Dear Applicant:

Thank you for your interest in filing for Crime Victims Compensation benefits. Our goal is to assist victims of crime in accessing financial assistance to help them recover from the traumatic effects of crime. If you need assistance in completing this application, please contact our staff at the telephone number listed at the bottom of this page. You may also contact the Victim/Witness Coordinator assigned to your case or the victim advocate organization in your community.

Idaho Crime Victims Compensation benefits are for victims of crimes committed in Idaho after July 1, 1986. The crime must be reported to law enforcement and you must file your application for benefits within one year of the date of the crime. These requirements may be waived if there is good cause for failing to meet the reporting and filing deadlines. To receive a waiver, you must attach a written explanation detailing your situation to your application for benefits. Idaho residents who are victims of crime while visiting another state must apply for victim compensation benefits in the state where the crime occurred. If that claim is denied, you may then file an application for benefits in Idaho.

To help speed up the application process, please be sure to:

- **Complete all pages of the application, especially the signature page.**

- **File separate applications for each victim seeking benefits.**

- **Be specific regarding the details of the crime. Include the date or time period of the crime, city or county where the crime occurred, the law enforcement agency investigating the crime and a detailed description of the crime.**

- **Provide a list of other sources of benefits available to the victim that may cover expenses for their injuries (i.e. Blue Cross, Medicaid, worker's compensation). Be sure to include insurance carrier information and policy numbers.**

- **Provide a list of treatment/service providers. Be sure to include names and addresses.**

- **Payments for services are based on rates established in the Worker's Compensation Medical Fee Schedule. Providers are prohibited from collecting any unpaid portion of a bill from the victim or claimant, unless the program is unable to make the full allowable payment based on applicable laws and rules.**

MAIL COMPLETED APPLICATION TO:

**CRIME VICTIMS COMPENSATION PROGRAM**
**P.O. BOX 83720**
**BOISE, ID 83720-0041**
**If you need help or would like a brochure, please call**
**(208) 334-6080 or (800) 950-2110 x-6080**
**Fax: 208-332-7559**
***Visit us on our website: http://www.crimevictimcomp.idaho.gov/***

*Rev. 5/2011*

# APPLICATION FOR COMPENSATION

RETURN APPLICATION TO:

**CRIME VICTIMS COMPENSATION PROGRAM**
**INDUSTRIAL COMMISSION**
**P.O. BOX 83720**
**BOISE ID 83720-0041**
**(208) 334-6080 or (800) 950-2110**

**PLEASE NOTE: YOU MUST COMPLETE ALL OF THE FOLLOWING INFORMATION ON EACH OF THE FOUR PAGES OF THIS APPLICATION. PLEASE PRINT CLEARLY.**

**********

**1. INFORMATION REQUIRED ABOUT THE VICTIM** SEX: MALE_____ FEMALE_____

VICTIM'S NAME: _____ MARITAL STATUS:_____

VICTIM'S MAILING ADDRESS: _____

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

VICTIM'S SOCIAL SECURITY NUMBER:_____ VICTIM'S BIRTH DATE: ___/_____/_____

VICTIM'S DATE OF DEATH: ___/____/_____ (if applicable)

EMAIL ADDRESS: _____

**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 _____

**2. IF THE VICTIM IS DECEASED, PROVIDE THE FOLLOWING INFORMATION (If the victim is not deceased, SKIP THIS SECTION AND GO TO SECTION NO. 3)**

DID THE VICTIM HAVE CHILDREN OR OTHER DEPENDENTS? _____ IF SO PLEASE COMPLETE THE FOLLOWING:

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

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

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*****CONTINUE TO PAGE 3 OF THE APPLICATION *****

*Rev. 5/2011*

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

YOUR NAME:_____

YOUR EMPLOYER'S NAME:_____ PHONE (_____)_____

YOUR SOCIAL SECURITY NUMBER: _____ PHONE (_____)_____

YOUR MAILING ADDRESS: _____

CITY/STATE:_____ ZIP: _____

YOUR EMAIL: _____

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

**********

**4. INFORMATION REQUIRED ABOUT THE CRIME**

TYPE OF CRIME: _____
DATE OF CRIME :_____TIME_____ ◉ AM ○ PM ( or From _____ To _____)
LOCATION OF CRIME: (Town/City)_____ (Street address where crime occurred)_____

LAW ENFORCEMENT AGENCY CRIME REPORTED TO:_____
DATE CRIME DISCOVERED:_____ DATE CRIME REPORTED :_____TIME _____ ◉ AM ○ PM

NAME OF INVESTIGATING OFFICER_____ REPORT NO :_____

NAME OF PERSON(S) WHO COMMITTED CRIME :_____

RELATIONSHIP TO VICTIM AND AGE OF PERSON(S) WHO COMMITTED CRIME :_____
(example: friend, acquaintance, uncle, brother, sister, stranger, etc.)

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

_____

_____

_____

NAME OF VICTIM/WITNESS COORDINATOR:_____

HOW DID YOU LEARN OF THIS PROGRAM?_____

**********

**5. STATISTICAL INFORMATION**: The following information is used for statistical purposes only. It is needed to comply with federal regulations.

Race: White _____ Black _____ Native American _____ Hispanic _____ Oriental/Asian _____ Other _____
Are you a U. S. citizen? Yes _____ No _____
Are you an Idaho resident? Yes____ No_____
Disabilities: Hearing _____ Mobility _____ Visual _____ Mental _____ Multiple _____ Other _____ None _____
**********

*****CONTINUE TO PAGE 4 OF THE APPLICATION*****

**6. INFORMATION REQUIRED ABOUT 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 & ADDRESS OF INSURANCE COMPANY:_____

PHONE NO: _____ POLICY and/or CLAIM NO: _____

TYPE OF COVERAGE: ☐ Medical ☐ Auto ☐ Life Insurance ☐ Homeowners
TYPE OF POLICY: ☐ Traditional ☐ HMO ☐ PPO ☐ HSA

**SECOND INSURANCE POLICY INFORMATION:**
NAME & ADDRESS OF INSURANCE COMPANY _____

PHONE NO: _____ POLICY and/or CLAIM NO. _____

TYPE OF COVERAGE: ☐ Medical ☐ Auto ☐ Life Insurance ☐ Home Owners
TYPE OF POLICY: ☐ Traditional ☐ HMO ☐ PPO ☐ HSA

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:

ATTORNEY'S NAME _____ PHONE NO (_____)_____

ATTORNEY'S ADDRESS_____

CITY/STATE_____ ZIP _____

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

**********

**7. 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** **COMPLETE MAILING ADDRESS, CITY, STATE ZIP**

_____

_____

_____

_____

_____

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******CONTINUE TO PAGE 5 OF THIS APPLICATION******

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

**********

**8. 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 _____**

**********

**9. 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_____**

**********

**10. 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_____**

*Rev. 5/2011*