

GEORGIA CRIME VICTIMS COMPENSATION PROGRAM APPLICATION

104 Marietta Street, Suite 440 – Atlanta, GA 30303
 Office (404) 657-2222 Fax (404) 463-7652 Toll Free (800) 547-0060 TTY (404) 463-7650
 Web Site: cjcc.ga.gov

SECTION 1. VICTIM / WITNESS INFORMATION		Please provide information on the individual who witnessed a violent crime, or was injured or killed as result of a violent crime.	
Name of Victim / Witness (First, Middle Initial, Last)		Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth (MM/DD/YY) / /
Street Address (including apartment #)		City	State
Best Contact Phone Number	Alternate Phone Number	E-Mail Address	
Please check all that apply: <input type="checkbox"/> Victim/Witness gainfully employed at the time of the crime <input type="checkbox"/> Victim/Witness unable to work due to the crime			
Please provide the date(s) victim/witness was out of work, due to crime:			
Demographic Data (Optional for Statistical Use Only)		(Optional - for Statistical Use Only)	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native American or <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____		Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of disability <input type="checkbox"/> Mental <input type="checkbox"/> Physical	

SECTION 2. SECONDARY CONTACT INFORMATION		If your contact information above becomes invalid, please provide information for a person we can contact to reach you about your claim or mail correspondence for you to their address.	
Name (First, Middle Initial, Last)		Best Contact Phone Number	Alternate Phone Number
Street Address (including apartment #)		City	State
			Zip Code

SECTION 3. BENEFITS REQUESTED		Please complete this section by checking all the benefits you are applying for. The program may request additional information once the application is received.	
<input type="checkbox"/> Medical Include your itemized bill(s) with your application.	<input type="checkbox"/> Lost Wages Include paystubs for at least 60 days prior to the crime.	<input type="checkbox"/> Loss of Support Include paystubs for at least 60 days prior to crime and proof of support.	<input type="checkbox"/> Counseling Include your itemized bill(s) with your application.
		<input type="checkbox"/> Funeral/Burial Include your itemized bill(s) and death certificate with your application.	<input type="checkbox"/> Crime Scene Clean-Up Include your itemized bill(s) with your application.
If applying for lost wages, 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 crime. If eligible, you can only be reimbursed when you missed work and were not paid, or your wages were only partially covered.			
Please check if you have requested/filed: <input type="checkbox"/> Restitution <input type="checkbox"/> Civil Action/Lawsuit			

SECTION 4. CLAIMANT INFORMATION		Complete this section if you are filing on behalf of the deceased victim, minor victim, an incapacitated adult victim, or if you are not the victim, but are paying bills on behalf of the victim.	
Claimant's Name (First, Middle Initial, Last)		Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth (MM/DD/YY) / /
Street Address (including apartment #)		City	State
			Zip Code
Relationship to Victim/Witness	Best Contact Telephone Number	Alternate Telephone Number	

SECTION 5. CRIME INFORMATION		Include with this application, a copy of the incident report from law enforcement, child protective services, the courts, medical authorities or any other official governmental or investigative authority.	
Location of Crime	County of Crime	Date of Crime	Date Crime Reported
Type of Crime Reported	Agency Crime Reported To	Name of Officer/Detective	
Offender's Name	Law Enforcement Case Number		

SECTION 6. INSURANCE INFORMATION		Please provide information on any insurance, Medicaid, or Medicare benefits that you have available to you. If you have insurance, please send a copy of your card with your application.			
Please check if you have applied for: <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Social Security Benefits <input type="checkbox"/> Other _____					
Name of Primary Insurance Company		Policy Number		Policy Number	
Address		City		State	Zip Code
Name of Secondary Insurance Company		Policy Number		Policy Number	
Address		City		State	Zip Code

SECTION 7. REFERRAL INFORMATION		Please tell us who referred you to the Crime Victims Compensation Program.			
Name of Referring Agency or Office			Name of Contact Person from Referring Agency or Office		

SECTION 8. SUBROGATION AGREEMENT ACKNOWLEDGEMENT		Please read carefully, a copy of this signed release shall be considered the same as the original.			
I hereby agree that if I am awarded any money by the Georgia Crime Victims Compensation Board, in consideration of such award, I assign, transfer and subrogate to the Board, all rights, claims, interests, and rights of action, to the extent of the Board's award, that I may have against other parties or entities that may be obligated to compensate me for the injuries or damages which form the basis for this application. I also hereby certify that, to date, I have not received any compensation except as noted on this form.					
_____ Victim/Witness/Claimant Signature (Original Signature Required)				_____ Date	

SECTION 9. MEDICAL AND CRIMINAL HISTORY ACKNOWLEDGEMENT		Please read carefully, a copy of this signed release shall be considered the same as the original.			
A Criminal History 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 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.					
_____ Victim/Witness/Claimant Signature (Original Signature Required)				_____ Date	

SECTION 10. ACKNOWLEDGEMENT OF UNDERSTANDING		Please read carefully, a copy of this signed release shall be considered the same as the original.			
I declare and affirm under the penalty of perjury that the statements made on this Application are true and correct. I hereby acknowledge that the Georgia Crime Victims Compensation Program will only award compensation if <u>all</u> of the program's eligibility requirements are met; I also acknowledge that the Georgia Crime Victims Compensation Program is <u>not</u> an entitlement program, and is the payor of last resort. As such, my benefits will be reduced by the monies I receive from any other source as a result of the crime, such as insurance, restitution, and civil suit settlements.					
_____ Victim/Witness/Claimant Signature (Original Signature Required)				_____ Date	

Form CV-1 Revised January 8, 2014