

## APPLICATION FOR VERMONT VICTIMS COMPENSATION

We realize that this is a difficult time for you. If you need help filling out this form, call the Victims Compensation Program at 1-800-750-1213 (VT only) or 802-241-1250. If you are Deaf or Hard of Hearing, please call our TTY #: 1-800-845-4874.

### Application Instructions

**You must complete all 4 pages of this application. Make sure that you:**

- 1) Sign and date the "Authorization to Obtain Information" section of the application **and** provide an alternative expiration date if desired
- 2) Sign and date the "Repayment, Restitution, and Subrogation" section of the application

After you fill out this application, please put it in an envelope and mail it to:

Victims Compensation Program  
58 S. Main St., Suite 1  
Waterbury, VT 05676-1599

If you do not have a stamp, please contact the Victims Compensation Program, and we will send you a postage-paid envelope for your application.

Please enclose your crime-related bills when you return your application. If you receive more bills in the future, please make sure that you send them to us at the above address.

### **Part I: Victim Information**

Victim's name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City or Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If you do not want us to contact you at the above address, please provide another mailing address and phone number: \_\_\_\_\_

#### **If the victim is under 18:**

Parent **or**  Legal Guardian Parent/Guardian Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If address is different from victim's address, please provide:  
\_\_\_\_\_

If in DCF custody, caseworker name: \_\_\_\_\_

#### **If the victim is deceased:**

Survivor's name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City or Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Relationship to deceased: \_\_\_\_\_

**Part II: Information about the Crime**

Please complete as much of the following information as you can.

If you do not have this information, leave the space blank and we will try to obtain the documentation from the police or your Victim Advocate.

Date of Crime: \_\_\_\_\_ Date crime reported: \_\_\_\_\_

Name(s) of suspect(s): \_\_\_\_\_

Town where the crime occurred: \_\_\_\_\_

Police department reported to: \_\_\_\_\_

Name of police officer: \_\_\_\_\_

Incident number: \_\_\_\_\_

**Type of crime:**

- Sexual assault     Domestic violence     Child sexual abuse
- Child physical abuse     Assault     Homicide     DUI
- Other \_\_\_\_\_

Are you represented by a private attorney in a civil lawsuit or insurance action regarding this crime?

- Yes     No

Attorney's name \_\_\_\_\_ Phone # \_\_\_\_\_

**Part III: Requests for Compensation**

Please complete as much of the following information as you can. If you do not have this information, leave the space blank.

**I am requesting compensation for the following crime-related losses:**

- Medical     Dental     Funeral     Counseling
- Lost Wages (time missed from work)     Mileage
- Other: \_\_\_\_\_

► Please send any crime-related bills that you receive to the Victims Compensation Program.

Doctor: \_\_\_\_\_ Phone # \_\_\_\_\_

Counselor: \_\_\_\_\_ Phone # \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone # \_\_\_\_\_

Funeral Home: \_\_\_\_\_ Phone # \_\_\_\_\_

**Insurance Information:**

Does the victim have health insurance or Medicaid or Medicare?

Yes  No

Name of insurance company: \_\_\_\_\_

Does the parent, guardian or survivor have health insurance or Medicaid or Medicare?

Yes  No

Name of insurance company: \_\_\_\_\_

**Employer:** \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City or Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of contact person at work: \_\_\_\_\_

Due to the crime, I have missed work for the following:

Dates:

Reason(s):

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

4. \_\_\_\_\_

**▶ Please be advised: If you are asking for compensation for lost wages (time missed from work), we will contact your employer.**

Were you compensated for time missed from work?  Yes  No

If you miss work in the future due to crime-related reasons, please contact us with the additional dates.

**Part IV: Optional Information**

**Where did you hear about the Victims Compensation Program?**

Police  Victim Advocate  DCF  Hospital  Counselor  Radio

TV  Internet  Other \_\_\_\_\_

The following information is requested to comply with federal regulations, and is for statistical purposes only:

Gender:  Male  Female Race: \_\_\_\_\_

**Each county has a Victim Advocate located in the State’s Attorney’s Office. We encourage you to call your Advocate with any questions you may have about the court process. For information on how to contact your Advocate, call the Victims Compensation Program at**

**1-800-750-1213(Voice – VT only)**

**1-802-241-1250 (Voice)**

**1-800-845-4874 (TTY – VT only)**

**1-802-241-1258 (TTY)**

**YOU MUST SIGN IN THE TWO PLACES BELOW TO BE ELIGIBLE FOR VICTIMS COMPENSATION**

**AUTHORIZATION TO OBTAIN INFORMATION**

I hereby voluntarily authorize, in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 42USC §§ 132d et seq.) any hospital, clinic, physician, health care provider or other person who attended or examined the victim named below; any funeral director, insurance company, counselor, attorney or other person who rendered related services; any employer of the victim or claimant; any police or governmental agency, including state or federal revenue services; or any organization having relevant knowledge, to furnish the Vermont Victims Compensation Program with any and all information in their possession with respect to the incident that is the basis for this claim. A photocopy of this authorization is as effective and valid as the original unless otherwise required by law. Further release of this information is prohibited. I understand that this authorization will expire one year from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying the Victims Compensation Program in writing, except to the extent it has already been relied upon.

(Alternative expiration date if desired): \_\_\_\_\_

Victim's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of victim or survivor: \_\_\_\_\_

Signature of parent or guardian, if victim is under 18: \_\_\_\_\_

Date: \_\_\_\_\_

**REPAYMENT, RESTITUTION AND SUBROGATION**

I understand that Vermont law requires me to contact and repay the Victims Compensation Program if I receive payments from the offender, a civil action, or an insurance company, and that the Victims Compensation Program has a lien against any monies I may recover as a result of this crime. I also understand that I must notify the Program if I hire a lawyer to represent me in any action related to this crime. I certify that the information in this application is true and correct to the best of my knowledge. I understand that my signature indicates that I agree with all statements specified in this agreement.

Victim's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of victim or survivor: \_\_\_\_\_

Signature of parent or guardian, if victim is under 18: \_\_\_\_\_

Date: \_\_\_\_\_