CRIME VICTIM COMPENSATION
HOMICIDE VICTIM'S SURVIVOR APPLICATION

(Please PRINT CLEARLY and fill out both sides)

Office Use Only

_____
Claim Number

_____
Compensation Specialist

Survivor's Name: _____
FIRST NAME LAST NAME SUFFIX

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____)_____ ALTERNATE PHONE: (_____)_____

DATE OF BIRTH: ____/____/____ SURVIVOR'S SOCIAL SECURITY # _____-____-_____

NAME OF HOMICIDE VICTIM: _____ THIS SURVIVOR'S RELATIONSHIP TO THE VICTIM:_____

SURVIVOR'S PRIMARY LANGUAGE: _____

IF THE ABOVE SURVIVOR IS A MINOR CHILD, ENTER INFORMATION HERE ABOUT THE PERSON COMPLETEING THIS FORM: NAME: _____DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

RELATIONSHIP TO CHILD: _____PRIMARY LANGUAGE: _____

COMPLETE THE FOLLOWING AND SIGN THE RELEASES ON THE BACK OF THE APPLICATION

1. CRIME-RELATED EXPENSES: CHECK THE TYPE(S) OF CRIME-RELATED EXPENSES FOR WHICH YOU ARE SEEKING COMPENSATION:

NOT ALL ELIGIBLE HOMICIDE VICTIM SURVIVORS ARE ELIGIBLE FOR ALL HOMICIDE VICTIM SURVIVOR BENEFITS

___ MEDICAL EXPENSES
___ MENTAL HEALTH EXPENSES
___ LODGING
___ DEPENDENT CARE
___ RESIDENTIAL SECURITY
___ EMERGENCY RELOCATION

___ LOST WAGES: (check all that apply)
__ FUNERAL, BURIAL, MEMORIAL SERVICE
__ GRIEF LEAVE FROM WORK
__ MEDICAL / MENTAL HEALTH APPOINTMENTS

___ TRANSPORTATION: (check all that apply)
__ FUNERAL, BURIAL, MEMORIAL SERVICE
__ MEDICAL / MENTAL HEALTH APPOINTMENTS
__ COURT ATTENDANCE

2. LOST WAGES: DATES MISSED DUE TO CRIME: _____

EMPLOYER: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP:_____

EMPLOYER'S PHONE: (____)_____ CONTACT PERSON'S NAME: _____

3. INSURANCE: CHECK ALL INSURANCES AVAILABLE TO THE SURVIVOR. (PROVIDE THE POLICY #, INSURANCE COMPANY NAME, AND ADDRESS) ☐ NO INSURANCE COVERAGE

☐ HEALTH INSURANCE: _____

☐ MEDICAID OR MEDICARE: _____

4. ATTORNEY: IS THE SURVIVOR REPRESENTED BY A PRIVATE ATTORNEY IN A CIVIL LAWSUIT OR INSURANCE ACTION RELATED TO THIS CRIME? ☐ YES ☐ NO ☐ NOT AT THIS TIME

ATTORNEY'S NAME: _____ PHONE: (_____)_____

ADDRESS:_____CITY/STATE/ZIP: _____

STATISTICAL INFORMATION: THIS INFORMATION IS REQUIRED BY FEDERAL REGULATION AND USED ONLY FOR STATISTICAL PURPOSES A.) **GENDER:** ☐ MALE ☐ FEMALE ☐ OTHER B.) **AGE:** ☐ 0-12 ☐ 13-17 ☐ 18-24 ☐ 25-59 ☐ 60 & OVER

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

☐ ASIAN OR FACIFIC ISLANDER ☐ NATIVE HAWAIIAN OR OTHER 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 BEFORE YOU CAN 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 agree that the CVC or its representatives may pursue restitution from the convicted offender in this matter to recover monies paid to me or to providers by the CVC and that by filing this application I have authorized the use of information in this application and subsequent claim files to pursue restitution from the convicted offender. 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 crime-related providers such as doctor, clinic, hospital, dentist, ambulance, etc.

Provider	Address, City, State, Zip	Telephone

I give permission to any healthcare provider, any medical biller, any funeral director or similar persons, any employer, any police or other government agency (included but not limited to: the Department of Justice, the Department of Human Services, University of Iowa Hospitals & Clinics, Iowa Workforce Development, or any other out-of-state Workforce Agency, Social Security Administration), any insurance company or any other person or agency, to give requested information related to this application, including medical & billing records and test results (which may include drug and alcohol and HIV & AIDS screening and related information), wage and employer information and/or mental health records and billing statements, to the CVC Program of the Iowa Department of Justice. 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.
- 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

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 crime-related 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.