



West Virginia
CRIME VICTIMS
COMPENSATION FUND
1900 Kanawha Blvd. E, Rm.-W334
Charleston WV 25305-0610



OFFICE OF THE COURT OF CLAIMS
CRIME VICTIMS COMPENSATION FUND

APPLICATION
FOR WEST VIRGINIA CRIME VICTIMS COMPENSATION

- ⇒ **Include all the documentation you can - if you have a copy of the police report, hospital or doctor bills, please send with the application.**
- ⇒ If you do not have this documentation, do not wait to mail the application if you are near the two-year deadline. Send the application as soon as you have it completed and follow-up with the documentation later.
- ⇒ ***Keep this page so that you will have our address and telephone number.***
- ⇒ **Be sure to let us know of any address or telephone number changes.**
- ⇒ If you need help completing the application, contact us or check with your local prosecuting attorney's Victim Assistance Coordinator, if available.
- ⇒ Sign this Application (**Page 4**) in front of a notary public.
- ⇒ ***Failure to notarize will delay the processing of your claim.***

Mail your completed application to:

**CRIME VICTIMS COMPENSATION FUND
1900 KANAWHA BLVD E ROOM W-334
CHARLESTON WV 25305-0610**

304.347.4850
877.562.6878 (toll free)
Fax 304.347.4915
e-mail: cvictims@wvlegislature.gov
www.legis.state.wv.us/joint/victims/.cfm

INFORMATION

THE WEST VIRGINIA CRIME VICTIMS COMPENSATION FUND

- ★ PROVIDES financial assistance to victims of crime for related expenses that cannot be reimbursed from insurance or other sources.
 - ★ COMPENSATION for medical, funeral/burial expenses, work loss, mileage to a medical treatment facility and to court for the prosecution of the offender, mental health counseling, and relocation expenses.
 - ★ ADMINISTERED by the West Virginia Court of Claims.
-

HOW IS THE SYSTEM FUNDED?

- ★ EVERY person who is convicted of or pleads guilty to a misdemeanor or felony offense, other than a non-moving traffic violation, is assessed additional court costs, which are transmitted to the State Treasurer for deposit into the Crime Victims Compensation Fund.
 - ★ NO tax dollars are used.
-

WHO CAN FILE A CLAIM?

- ★ ANY innocent victim who suffers personal injury as the result of a crime.
 - ★ ANY individual who is the dependent of a deceased victim of crime. (A dependent is one who has received over one half of his/her support from the victim.)
-

WHAT IS REQUIRED?

- ★ The crime **MUST** be reported to law enforcement officials within **72 hours**.
 - ★ The claimant must fully cooperate with law enforcement officials.
 - ★ The claim for compensation **MUST BE FILED** within **2 years** of the date of the crime.
-

IS THERE A LIMIT TO THE AMOUNT RECOVERABLE?

- ★ In injury claims, the maximum is \$35,000.00.
 - ★ In death claims, the maximum is \$50,000.00 (including \$10,000.00 for funeral and burial expenses.)
-

HOW IS A CLAIM PROCESSED?

- ★ The Claim Investigator reviews the claim and files a Finding of Fact and Recommendation.
 - ★ A Judge of the Court of Claims evaluates the claim without a hearing and renders a decision.
 - ★ A hearing on the matter will be held if either the claimant or the Claim Investigator disagrees with the decision rendered.
-

IS THE LOSS OF OR DAMAGE TO PROPERTY RECOVERABLE?

- ★ No. Damaged or stolen property, including money, is **NOT** recoverable. However, prosthetic devices such as eyeglasses and dentures are compensable.
-

IS THERE A FILING FEE?

- ★ No.
-

DO YOU NEED AN ATTORNEY?

- ★ No. But if a claimant seeks the services of an attorney to file the claim, reasonable fees will be paid by the Fund at no cost to the claimant.
-

If you are not sure of your eligibility, call us for additional information. We care!

WEST VIRGINIA CRIME VICTIMS COMPENSATION FUND

1

Office Use Only

West Virginia Crime Victims Compensation Fund
1900 Kanawha Blvd., E., Room W-334
Charleston, WV 25305-0610
Voice: 304-347-4850 & 877-562-6878
Fax: 304-347-4915
Email: cvictims@wvlegislature.gov

Office Use Only

Claim No.:

CV- _____ - _____ - _____

Date Received:

APPLICATION

PLEASE COMPLETE ALL SECTIONS and PRINT CLEARLY

VICTIM Information

VICTIM'S FIRST NAME MI VICTIM'S LAST NAME

VICTIM'S MAILING ADDRESS

CITY STATE ZIP CODE

(_____) _____
(AREA CODE) HOME PHONE NUMBER

(_____) _____
(AREA CODE) DAYTIME PHONE NUMBER

E-MAIL ADDRESS (please print clearly)

XXX-XX-_____
SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

_____/_____/_____
DATE OF BIRTH

- American Indian or Alaska Native
- Asian
- Black or African American
- Caucasian / White Non-Latino
- Native Hawaiian or Other Pacific Islander
- Hispanic or Latino
- Multiple Races
- Other _____
- Not Reported

CLAIMANT Information (only if not the victim)

CLAIMANT'S FIRST NAME MI CLAIMANT'S LAST NAME

CLAIMANT'S MAILING ADDRESS

CITY STATE ZIP CODE

(_____) _____
(AREA CODE) HOME PHONE NUMBER

(_____) _____
(AREA CODE) DAYTIME PHONE NUMBER

E-MAIL ADDRESS (please print clearly)

XXX-XX-_____
SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

_____/_____/_____
DATE OF BIRTH

RELATIONSHIP TO VICTIM

ADDITIONAL VICTIM INFORMATION

- Male
- Female
- Unknown
- Single
- Married
- Separated
- Divorced

Are you claiming mileage expense? (Victim ONLY)

- To Court
- To Medical Treatment Facility

VICTIM EMPLOYMENT INFORMATION

Was the Victim employed on the date of the injury? NO YES

Did the Victim lose earnings that were not reimbursed? NO YES

Did the Victim lose work due to injury? NO YES

EMPLOYER'S FULL NAME ADDRESS CITY STATE/ZIP

EMPLOYER'S PHONE NUMBER WORK RELATED REMARKS

CRIME INFORMATION

DATE OF CRIME: _____/_____/_____

COUNTY OF CRIME: _____

LOCATION WHERE INJURY OCCURRED _____ CITY _____ STATE/ZIP CODE _____

POLICE AGENCY CRIME WAS REPORTED TO _____ ADDRESS _____ CITY _____ STATE/ZIP CODE _____

INVESTIGATING OFFICER'S NAME (if known) _____ WHO REPORTED THE INCIDENT TO POLICE? (IF KNOWN) _____

_____/_____/_____ Date Reported _____ Time Reported _____ If not reported within 72 hours, explain why _____

Suspect's Name Adult Juvenile 2nd Suspect's Name Adult Juvenile 3rd Suspect's Name Adult Juvenile

Did the victim know the suspect(s)? Yes No If yes, in what way? _____ Was victim living in same household with suspect(s)? Yes No

Please check the box that **most closely** describes the type of crime that occurred:

- | | |
|--|---|
| <input type="checkbox"/> Adult Sexual Assault | <input type="checkbox"/> Elder Abuse |
| <input type="checkbox"/> Arson | <input type="checkbox"/> Hate Crime: Racial/Religious/Gender/Sexual Orientation/Other |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Homicide |
| <input type="checkbox"/> Child Physical Abuse/Neglect | <input type="checkbox"/> Human Trafficking: Sex/Labor |
| <input type="checkbox"/> Child Pornography: Production/Possession/Distribution | <input type="checkbox"/> Robbery |
| <input type="checkbox"/> Child Sexual Abuse | <input type="checkbox"/> Stalking |
| <input type="checkbox"/> DUI/DWI Incident | <input type="checkbox"/> Terrorism/Mass Violence |
| <input type="checkbox"/> Other: _____ | |

Court Proceedings

Has the suspect(s) been charged? Yes No

COURT: Magistrate Court Circuit Court Juvenile Court Other (Specify) _____

Charge(s) _____

Narrative—In your own words, briefly describe what happened. Please do not write "See police report." Use additional sheets if necessary.

VICTIM'S INJURY INFORMATION

BRIEFLY DESCRIBE VICTIM'S INJURIES _____

WHERE WAS THE VICTIM TAKEN FOR EMERGENCY TREATMENT? ADDRESS CITY STATE/ZIP CODE

Was the victim hospitalized? YES NO From _____ to _____
DATE DATE

HOSPITAL NAME (IF DIFFERENT FROM EMERGENCY TREATMENT FACILITY) ADDRESS CITY STATE/ZIP CODE

ADDITIONAL PROVIDERS SEEN: _____

IMPORTANT: SUBMIT A COPY OF EACH OF THE VICTIM'S MEDICAL BILLS. INSURANCE STATEMENTS ARE NOT ACCEPTABLE.

VICTIM'S DEATH INFORMATION

DATE OF DEATH ____/____/____ DID VICTIM HAVE ANY DEPENDENTS? _____

FUNERAL HOME ADDRESS CITY STATE/ZIP CODE

NAME OF EXECUTOR OR ADMINISTRATOR OF VICTIM'S ESTATE, if any ADDRESS CITY STATE/ZIP CODE

COPIES OF THE FOLLOWING DOCUMENTS SHOULD BE SUBMITTED WITH THE APPLICATION OR AS SOON AS POSSIBLE THEREAFTER:

DEATH CERTIFICATE ~ SOCIAL SECURITY BENEFIT INFORMATION ~ FUNERAL & BURIAL EXPENSES
COURT ORDER FOR ADMINISTRATOR OF ESTATE ~ PROOF OF GUARDIANSHIP ~ BIRTH CERTIFICATES OF VICTIM'S MINOR CHILDREN

INSURANCE AND REIMBURSEMENT SOURCES

By law, you must first use all existing sources of financial assistance or reimbursement, including all insurances before receiving payment from the Crime Victims Compensation Fund.

CHECK ALL COVERAGE TYPES HELD BY THE VICTIM AT TIME OF INCIDENT

- | | |
|---|--|
| <input type="checkbox"/> MEDICAID | <input type="checkbox"/> MEDICARE |
| <input type="checkbox"/> HEALTH INSURANCE | <input type="checkbox"/> SOCIAL SECURITY |
| <input type="checkbox"/> AUTO INSURANCE | <input type="checkbox"/> LIFE INSURANCE |
| <input type="checkbox"/> WORKERS COMPENSATION | |

INSURANCE COMPANY NAME ADDRESS CITY STATE/ZIP CODE

DEPENDENTS OF VICTIM INFORMATION

A DEPENDENT IS ONE WHO HAS RECEIVED OVER ONE HALF OF HIS/HER SUPPORT FROM THE VICTIM.

<u>DEPENDENT'S NAME</u>	<u>DEPENDENT'S FULL ADDRESS</u>	<u>RELATIONSHIP TO VICTIM</u>	<u>DATE OF BIRTH</u>
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____

ATTORNEY INFORMATION (if applicable)

You are not required to have an attorney to file your application. However, if you do, the attorney fees are paid by the Crime Victims Fund.

- | | |
|---|--|
| <input type="checkbox"/> Attorney is ATTORNEY OF RECORD
(All communication will be with ATTORNEY) | <input type="checkbox"/> Attorney is ASSISTING ONLY
(All communication will be with CLAIMANT/VICTIM) |
|---|--|

ATTORNEY'S NAME ADDRESS CITY STATE/ZIP CODE

ATTORNEY'S SIGNATURE TELEPHONE NUMBER ATTORNEY'S EMAIL ADDRESS (please print clearly)

