IF CRIME STRIKES

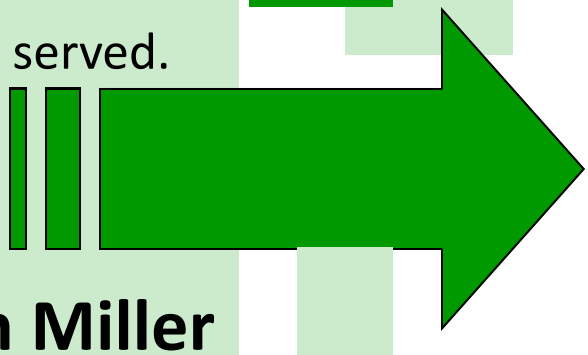
YOU, OR SOMEONE YOU CARE ABOUT ...

The Crime Victim Compensation Program

may help with crime related expenses

Justice is not served until victims are served.

APPLICATION INSIDE



Iowa Attorney General Tom Miller

Iowa Department of Justice

Crime Victim Assistance Division

Crime Victim Compensation Program

2016

APPLICATION FOR CRIME VICTIM COMPENSATION

(Please PRINT CLEARLY and fill out both sides)

1. Crime victim and applicant's information:

Crime victim's name:_____Type of crime: _____

Address: _____

Mail will be sent to the address you put on this line. If you do not want mail sent to your home address please provide an alternative address.

City/State: _____ Zip: _____ Phone: (_____)_____

Crime victim's date of birth: _____ Crime victim's social security #: _____

Name of **APPLICANT** if not victim: _____ Relationship to victim: _____

Parent, guardian, or victim's survivor

Named applicant's social security #: _____ Applicant's primary language: _____

Do you need application(s) for other family members or household members? ☐ Yes ☐ No If Yes, how many? __

2. Criminal report and investigation information:

City or location of crime: _____ Victim's injuries: _____

Crime date: _____ Crime discovery date: _____ Was the crime reported to Law enforcement? Yes No If Yes, Crime report date: _____

If No, please briefly state why_____

Investigating Law enforcement agency: _____ L.E. case #: _____

Investigating officer's name: _____Offender name(s): _____

3. Please mark the crime related expenses for which the crime victim or the applicant seeks compensation:

- ☐ Lost wages due to crime related injuries
- ☐ Funeral and burial expenses
- ☐ Lost wages to attend justice proceedings
- ☐ Crime scene clean up of a residence
- ☐ Victim's Medical or dental expenses
- ☐ Replacement of home security items
- ☐ Transportation/mileage expenses
- ☐ Replacement of clothes or bedding held as evidence
- ☐ Victim's Counseling expenses
- ☐ Child or dependent adult care expenses
- ☐ Other Counseling expenses: victim's immediate family or household member(s)
- ☐ Housing Assistance
- ☐ Emergency Relocation

4. If the victim lost wages as a result of the crime, complete the following:

Employer: _____ Contact person: _____

Phone:_____ Address:_____ City, State, Zip: _____

5. List your insurance company name, address, and policy number for each of these insurance types:

☐ I have no Insurance.

☐ Health: _____

☐ Medicaid or Medicare: _____

☐ Worker Compensation: _____

☐ Automobile, home, or boat: _____

6. The following information about your current status is necessary to comply with Federal Regulations.

1. Gender: ☐ Male ☐ Female ☐ Other **2. Age:** ☐ 0 - 12 ☐ 13-17 ☐ 18-24 ☐ 25- 59 ☐ 60 & over

3. Disabled: ☐ Yes ☐ No **4. Ethnicity:** ☐ White ☐ Native American ☐ African American ☐ Asian or Pacific Islander ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Multiple Races ☐ Other

5. Referred to program by: ☐Police/Sheriff ☐County Attorney ☐Media ☐Hospital ☐Victim Services

☐ List Agency: _____

To apply online, go to www.iowattorneygeneral.gov and Click on "For Crime Victims"

RELEASE OF INFORMATION AND REPAYMENT AGREEMENTS

SECTION 1 MUST BE SIGNED TO COMPLETE YOUR APPLICATION FOR CRIME VICTIM COMPENSATION (CVC)
SECTIONS 2 AND 3 MUST BE COMPLETED AND SIGNED TO RECEIVE MEDICAL AND COUNSELING BENEFITS
(Use more paper for provider lists if necessary)

SECTION 1: REPAYMENT AND SUBROGATION AGREEMENT

I understand that Iowa law requires me to repay the Crime Victim Compensation Program (CVC) if I receive any payment from the offender, a civil lawsuit, an insurance program, or another government or private agency after I receive payment from CVC for the same expenses. I also agree to notify the CVC if I have an attorney represent me in any action related to this crime. I certify the information in this application is true and correct to the best of my knowledge. I understand that with my signature I agree to all statements in this agreement.

X SIGNATURE_____ **DATE**_____

Applicant signature (Parent or guardian must sign if victim is a minor or dependent adult; applicant must signed if victim is deceased.)

SECTION 2: INFORMATION RELEASE

If known, list all providers such as doctor, clinic, hospital, dentist, ambulance, funeral home, etc.

Provider	Address, City, State, Zip	Telephone

I give permission to any hospital, clinic, doctor, insurance company, employer, person, funeral home, or agency, including the University of Iowa Hospitals and Clinics, to give requested information, including medical records and test results which may include drug and alcohol and HIV & AIDS screening and related information to the CVC Program of the Iowa Department of Justice. This release does not authorize records protected under 42 CFR, Iowa Code Chapter 228 or Iowa Code section 141A.9. This authorization is valid for information already in existence and information generated while the authorization is in effect. I understand that:

- The CVC Program will request only information needed to determine benefits for which I am eligible.
- Iowa and federal law requires the CVC Program to keep confidential all confidential information received;
- This information release is valid for one year from the date of my signature and I can cancel the release by writing to the CVC Program at any time, except that if any information has already been received and used, it is not subject to cancellation.
- A photocopy of this signed form is as valid as the original; and
- My signature gives permission for the release of all information specified in this permission form.

X SIGNATURE_____ **DATE**_____

Applicant signature (Parent or guardian must sign if victim is a minor or dependent adult; applicant must signed if victim is deceased.)

SECTION 3: MENTAL HEALTH SPECIAL MEDICAL INFORMATION RELEASE

The CVC will keep confidential all mental health counseling , drug or alcohol treatment, HIV and AIDS screening and related information, including counseling notes.

Disclosure Notice: Federal and State laws specifically require that any disclosure or re-disclosure of mental health, drug/alcohol, HIV screening and 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 CFR 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. Federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient. (See also Iowa Code Chapter 228 and section 141A.9 and applicable laws.)

If known, list all providers such as counselor, agency, hospital clinic, mental health provider, etc.

Provider	Address, City, State, Zip	Telephone

- I specifically authorize any hospital, clinic, doctor, insurance company, agency or mental health provider, including the University of Iowa Hospitals and Clinics, to release information to the CVC Program of the Iowa Department of Justice. I specifically authorize disclosure and re-disclosure of this information as provided in section 3 of this form. This authorization is valid for information already in existence and any information generated while authorization is in effect. I understand that:
- The CVC Program will request only information needed to determine about CVC benefits for which I am eligible.
- This information release is valid for one year from the date of my signature and that I can cancel this release by writing to the CVC program at any time, except that if information has already been received and used it is not subject to cancellation.
- I have a right to inspect the disclosed mental health information at any time by contacting the mental health provider who has the records.
- A photocopy of this signed form is as valid as the original; and
- My signature gives permission for the release of all information specified in this permission form.

X SIGNATURE_____ **DATE**_____

Applicant signature (Parent or guardian must sign if victim is a minor or dependent adult; applicant must signed if victim is deceased.)

A Message to Crime Victims From

Iowa Attorney General Tom Miller

If you or someone you care about has suffered personal physical or emotional injury from a violent crime, contact the Crime Victim Compensation Program. The program may help you with certain out-of-pocket expenses resulting from the crime. The program can also help you find other resources to meet your crime related needs.

The Crime Victim Compensation Program is funded entirely with fines and penalties paid by state and federal convicted criminals. Please read this brochure to see if the program can help you, your family, or a loved one.

The Crime Victim Compensation Program cannot erase the painful memories of a crime, but I hope it may ease the financial burden caused by the crime.

Crime Victim Assistance Division
Crime Victim Compensation Program
Lucas State Office Building, Ground Floor
321 East 12th Street
Des Moines, Iowa 50319

Phone: 515-281-5044
Toll-Free: 1-800-373-5044
FAX 515-281-8199

Relay Iowa:
1-800-735-2942 TT
1-800-735-2943 VOICE

http://www.iowaattorneygeneral.gov and Click on "For Crime Victims"

After You Apply for Crime Victim Compensation …

The Compensation Specialist may ask you for more information. Keep this page and information handy:

Application Number: _____

Compensation Specialist: _____

Notes: _____

_____

_____

_____

Tear off here and keep this section →

CRIME VICTIM COMPENSATION QUICK FAQS

1. You do not need a lawyer to apply for the Crime Victim Compensation Program.
2. The program pays certain out-of-pocket expenses related to an eligible victim's injury from a crime in Iowa.
3. Funds for the program come entirely from fines and penalties paid by convicted criminals, not tax dollars.
4. The program is the payer-of-last-resort after insurance, other government programs, and other sources.
5. Eligibility determination may take eight weeks.
6. For eligible crime victims, the program will pay benefits after all required verification is received.
7. The program does not cover property crime, property loss, legal fees, or pain and suffering.
8. Restitution from the offender is collected by the program only after any restitution owed to the victim is paid.
9. Restitution is not collected from an offender if the collection might cause danger or hardship to the victim.

WHO CAN RECEIVE CRIME VICTIM COMPENSATION?

- A victim who has been physically or emotionally injured by a violent crime committed in Iowa.
- The survivor(s) of a homicide victim.
- A victim injured in the following car or boat crimes:
  1. Driving intoxicated (OWI),
  2. Hit and run driving,
  3. Reckless driving,
  4. Vehicular homicide, or
  5. Use of a vehicle as a weapon.
- Secondary victims, which include a victim's spouse, child, parent, sibling, and a person who lived in the victim's household at the time of the crime.
- Iowans injured by violent crime in a state or a nation that does not have a crime victim compensation program.
- A person, regardless of income or resources, injured by a compensable crime in Iowa, who has certain out-of-pocket expenses related to the crime.

TO APPLY FOR CRIME VICTIM COMPENSATION…

Apply online by visiting www.iowaattorneygeneral.gov. Or,

1. Complete the Application attached to this brochure;
2. Sign the Repayment and Subrogation Agreement;
3. Sign the Medical & Mental Health Information Releases;
4. Send the forms to the Program.

CRIME VICTIM COMPENSATION BENEFITS

Benefits may be compensated to crime victims up to the following maximum amounts:

LOST WAGES:	
Lost wages due to a victim's crime related injury *	$6,000
Lost wages of a homicide victim's survivor *	$6,000
Lost wages for medical or counseling appointments	$1,000
Lost wages to attend justice system proceedings	$1,000
COUNSELING:	
Counseling for a victim or homicide victim survivor	$5,000
Counseling for a secondary crime victim	$2,000
MEDICAL:	
Medical care for a crime victim	$25,000
Medical care for a homicide victim's survivor	$3,000
OTHER:	
Funeral and Burial of a homicide victim	$7,500
Housing assistance (**once per lifetime**)	$2,000
Victim's residential crime scene clean up	$1,000
Crime related child or dependent adult care	$1,000
Crime related travel	$1,000
Emergency relocation (**once per lifetime**)	$1,000
Replace clothes or bedding held as evidence	$200
Replace home security items	$500

* Compensation paid for more than two weeks of a crime victim's lost wages requires a disability statement.

The disability statement must be completed and signed by a physician or licensed mental health practitioner who provided continued care for the victim.

WHAT ARE THE PROGRAM ELIGIBILITY REQUIREMENTS?

- A report to law enforcement must be made within 72-hours of the crime or the discovery of the crime. This requirement may be waived for good cause.
- An application must be filed within two years of the crime date or the date the crime was discovered. This requirement may be waived for good cause.
- The victim must cooperate with the reasonable requests of law enforcement officers and prosecutors in the investigation and prosecution of the crime.
- A victim must not have been committing or attempting to commit a crime that caused their injuries.
- A victim must not have consented to, provoked, or incited the crime that caused their injuries.