CRIME VICTIMS COMPENSATION APPLICATION

State of Illinois
Court of Claims

State of Illinois
Attorney General

APPLICATION INSTRUCTIONS

- **Who should fill out the application?** A person who was the victim of a violent crime should fill out the application. If the victim is under the age of 18 or under a legal disability, then the victim's parent or legal guardian should fill out the application. If the victim is deceased, a relative of the victim should fill out the application. **The application must be signed by the victim or the victim's parent or legal guardian if the victim is under 18 or under a legal disability.**

- **Documents.** Please send copies of all the documents you have with the completed application (e.g., police report, plenary order of protection, civil no-contact order, hospital or doctor bills). If you do not have all the documents, send whatever documentation you have with the completed application. Collect copies of any additional information so that you will have it when we contact you.

- **Police reports.** To complete our investigation, we must get a police report for the incident. If you have the police report number, please include it in the crime section. If you do not have the num-ber, please provide as much information about the crime as possible.

- **Please provide all of the requested information.** Attach additional sheets if the application does not provide sufficient space. Mail your completed application to:

  Office of the IllinoisAttorney General
  Crime Victims Compensation Bureau
  115 South LaSalle Street
  Chicago, IL 60603

- **Address or phone number change.** Once you have submitted an application, you must let us know if your address or phone number changes; without the correct information, your claim may not be recommended for payment. Send a letter informing us of your new contact information.

- **If we determine that you are eligible for the program, additional forms will be sent to you.** These forms must be filled out and returned to our office within 30 days before any expenses can be reimbursed.

- **If you need help completing this application** or would like referrals for services, contact the Office of the IllinoisAttorney General at 1-800-228-336. Individuals with hearing or speech disabilities can reach us by using the 7-1-1 relay service.

Section I. Victim and Claimant Information

- If you were the victim of a violent crime and you are over the age of 18, please fill in the victim information only. You will also be the claimant so it is not necessary for you to repeat your contact information in Part B. The claimant is someone who is applying for compensation due to a violent crime.
- If you are applying on behalf of a victim (i.e., you are the parent of a minor child or the relative of a deceased victim) please put the victim's information in Part A and your contact information in Part B. The person who fills out Part B should also be the person signing the application.
- Your correct information is necessary for our office to contact you with further questions and to send documents. If it is not correct, you may not be able to receive payment.
- A Social Security number is requested but it is not necessary.
- An advocate works with crime victims and provides assistance and referrals. You do not need an advocate to apply for compensation. However, if you are working with an advocate and you would like us to try and obtain information about your case from your advocate, please list the information in Section C.
- If there is another individual who you would like us to discuss your claim with, please provide that person's name in Section C. If the analysts working on your claim are unable to reach you, your claim may not be recommended for payment. It is helpful, but not necessary, to have another means of getting information about the claim to avoid becoming ineligible for the program.
- If you are the spouse or parent of a victim applying for your own expenses, please complete a separate application for yourself.

Section II. Crime and Court Information

- This section collects information about the crime and any court proceedings that have taken place as a result of the crime. Not all of the sections may apply to your situation; provide as much information as you have available.
- Include a police report number, if known.
- Please submit one application per crime.

Section III. Losses Claimed

- This section collects information on what types of compensable loss you may have incurred as a result of the crime. Compensable losses are those types of losses that are covered by the Crime Victims Compensation Program.
- If you have any questions or would like to have more information on the types of expenses that are compensable, please call 1-800-228-3368 (Voice), 7-1-1 relay service.

Section IV. Medical Information and Benefits

- Complete this section if you are applying for medical, dental or counseling expenses. If you are not interested in applying for these expenses, check “no” and leave this section blank.
- If you are a spouse or parent applying for counseling expenses you incurred because of the crime against your spouse or child, fill out a separate application listing yourself as the victim.
- Counseling expenses can only be considered for payment if the counseling is provided by one of the following: licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed professional counselor or a Christian Science practitioner.

Section V. Employment Information

- Complete this section if you are applying for lost earnings. Reimbursement is available for earnings lost due to time off recovering from the crime and attending court.
- If you are a spouse or parent applying for lost earnings for time you missed from work to care for your spouse or child, fill out a separate application listing yourself as the victim.

Section VI. Funeral/Burial Information & Death Benefits

- Fill out this section if you are applying on behalf of a deceased victim.
- Loss of support is provided when a crime victim was working prior to the crime, but due to his or her death is no longer able to provide monetary support or meet a legal obligation to provide monetary support.
- We require information on all of the dependents of the victim before any recommendations can be made. Include the name(s) and phone number(s) of any dependents.

Section VII. Certification and Authorization

- The Acknowledgement of Subrogation indicates that you have read the section, understand and agree to subrogate your rights to recovery should you get restitution from the criminal case or money from a civil lawsuit. This means that if you, or any vendors on your behalf, receive money from the Crime Victims Compensation Program, you agree that if you recover money from any other source, such as from the offender or a civil suit, that you will repay the money you received from the Crime Victims Compensation Program.
- The Release of Information authorizes the Office of the Illinois Attorney General to request medical, financial and other necessary information to process your claim. The Office of the Illinois Attorney General will request only what is necessary to investigate the claim.
- Read the Certification of Application, which certifies that the information you have given in the application is true and accurate, under penalties of perjury. Make sure that you have provided the most complete and accurate available information before you sign.
- The application requests information about an attorney. However, you do not need an attorney to apply for this program.

CRIME VICTIMS COMPENSATION APPLICATION

STATE OF ILLINOIS
COURT OF CLAIMS

STATE OF ILLINOIS
ATTORNEY GENERAL

COMPLETE ALL SECTIONS TO THE BEST OF YOUR ABILITY.
SEE INSTRUCTIONS FOR INFORMATION ON FILLING OUT THE APPLICATION.
If you need help, call the Attorney General's Office at **1-800-228-3368 (Voice), 7-1-1 relay service.**

SECTION I. VICTIM & CLAIMANT INFORMATION

Office Use Only

A. VICTIM INFORMATION

Victim's Name: _____
Last First

Date of Birth: _____ /_____ /_____ Male ☐ Female ☐

Street Address: _____ Apt #_____

City:_____ State: _____ Zip Code: _____

E-mail Address:_____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Work Phone: (____) _____ - _____ Other Phone: (____) _____ - _____

Social Security No.: _____ - _____ - _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Civil Union Partner ☐

The following information is used for statistical purposes only according to federal regulations. Providing this information is voluntary and will not affect your application. Victim's Ethnic Group: ☐ Black (not Hispanic) ☐ American Indian or Alaskan Native ☐ White (not Hispanic) ☐ Hispanic (any Spanish culture) ☐ Asian or Pacific Islander (including Indian subcontinent) ☐ Other. Country of Birth _____
Do you have a disability? ☐ Yes ☐ No, If yes, nature of disability ☐ physical ☐ mental ☐ developmental.

How did you learn about Crime Victims Compensation? _____

B. CLAIMANT INFORMATION

Complete only if you are parent/legal guardian of a victim under the age of 18 or survivor of a deceased victim. Male ☐

Claimant's Name: _____ Date of Birth: ___ / ___ / _____ Female ☐
Last First

Street Address: _____ Apt #_____ City: _____

State: _____ Zip Code: _____ E-mail Address: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Work Phone: (____) _____ - _____ Social Security No.: _____ - _____ - _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Civil Union Partner ☐

Relationship to victim:_____

C. CONTACT INFORMATION

- Is English your preferred language? Yes ☐ No ☐
  If no, language you are most comfortable speaking: _____
- Are you working with an advocate? Yes ☐ No ☐ If yes, please provide the following:
  Name: _____ Telephone: (____) ____ - _____
  Organization: _____ E-mail Address: _____
- Is there another person you would prefer us to contact to discuss your claim? Yes ☐ No ☐
  Name: _____ Telephone: (____) ____ - _____
  Relationship to you: _____

SECTION II. CRIME AND COURT INFORMATION

A. CRIME INFORMATION

Police Report #_____

Date of Crime: ___ / ___ / ____ Date Crime Reported: ___ / ___ / ____

Street Address where crime occurred: _____City:_____ County:_____

Name of Agency/Police Department crime reported to:_____

Briefly Describe crime:_____

Briefly Describe injuries:_____

- Do you know the identity of the offender(s)? Yes ☐ No ☐
  If yes, offender(s) name(s):_____
  Relationship, if any, between victim and offender(s):_____
- Was the offender(s) arrested? Yes ☐ No ☐ Unknown ☐
- Was a sexual assault evidence collection kit performed at a hospital? Yes ☐ No ☐
- Was the victim on probation or parole for a felony at the time of the crime? Yes ☐ No ☐

B. CRIMINAL COURT INFORMATION (If known, please complete)

- Has an offender been charged in court? Yes ☐ No ☐ Unknown ☐
  If yes, what is the charge?_____ Criminal Case # _____ County: _____
  Assistant State's Attorney Name:_____ Telephone: (____) _____ - _____
- Have you attended court for this case? Yes ☐ No ☐
- Were you required to testify for this case? Yes ☐ No ☐ If yes, on what date? ___ / ___ / _____
- What was the outcome of the criminal case? _____
- Has restitution been ordered against an offender?: Yes ☐ No ☐ If yes, how much? $_____

C. ORDER OF PROTECTION INFORMATION

- Did you obtain a Plenary Order of Protection or Civil No-Contact Order? Yes ☐ No ☐
  If yes, please attach a copy of the order and enter the number: OOP# _____ CNCO# _____

D. CIVIL CASE INFORMATION

- Has a civil lawsuit been filed against anyone in relation to this incident? Yes ☐ No ☐
  If yes, please provide Civil Case # _____ County: _____
  Name of lawyer handling your civil suit: _____ ARDC No.: _____
  Telephone: (____) _____ - _____ E-mail Address: _____

SECTION III. LOSSES CLAIMED

- Did the victim experience a financial loss of tuition because of the crime? Yes ☐ No ☐
- Was it necessary to purchase a wheelchair or other equipment to make the home accessible for the victim for an injury that happened during the crime? Yes ☐ No ☐
- Have you had to replace (or purchase) eyeglasses, hearing aids or prosthetic devices because of the crime? Yes ☐ No ☐
- Was it necessary to leave your home because of the crime? Yes ☐ No ☐
  If yes, were you able to return to your home? Yes ☐ No ☐
  If no, did you relocate to a new home? Yes ☐ No ☐
- Did the police take clothing or bedding as evidence that you had to replace? Yes ☐ No ☐
- Was it necessary to replace locks and/or windows because of the crime? Yes ☐ No ☐
- Was it necessary to hire personnel to do crime scene clean-up? Yes ☐ No ☐
- Was it necessary to hire other people to perform tasks that the victim is now unable to perform because of the crime? Yes ☐ No ☐

SECTION IV. MEDICAL INFORMATION & BENEFITS

- Does the victim have medical or dental costs because of the crime? Yes ☐ No ☐
- Does the victim have counseling costs because of the crime? Yes ☐ No ☐
- Do you expect more medical, dental or counseling costs because of the crime? Yes ☐ No ☐

List the names and phone numbers of all doctors, hospitals, counselors or other medical service providers who treated the victim for injuries because of the crime. Please attach copies of any bills that you currently have. If you receive bills at a later date, please send them at that time.

Medical Provider	City	Provider Phone No.	Date(s) of Services	Amount of Bill
		( )		
		( )		
		( )		
		( )		
		( )		

- Do you have any type of medical insurance coverage? Yes ☐ No ☐
  If yes, please check each type of coverage that is available to cover the above charges.
  Note: Compensation is available only after all other medical benefits have been exhausted.

☐ Medical Card (Public Aid or AFDC) Card Number: _____
☐ Medicare or Medical Assistance Provider's Name: _____
☐ Private, Group, Employer or Union Health Insurance Provider's Name: _____
☐ Workers Compensation Provider's Name: _____
☐ Veteran's Administration, Champus Provider's Name: _____
☐ SSI or SSDI Provider's Name: _____
☐ Proceeds of Personal Injury or Other Litigation Case Number: _____
☐ Hospital uninsured discount or other financial assistance program

SECTION V. EMPLOYMENT INFORMATION

- Are you applying for any wages you lost because of the crime? ..... Yes ☐ No ☐
  If yes, please answer the following questions and fill in the chart below.
  - o Were you employed at the time of the crime? ..... Yes ☐ No ☐
  - o Did you receive disability benefits or sick pay for time missed from work after the crime? ..... Yes ☐ No ☐
  - o Since the crime, have you returned to work? ..... Yes ☐ No ☐
    If yes, date you returned to work: _____ / _____ / _____

Please list all employment during the six (6) months before the crime:

Name of Employer	Employer's Address	Employer's Phone No.	Victim's Net Monthly Wages (Take Home Pay)
		( )	
		( )	
		( )	

SECTION VI. FUNERAL/BURIAL INFORMATION & DEATH BENEFITS

A. FUNERAL AND BURIAL

- Are you requesting funeral and/or burial costs? Yes ☐ No ☐
  If yes, in what amount? $_____

- Have these costs already been paid? Yes ☐ No ☐
  If yes, in what amount? $_____

Name of Person(s) Who Paid	Phone No. of Person Who Paid	Relationship Between Victim and Person Who Paid	Amount Paid
	( )		
	( )		
	( )		

- Name of Funeral Home: _____ Telephone: (___) _____ - _____
- Funeral Home City: _____
- Name of Cemetary: _____ Telephone: (___) _____ - _____

B. INSURANCE

- Did the victim have a life insurance policy? Yes ☐ No ☐
  If yes, provide details about the life insurance coverage:

Name of Insurance Company	Name of Beneficiary	Beneficiary's Phone No.	Amount Paid
		( )	
		( )	

C. LOSS OF SUPPORT TO DEPENDENTS

- Was the victim employed during the six (6) months before the crime? Yes ☐ No ☐
- If yes, are you claiming loss of support? Yes ☐ No ☐
  If yes, fill out the rest of this section.

- At the time of death, did the deceased victim contribute financial support to:
  - o A spouse? Yes ☐ No ☐ Amount per month? $ _____
  - o Any dependents? Yes ☐ No ☐ Amount per month? $ _____

Please list all minor (18 years or under) dependents and any other dependents of the victim:

Name of Dependent	Relationship to Victim	Date of Birth	Name/Phone Number of Legal Guardian

SECTION VII. CERTIFICATION AND AUTHORIZATION

Acknowledgement of Subrogation: As required by the subrogation provision of the Illinois Crime Victims Compensation Act, 740 ILCS 45/17, I will contact and repay the Crime Victims Compensation Program if I receive any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private agency to cover expenses for which I receive payment from the Compensation Program. I understand that I will be responsible for repaying the Compensation Program any amount for which it is later determined that I was not eligible.

Release of Information: I hereby authorize any hospital, physician, health care provider, mental health provider, funeral director, or other person who rendered related services; any employer of the victim or claimant; any law enforcement or governmental agency; any insurance company; or any other individual company, agency or organization having relevant knowledge, to furnish any and all information in their possession with respect to the incident that is the basis for this claim to the Crime Victims Compensation Bureau of the Illinois Attorney General's Office. This information is to be used in any way necessary related to my claim for an award of compensation from the Illinois Crime Victims Compensation Program.

I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS, and AIDS-related conditions.

I understand that at any time I may revoke this authorization from the Illinois Attorney General's Office, except to the extent that action has been taken in reliance on this authorization. This authorization will expire in 3 years from the date the victim/claimant signed or when this claim is resolved.

This authorization complies with the requirements of 45 C.F.R. § 164.508, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule. A photocopy or facsimile copy of this authorization shall have the same effect as the original.

Certification of Application: I hereby certify, subject to the penalties of perjury, that all of the information that I have provided in this application is true, accurate, and complete to the best of my knowledge. I understand that if I willfully provide any information that is false, incomplete, or misleading, I may be denied benefits and/or I may be prosecuted for crimes punishable by imprisonment, a fine, or both.

_____ _____

Applicant's Signature **Date Signed**

If the applicant is represented by counsel for this crime victims compensation claim, please provide the following:

Name of Lawyer: _____ ARDC No: _____

Address: _____ City: _____ State: _____ Zip Code :_____

Telephone: (___) _____ - _____ E-mail Address: _____

740 ILCS 45/12 prohibits the charging of fees for presenting this form to the Court of Claims.

Please return completed application and all subsequent information to:

Office of the Illinois Attorney General
Crime Victims Services Bureau
115 South LaSalle Street
Chicago, IL 60603