CRIME VICTIM COMPENSATION
SECONDARY VICTIM APPLICATION

Please PRINT CLEARLY and fill out both sides completely

Office Use Only

_____
Claim Number

_____
Compensation Specialist

SECONDARY VICTIM'S NAME:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____)_____

SECONDARY VICTIM'S DATE OF BIRTH: ____ /____/_____ SEC. VICTIM'S SOCIAL SECURITY #:_____

NAME OF PRIMARY VICTIM: _____SEC. VICTIM'S RELATIONSHIP TO PRIMARY VICTIM: _____

IF THE SECONDARY VICTIM IS A MINOR CHILD, ENTER INFORMATION HERE ABOUT THE PERSON COMPLETING THIS FORM:

Name: _____ Social Security #: _____

Date of birth: _____/_____/_____ Relationship to secondary victim: _____

CHECK THE CRIME-RELATED EXPENSES FOR WHICH THE SECONDARY VICTIM IS SEEKING COMPENSATION:

☐ COUNSELING FOR THE SECONDARY CRIME VICTIM

☐ TRANSPORTATION/LODGING FOR: ☐ MEDICAL/MENTAL HEALTH PAYMENTS ☐ COURT ATTENDANCE

☐ LOST WAGES FOR: ☐ PARENT OR GUARDIAN WHEN TAKING THE PRIMARY VICTIM TO MEDICAL AND COUNSELING APPOINTMENTS ☐ COURT ATTENDANCE

☐ DEPENDENT CARE ☐ RESIDENTIAL SECURITY ITEMS ☐ EMERGENCY RELOCATION

EMPLOYMENT INFORMATION (PLEASE COMPLETE IF SEEKING LOST WAGES):

EMPLOYER: _____EMPLOYER'S PHONE NUMBER: (_____)_____

EMPLOYER'S ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

CONTACT PERSON: _____DATES OF WORK MISSED: _____

INSURANCE INFORMATION: (GIVE THE COMPANY NAME, ADDRESS, AND POLICY NUMBER FOR EACH)

☐ NO INSURANCE

☐ HEALTH: _____

☐ MEDICAID OR MEDICARE:_____

☐ AUTOMOBILE, HOME, OR BOAT: _____

INFORMATION FOR STATISTICS: REQUIRED BY FEDERAL REGULATIONS:

A.) GENDER: ☐ MALE ☐ FEMALE **B.) AGE:** ☐ 0-12 ☐ 13-17 ☐ 18-24 ☐ 25-59 ☐ 60 & OVER

C.) DISABLED: ☐ YES ☐ NO **D.) ETHNICITY:** ☐ CAUCASIAN ☐ NATIVE AMERICAN ☐ AFRICAN AMERICAN ☐ ASIAN

☐ HISPANIC ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ MULTIPLE RACES ☐ OTHER: _____

E.) REFERRED BY: ☐ POLICE/SHERIFF ☐ COUNTY ATTORNEY ☐ MEDIA ☐ HOSPITAL ☐ VICTIM SERVICES

☐ OTHER _____

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: HEALTH CARE INFORMATION RELEASE

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

Provider	Address, City, State, Zip	Telephone

I give permission to any hospital, clinic, doctor, insurance company, employer, person, 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.)