAN OR ALASKA NATIVE____ ASIAN____
BLACK OR AFRICAN AMERICAN____ HISPANIC OR LATINO____
MULTIPLE RACES____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER____
WHITE/CAUCASIAN____ SOME OTHER RACE____

DISABILITIES PRIOR TO CRIME (VOLUNTARY - CHECK WHICH APPLIES):

HEARING____ VISUAL IMPAIRMENTS____ MOBILITY ISSUES____
COGNITIVE IMPAIRMENTS____ MENTAL HEALTH CONDITIONS____
OTHER (Please Describe) _____

VICTIM'S DATE OF DEATH: ____/____/_____ [if applicable]:

IF THE VICTIM IS DECEASED, PLEASE PROVIDE THE FOLLOWING INFORMATION:

MARITAL STATUS OF VICTIM: _____ NAME OF SPOUSE_____

DID THE VICTIM HAVE CHILDREN OR OTHER DEPENDENTS? No____ Yes____If yes, please continue.

Name of Child/Dependent	Child/Dependent Date of Birth	Child/Dependent Relationship to Victim

If additional space is needed, please attach separate sheet of paper.

CLAIMANT INFORMATION - IF YOU ARE SIGNING THIS APPLICATION FOR A MINOR, INCAPACITATED OR DECEASED VICTIM, THE FOLLOWING INFORMATION IS REQUIRED ABOUT YOU

YOUR FULL NAME [REQUIRED]: _____

YOUR EMAIL [REQUIRED to ensure timely communication]: _____

Continue to next pages.

YOUR RELATIONSHIP TO VICTIM: _____ (IF LEGAL GUARDIAN and /or CONSERVATOR – YOU MUST PROVIDE COPY OF COURT ORDER)

YOUR SOCIAL SECURITY NUMBER: _____

YOUR DATE OF BIRTH: _____ YOUR PHONE NUMBER: _____

YOUR MAILING ADDRESS: _____

CITY/STATE:_____ ZIP: _____

VICTIM EMPLOYMENT

DID THE VICTIM MISS AT LEAST A WEEK OF WORK AS A RESULT OF CRIME RELATED INJURIES? No____ Yes_____If yes, please complete the following:

VICTIM'S EMPLOYER'S (BUSINESS NAME) AT THE TIME OF CRIME:_____

VICTIM'S EMPLOYER'S MAILING ADDRESS :_____

CITY/STATE:_____ ZIP:_____ PHONE: (_____)_____

CONTACT PERSON_____ PAY RATE $_____ PER HOUR

DATES MISSED WORK: FROM_____ TO _____

DID THE VICTIM RECEIVE TIPS OR GRATUITIES? No_____ Yes _____ If yes, please estimate the amount per week the victim received _____

CRIME INFORMATION

TYPE OF CRIME: _____

DATE OF CRIME_____

IF THE CRIME WAS ONGOING, WHEN DID IT START_____ WHEN DID END _____

LOCATION OF CRIME (TOWN/CITY):_____

ADDRESS WHERE THE CRIME OCCURRED (IF KNOWN)_____

DATE CRIME WAS REPORTED_____

REPORT NUMBER: _____

LAW ENFORCEMENT AGENCY CRIME REPORTED TO: _____

NAME OF INVESTIGATING OFFICER_____

NAME OF PERSON(S) WHO COMMITTED CRIME: _____

ALLEGED OFFENDERS' RELATIONSHIP TO VICTIM: _____

Continue to next pages.

BRIEFLY DESCRIBE INCIDENT (If additional space is needed, please attach separate sheets of paper)

_____

_____

_____

NAME OF VICTIM/WITNESS COORDINATOR: _____

INSURANCE AND OTHER BENEFIT SOURCES

CHECK IF THE VICTIM IS COVERED BY ANY OF THE FOLLOWING BENEFITS:

□ AUTO INSURANCE □ MEDICAL INSURANCE □ HEALTH & ACCIDENT INSURANCE
□ WORKERS COMPENSATION □ DISABILITY INSURANCE □ SOCIAL SECURITY BENEFITS
□ INDIAN HEALTH SERVICES

□ MEDICARE: MEDICARE NO. _____ □ MEDICAID: MEDICAID NO._____
Effective Date:_____ Effective Date:_____

□ OTHER: (explain)_____

NAME OF INSURANCE COMPANY:_____

POLICY and/or CLAIM NO: _____

TYPE OF COVERAGE: [ ] Medical [ ] Auto [ ] Life Insurance [ ] Homeowners
TYPE OF POLICY: [ ] Traditional [ ] HMO [ ] PPO [ ] HAS

ARE YOU BEING REPRESENTED BY A PRIVATE ATTORNEY IN A CIVIL LAWSUIT OR INSURANCE ACTION RELATING TO THIS INCIDENT?
[ ] Yes [ ] No If yes, please provide:

NAME OF LAW OFFICE_____ LOCATION (TOWN/CITY) _____

ATTORNEY'S NAME _____ PHONE NUMBER _____

IF YOU HAVE NOT SUED THE PERSON WHO COMMITTED THE CRIME, DO YOU PLAN TO? [ ] Yes [ ] No

INFORMATION REQUIRED REGARDING MEDICAL, DENTAL, MENTAL HEALTH TREATMENT, ETC.

LIST NAMES OF ALL DOCTORS, DENTISTS, CLINICS, HOSPITAL, COUNSELORS, AMBULANCE, AND ANY OTHERS WHO HAVE PROVIDED TREATMENT OR SERVICES TO THE VICTIM RELATING TO THE CRIME. (Attach additional pages if necessary).

COMPLETE NAME OF PROVIDER **ADDRESS IF KNOWN. IF NOT, LIST TOWN/CITY**

_____

_____

_____

_____

_____

HOW DID YOU HEAR ABOUT THE IDAHO CRIME VICTIMS' COMPENSATION PROGRAM?

_____

Continue to next pages.

RELEASE OF INFORMATION

PRINTED NAME OF VICTIM: _____ DATE_____

PRINTED NAME OF CLAIMANT (PARENT/LEGAL GUARDIAN) _____

RELATIONSHIP TO VICTIM_____

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 the abovementioned 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.

SIGNATURE OF VICTIM/CLAIMANT_____

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.

SIGNATURE OF VICTIM/CLAIMANT_____

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.

SIGNATURE OF VICTIM/CLAIMANT_____

Completed and signed applications can be sent via:

Email to: cvcp.admin@iic.idaho.gov
Fax: 208-332-7559
Mail to: IDAHO CRIME VICTIMS COMPENSATION PROGRAM
P.O. BOX 83720
BOISE, ID 83720-0041

CVCP staff are available to discuss application questions with victims who call 208-334-6080.