INSTRUCTIONS
To expedite the processing of your application, please submit a Complete Application Packet, which includes items 1 thru 3 below.

1
Please complete the entire application, printing clearly. Sign every place where an original signature is requested.

2
Provide us with a police or incident report that lists the victim or witness name, and a summary of the incident.

3
Submit at least one itemized bill for services related to the crime, or all of the documents for Economic Support. A complete list of the documents required for Economic Support is available on our website.

4
Mail the complete application packet to Criminal Justice Coordinating Council, Crime Victims Compensation Program 104 Marietta Street NW, Suite 440 Atlanta, GA 30303

If you would like help completing your application, or if you have questions, please call us. We have Program Advocates available to assist you.

Office (404) 657-2222
Toll Free (800) 547-0060
TTY (404) 463-7650
Fax (404) 463-7652
crimevictimscomp.ga.gov

APPLICATION AND INSTRUCTIONS
CRIME VICTIMS COMPENSATION PROGRAM

The Georgia Crime Victims Compensation Program (CVCP) may be able to ease the financial burden incurred by innocent victims and witnesses of crime, when other resources are exhausted.

Eligible program applicants can receive compensation of up to $25,000 to help with medical and dental care, counseling, economic support, crime scene sanitization, and funeral expenses when the costs are not covered by other sources.

BENEFITS COVERED

Medical and Dental Expenses ................. UP TO $15,000
Economic Support Expenses .................. UP TO $10,000
Funeral Expenses ............................. UP TO $6,000*
Counseling Expenses ......................... UP TO $3,000**
Crime Scene Sanitization Expenses ........ UP TO $1,500

*A death certificate must be submitted with your application for funeral benefits. For crimes prior to May 6, 2015, the categorical cap is $3,000.

**Please refer to our website for the counseling benefits fee schedule.

PLEASE NOTE

If you do not have some or all of the required documentation (such as an itemized bill or police report), you may still submit a signed application to begin the claim review process. Your claim will be incomplete and we will follow up with you for the additional documents that are needed.

You may also submit an application even if there is no known offender. While the incident must be reported to law enforcement or an investigative agency (DFCS, APS, the courts, medical authorities, or the school system), arrest and/or prosecution of an offender is not a program or eligibility requirement.

In addition to mailing your Complete Application Packet, you may also fax or email it to start a claim, but we will require an application with your original signature in order to fully process your application. You may also bring the Complete Application Packet to our office.

You may be asked to complete a medical release form when requesting medical or counseling benefits. Submitting the release with your Complete Application Packet may expedite processing.

We are the payor of last resort. We cover expenses not paid by insurance, including Medicaid/Medicare or other monetary resources.

Benefits received are based on actual eligible expenses and itemized bills must be submitted with your application for review.
**SECTION 1. VICTIM/WITNESS INFORMATION**

Please provide information on the individual who was killed or injured as a result of a violent crime, or who witnessed a violent crime.

- **Victim/Witness Name (First, Middle, Last)**
- **Gender**
  - Male
  - Female
- **Date of Birth (MM/DD/YY)**
- **Social Security Number (or TIN)**
- **Street Address (including apartment #)**
- **City**
- **State**
- **Zip Code**
- **Best Contact Phone Number**
- **Alternate Phone Number**
- **Email Address**

How would you like to receive claim updates?  □ Email  □ Mail

**Demographic Data (For Statistical Use Only)**

- **Race:**
  - American Indian/Alaska Native
  - Asian
  - Black/African American
  - Native Hawaiian and Other Pacific Islander
  - White/Non-Latino/Caucasian
  - Hispanic/Latino
  - Other Race _____________________

- **If 17 or older, is the victim a veteran?**  □ Yes  □ No
- **Is the victim disabled?**  □ Yes  □ No
- **If yes, is the disability as a result of the crime?**  □ Yes  □ No

**SECTION 2. SECONDARY CONTACT INFORMATION**

If your contact information above changes, please provide information for a person we can contact to reach you about your claim. Please Note: We will not disclose any information about the claim to your secondary contact.

- **Secondary Contact Name (First, Middle, Last)**
- **Best Contact Phone Number**
- **Alternate Phone Number**

**SECTION 3. CLAIMANT INFORMATION**

Complete this section if you are filing on behalf of a deceased victim, minor victim, incapacitated adult victim, or if you are not the victim, but are paying bills on behalf the victim.

- **Claimant Name (First, Middle, Last)**
- **Gender**
  - Male
  - Female
- **Date of Birth (MM/DD/YY)**
- **Social Security Number (or TIN)**
- **Street Address (including apartment #)**
- **City**
- **State**
- **Zip Code**
- **Relationship to Victim/Witness**
- **Best Contact Phone Number**
- **Alternate Phone Number**
- **Email Address**

How would you like to receive claim updates?  □ Email  □ Mail

**Demographic Data (For Statistical Use Only)**

- **Race:**
  - American Indian/Alaska Native
  - Asian
  - Black/African American
  - Native Hawaiian and Other Pacific Islander
  - White/Non-Latino/Caucasian
  - Hispanic/Latino
  - Other Race _____________________

- **Are you a veteran?**  □ Yes  □ No
- **Are you disabled?**  □ Yes  □ No

**SECTION 4. BENEFITS REQUESTED**

Please complete this section by checking all the benefits you are applying for and submit itemized bills for services related to the crime. Please Note: a death certificate is required for funeral benefits.

- □ Medical
- □ Loss of Income
- □ Loss of Support
- □ Counseling
- □ Funeral/Burial
- □ Crime Scene Sanitization

**Please Note:** If applying for loss of income, you cannot be reimbursed if your wages were fully covered (e.g., sick or annual leave, vacation, disability etc.) while you were out due to the crime. If eligible, you can only be reimbursed when you missed work and were not paid, or your wages were only partially covered.

**Was the victim or witness gainfully employed at the time of the crime?**  □ Yes  □ No

If yes, please provide the date(s) the victim or witness was out of work due to the crime:

**Please check if you have requested/filed for:**

- □ Restitution
- □ Workers Compensation
- □ Law Suit/Civil Action
- □ Donations (e.g. Private, Memorial Fund, Go Fund Me, etc.)

**If benefits are awarded, please indicate if you would like to receive Direct Deposit (ACH Payment) or a Check**  □ Direct Deposit (ACH Payment)*  □ Check

*Please Note: Your first payment will be made by check as additional information is needed to set up Direct Deposit/ACH.

**SECTION 5. MEDICAL RECORDS/INFORMATION AUTHORIZATION**

Some medical and counseling reimbursement may require a medical release form. While not required, submitting a medical release with your completed application packet may expedite processing later, if needed.

Please check the applicable box:

- □ I am submitting the Medical/Information Authorization form, along with medical and/or counseling bills, with this application.
- □ I opt to complete the Medical/Information Authorization Form at a later time, if needed.

**SECTION 6. INSURANCE INFORMATION**

Please provide us your insurance information, including Medicaid/Medicare.

Do you have insurance, including Medicaid/Medicare?  □ Yes  □ No  If yes, Name of Insurance Company:
**SECTION 7. CRIME INFORMATION**

<table>
<thead>
<tr>
<th>County of Crime</th>
<th>Date of Crime (MM/DD/YY)</th>
<th>Date Crime Reported (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Crime Reported to</td>
<td>Law Enforcement Agency Case Number (if known)</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION 8. GOOD CAUSE**

Was the crime reported to proper authorities within 72 hours?  **☐ Yes ☐ No**

If no, to prevent delay of your application, please explain why not:

**SECTION 9. REFERRAL INFORMATION**

<table>
<thead>
<tr>
<th>Name of Referring Agency or Office</th>
<th>Name of Contact Person from Referring Agency or Office</th>
<th>Agency Phone Number</th>
</tr>
</thead>
</table>

Please check which one applies:

- ☐ The Referring Agency helped me with completing and/or submitting the required application and documents.
- ☐ The Referring Agency only told me about the Program or shared materials with me.

**SECTION 10. HOW DID YOU HEAR ABOUT US?**

| ☐ Referring Agency listed in Section 9 | ☐ Internet Search | ☐ Brochures, Poster, etc. |
| ☐ United Way 211 | ☐ Newspaper | ☐ Other State Agency |
| ☐ Clergy/Religious Leader | ☐ Radio/Television | ☐ Social Media (Facebook/Twitter/Instagram, etc.) |
| ☐ My Doctor/Dentist | ☐ Funeral Home | ☐ Law Enforcement Personnel |
| ☐ My Counselor | ☐ Family/Friend/Neighbor | ☐ Other ____________________________ |
| ☐ Hospital Staff | ☐ Victim Services Advocate | |

**SECTION 11. SUBROGATION AGREEMENT ACKNOWLEDGEMENT**

By signing this section, I certify to date that I have not received any compensation as a result of this crime. I also acknowledge that if I recover any money by legal judgment, settlement, restitution, fund raising efforts via the internet (e.g. Go Fund Me, church groups, memorial funds, etc.), etc. resulting from this crime, based on the recovery agreement, I may be responsible for repaying some or all amounts awarded to me, or on my behalf, by the Georgia Crime Victims Compensation Program. As such, I hereby agree that in consideration of an award by the Georgia Crime Victims Compensation Program, I assign, transfer and subrogate all claims, interests and rights of action that I may have against other parties or authorities up to the amount awarded by the Program.

**SECTION 12. CRIMINAL HISTORY & MEDICAL ACKNOWLEDGEMENT**

A criminal history report will be completed on all victims/witnesses and claimants 18 years of age and older. I hereby authorize and understand that a criminal history report will be analyzed to determine eligibility for the Georgia Crime Victims Compensation Program; I also authorize any hospital, physician, medical facility, insurer or any other person or law enforcement agency that has knowledge relative to my claim to furnish information to the Georgia Crime Victims Compensation Board. If psychiatric assistance is requested, a separate authorization form may be required.

**SECTION 13. ACKNOWLEDGEMENT OF UNDERSTANDING**

I hereby acknowledge that the Georgia Crime Victims Compensation Program will only award compensation if all of the programs eligibility requirements are met. I also acknowledge that the Georgia Crime Victims Compensation Program is the payor of last resort. As such, my benefits will be reduced by any monies I receive from any other source as a result of the crime, including insurance, restitution, fund raising efforts via the internet and civil suit settlements.

**Victim/Witness/Claimant Signature** (Original signature required)  **Date**