pennsylvania
COMMISSION ON CRIME AND DELINQUENCY

Victims Compensation Assistance Program
Office of Victims' Services
CLAIM FORM

FOR OFFICIAL USE ONLY
Claim #

Most types of expenses have a monetary limit.
In most cases the maximum award may not exceed $35,000

Choose one: □ Personal Injury □ Death □ Stolen Cash

Section 1: Victim Information

Victim's First and Last Name			
Date of Birth (MM/DD/YY)	Social Security Number	Marital Status	Safe Daytime Phone Number
Current Street Address		City	
State	Zip Code	County	Safe Email Address

Section 2: Claimant Information

If victim is the claimant, check here: □
Claimant must be 18 years or older.

Claimant's First and Last Name	Date of Birth (MM/DD/YY)	Social Security Number	Safe Daytime Phone #
Current Street Address		City	
State	Zip Code	County	Safe Email Address
Relationship to Victim:			

Section 3: Crime Information

Date of Crime (MM/DD/YY)	Date Reported to Police; Date PFA Filed; or Date of Sexual Assault Forensic Exam (MM/DD/YY)

Location/Street Address of Crime	City	County	State
Name of Police Department	Police Incident Number		
Did it happen at work? □ Yes □ No	Were the injuries caused by a motor vehicle? □ Yes □ No		
Name of Person(s) Who Committed Crime			
Briefly describe the crime and injuries:			

It is okay to skip sections as not all sections will apply to you.

Section 4: Medical Expenses	**Complete if filing for medical expenses. Monetary limits apply.**

Are medical expenses being filed for the victim? □ Yes □ No
Were you covered by insurance at the time of the crime? □ Yes □ No
Are you covered by insurance now? □ Yes □ No

- Provide all itemized medical bills related to the crime. Medical bills must be in the name of the victim. Medical expenses could include hospital, doctor, dentist, medications, medical supplies, home care, childcare and replacement services.
- Provide copies of cancelled checks and/or receipts for any bills paid by the victim/claimant.
- If you are covered by insurance, all medical bills must be submitted to your insurance or benefit plan before the program can consider the expenses. Provide insurance statements of all payments and/or rejections for corresponding bills.

Section 5: Counseling Expenses	**Complete if filing for counseling expenses. Monetary limits apply**
Are counseling expenses being filed for the victim? □ Yes □ No	Are counseling expenses being filed for a person other than the victim? □ Yes □ No

If counseling is being filed for a person other than the victim, please provide the following:
Name _____ Date of birth _____ Relationship to Victim _____
Name _____ Date of birth _____ Relationship to Victim _____
Name _____ Date of birth _____ Relationship to Victim _____

Were you covered by insurance at the time of the crime? □ Yes □ No
Are you covered by insurance now? □ Yes □ No

- Provide all itemized counseling bills related to the crime.
- Provide copies of cancelled checks and/or receipts for any bills paid by the victim/claimant.
- If you are covered by insurance all counseling bills must be submitted to your insurance or benefit plan before the program can consider the expenses. Provide insurance statements of all payments and/or rejections for corresponding bills.

Section 6: Stolen Benefit Cash	**Complete if filing for stolen cash. Monetary limits apply.**

Main Source of Income (Choose all that apply)
□ Social Security Retirement □ Supplemental Security Income □ Retirement/Pension □ Disability
□ Social Security Disability □ Social Security Survivor Benefits □ Court Ordered Child/Spousal Support

Amount of Cash Stolen $	Do you have homeowner's or renter's insurance? □ Yes □ No	Are you required to file IRS tax returns? □ Yes □ No

- Provide a copy of your benefit statement(s) which apply to the month and year of the crime.
- Provide a copy of the homeowner's or renter's insurance statement showing coverage or rejection of the stolen cash if you answered 'yes' that you have homeowner's or renter's insurance.
- Provide a copy of your Federal IRS tax returns for the year of the crime if you answered 'yes' that you are required to file Federal IRS taxes.

If earnings from employment are your main source of income, you are not eligible for this benefit.

Section 7: Loss of Earnings

Complete if victim or claimant is filing for loss of earnings. Monetary limits apply.

Did you miss work and lose pay due to crime-related injuries? □ Yes □ No
Did you miss work and lose pay due to court appearances? □ Yes □ No
Did you miss work and lose pay due to trauma related to a homicide? □ Yes □ No

How are you employed?	Dates of Disability (MM/DD/YY)
□ Full Time □ Part Time □ Self-Employed	From _____ thru _____

Name of Employer	Street Address

City	State	Zip Code

Telephone Number	Fax Number	Email Address

If filing for loss of earnings due to crime-related injuries a physician verification certifying disability is needed. Certification can come from a medical doctor, psychiatrist, psychologist, physician assistant, certified registered nurse practitioner, or dentist.

Name of Provider Certifying Disability	Street Address

City	State	Zip Code

Telephone Number	Fax Number	Email Address

- Provide two pay stubs immediately prior to the crime incident, W-2 statements, or most recently filed IRS tax returns including all schedules.
- If self-employed, provide most recently filed IRS tax returns including all schedules.
- Provide documentation of any reimbursements received, such as sick, vacation, personal, or disability pay, Food Stamps, Cash Assistance, Unemployment Compensation or Workers Compensation.

Section 8: Funeral Expenses

Complete if filing for funeral expenses. Monetary limits apply.

Was there a life insurance policy on the victim?
□ Yes □ No
Was the claimant the beneficiary?
□ Yes □ No

Was there a Social Security death benefit?
□ Yes □ No

- Provide copies of itemized funeral bills and/or receipts in the claimant's name. Funeral expenses could include the funeral home, cemetery, funeral flowers, clothing for the deceased, memorial monument, or memorial meal expenses.
- If there was life insurance, and the claimant was the beneficiary, provide a copy of the life insurance statement showing how much was received.

Section 9: Loss of Support **This section is for death claims only.**	**Complete if filing for loss of support.** **Monetary limits apply.**

Were you or others financially dependent on the victim at the time of the crime? □ Yes □ No

Name _____ Date of Birth _____ Relationship to Victim _____
Name _____ Date of Birth _____ Relationship to Victim _____

Name of Victim's Employer	Street Address	
City	State	Zip Code
Telephone Number	Fax Number	Email Address

- Provide copies of victim's most recently filed IRS tax returns, including all schedules or a Court Order showing child/spousal support.
- Statement(s) for any benefit(s) received as a result of the death, such as Social Security benefits, life insurance, veteran's benefits, pension survivor benefits, or other benefit statements.
- Birth Certificates for dependent children.

Section 10: Relocation	**Complete if filing for relocation expenses.** **Monetary limits apply.**
Are you filing for relocation expenses? □ Yes □ No	What date did you relocate? (MM/DD/YY)

Please provide a verification letter explaining that the immediate need for relocation is necessary to protect the safety and health of the victim and individuals residing in the same household from one of the following: human service agency, law enforcement agency, or medical provider. If a letter cannot be furnished, please identify the agency we may contact to verify the immediate need related for relocation.

Agency Name	Street Address	
City	State	Zip Code
Telephone Number	Fax Number	Email Address

- Provide copies of itemized bills and or receipts related to relocation

Section 11: Crime Scene Cleanup	**Complete if filing for crime scene cleanup expenses.** **Monetary limits apply.**

Are you filing for crime-scene cleanup expenses? □ Yes □ No

- Provide copies of all itemized bills and/or receipts related to the crime scene cleanup.

This benefit is to pay for expenses related to the costs of cleaning a crime scene of a private residence. Crime scene cleanup does not include property damage.

Section 12: Transportation	**Complete if filing for transportation expenses.** **Monetary limits apply.**

Are you filing for expenses incurred traveling for medical appointments or court? □ Yes □ No

Victim Statistical Information

Completion of this section is strictly optional.
The following information is used for statistical purposes only.

Race/Ethnicity: □ White □ Black/African American □ Hispanic/Latino □ American Indian/Alaskan Native
□ Asian □ Native Hawaiian/Other Pacific Islander □ Some Other Race □ Multiple Races

Gender: _____

Primary Language: _____

How did you find out about the Program: □ Hospital □ Prosecutor □ Brochure □ Police □ Website/App
□ Victim Service Program □ Other _____

Victim Service Program Information

Did a Victim Advocate assist you in completing this form? □ Yes □ No

Name of Victim Service Program to receive copies of claim correspondence		Name of Victim Advocate who assisted in filing this claim	
Street Address	City	State	Zip Code
Telephone Number	Fax Number	Email Address	

Attorney Representation

Complete this section if you are working with an attorney to file a claim, a civil suit or an insurance action as a result of the crime.

Are you represented in this matter by an attorney?
In filing a claim? □ Yes □ No In a civil lawsuit? □ Yes □ No In an insurance action? □ Yes □ No

Name of Law Firm		Name of Attorney	
Street Address	City	State	Zip Code
Telephone Number	Fax Number	Email Address	

If you need assistance in filing a compensation claim, please contact a Victim Service Provider in your county, your county District Attorney's Office, or call the Victims Compensation Assistance Program at (717) 783-5153 or toll free at (800) 233-2339.

Please visit www.pcv.pccd.pa.gov to find your local Victim Service Provider

Acknowledgement & Reimbursement Agreements and Authorization to Obtain Information

The Acknowledgement and Reimbursement Agreement and Authorization to Obtain Information must be signed before a claim can be verified and processed for payment.

Acknowledgement and Reimbursement Agreement: The decision to approve my claim is that of the Program. I may object to all or part of the Program's decision in writing within 30 days from the date of the decision. I must prove the exact amount of my losses before the Program will consider awarding compensation from the Crime Victims Compensation Fund. I may later file for reimbursement of any additional expenses incurred relating to the crime. My claim may be denied if I do not cooperate fully with law enforcement agencies, the courts, and the Program, or maintain a valid address with the Program. Making a false claim would be a criminal offense under 18 P.S.§ 11.1303 of the Crime Victims Act. Making a false statement in this claim form with the intent to mislead the Program would be a criminal offense under 18 Pa. C.S. § 4904, Unsworn Falsification. Making a false statement which the Program relies upon to award compensation is a criminal offense under 18 Pa.C.S.§ 3922, Theft by Deception.

I understand that the Crime Victims Compensation Fund is the payor of last resort. I specifically agree to inform the Program of and repay to the Commonwealth any funds that I may receive from any other source that has not already been considered, as a result of the crime and to the extent of the award. That is, I agree to repay any funds that I receive from the offender or any other person or source, which compensates me for the injury I suffered, including proceeds from an insurance policy, as well as any award or settlement from a civil law suit, which was stems from the crime that is the basis for this claim. I further agree that if the claim is at any time determined to be in error, false or fraudulent, I will refund the Program all sums of money paid by the Program.

Authorization to Obtain Information: I hereby authorize any funeral director or other person who rendered related services, any employer of the victim or claimant, any police or government agency, including state or federal taxing authorities, any insurance company, or any organization having relevant knowledge to furnish to the Office of Victims' Services, Victims Compensation Assistance Program, any and all information in their possession with respect to the crime that is the basis for this claim

_____ _____

Claimant's Signature Date

HIPAA Authorization and Release Agreement

If applying for medical or counseling expenses, this acknowledgement must be signed before the claim verification process can begin.

I hereby authorize, in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 42 U.S.C. § 1320d, et seq.), any hospital, physician, health care provider or other person who attended, examined, or provided treatment to _____ (print name of victim) to furnish to the Office of Victims' Services, Victims Compensation Assistance Program any and all information in their possession with respect to the crime that is the basis for this claim. Copies of this authorization may be used in place of the original. **I understand that I may revoke this authorization at any time by providing the Office of Victims' Services, Victims Compensation Assistance Program, with a written, dated request to do so. Further, this authorization expires in 5 years from the date of my signature below or on the date that this claim is closed, whichever is sooner.

_____ _____

Claimant's Signature Date

Mailing Address
PO Box 1167
Harrisburg, PA 17108-1167

Street Address
3101 North Front Street
Harrisburg, PA 17110

Phone and Fax Numbers
800-233-2339
717-783-5153
717-787-4306 (FAX)

Email
ra-davesupport@pa.gov

Website:
www.pcv.pccd.pa.gov