CRIME VICTIMS COMPENSATION APPLICATION

State of Illinois
Court of Claims

State of Illinois
Attorney General

APPLICATION INSTRUCTIONS

- **Who should fill out the application?** The application must be completed by one of the following: 1) A person who was the victim of a violent crime should fill out the application; or 2) If the victim is under the age of 18 or under a legal disability, then the victim's parent or legal guardian should fill out the application; or 3) When seeking reimbursement for their own expenses, the parent, spouse, or child of a person injured or killed as a result of a violent crime can fill out the application; or 4) Any person that has paid or become obligated to pay expenses of the victim (medical / hospital, funeral / burial, psychological treatment of a mental or emotional condition caused or aggravated by the crime) can fill out an application. **The application must be signed by either the applicant, or the victim's parent or legal guardian if the victim is under 18 or under a legal disability.**

- **Documents.** Documents to support your request for compensation will be required to process your claim. If available, please send copies of all the documents you have with the completed application (e.g., police report, plenary order of protection, civil no-contact order, hospital, or doctor bills). If you do not have all the documents available, collect copies of any additional documentation so that you will have it available when we contact you.

- **Police reports.** To complete our investigation, we must get a police report for the incident. If you have the police report number, please include it in the crime section. If you do not have the report number, please provide as much information about the crime as possible.

- **Please complete the application by providing all of the requested information.** Attach additional sheets if the application does not provide sufficient space. Review the application after completion to ensure all required information has been included. Mail your completed application to:

  Office of the Illinois Attorney General
  Crime Victim Compensation Bureau
  115 South LaSalle Street, 12th Floor
  Chicago, IL 60603

- **Address or phone number change.** Once you have submitted an application, you must notify the Attorney General's Office immediately if your mailing address or phone number changes. Failure to provide corrected contact information may result in claim being closed without payment being recommended.

- **If we determine that you are eligible to receive reimbursement from for the program,** we may request additional documentation from you to support your request for reimbursement. All forms that must be completed or documents requested by the Attorney General must be returned to the office within 45 days before any expenses can be reimbursed.

- **If you need help completing this application** or would like referrals for services, contact the Office of the Illinois Attorney General at 1-800-228-3368. Individuals with hearing or speech disabilities can reach us by using the 7-1-1 relay service.

Section 1. Victim and Applicant Information

- If you were the victim of a violent crime and you are over the age of 18, please fill in the victim information only. You are the victim and the applicant so it is not necessary for you to repeat your contact information in Part B. You must sign the application.
- If you are the parent, spouse, or child of a person who was physically harmed because of violent crime, you can request reimbursement for your own losses that resulted from the crime. In these instances, you are a statutorily defined victim. If you are the statutorily defined victim and over the age of 18, please fill in the victim information only. In these instances you are the statutory victim, and the applicant so it is not necessary for you to repeat your contact information in Part B. You must sign the application.
- If you are applying on behalf of a minor, disabled, or deceased victim (i.e., you are the parent of a minor child or the relative of a deceased victim) please put the victim's information in Part A and your contact information in Part B. If you complete the application on behalf of a minor, disabled, or deceased victim, you should sign the application.
- If you are applying to receive reimbursement for expenses you paid or became obligated to pay on behalf of the victim, you are the applicant. **You must complete Part A with information for the victim that was physically harmed. You must complete Part B with your information. You must sign the application.**
- Your correct information is necessary for our office to contact you with further questions and to send documents. If your contact information is not correct, you may not be able to receive payment.
- An advocate works with crime victims and provides assistance and referrals. You do not need an advocate to apply for compensation. However, if you are working with an advocate and you would like us to speak with your advocate regarding your claim or obtain information about your case from your advocate, please list the information in Section C.
- If there is another individual who you would like us to discuss your claim with, please provide that person's name in Section C. If the analysts working on your claim are unable to reach you, your claim may not be recommended for payment. It is helpful, but not necessary, to have another means of getting information about the claim to avoid becoming ineligible for the program. If the person listed cannot be contacted or is unable to provide the necessary information, you will be contacted to discuss the claim.
- If you are the spouse or parent of a victim applying for your own expenses, please complete a separate application for yourself.

Section 2. Crime and Court Information

- This section collects information about the crime and any court proceedings that have taken place as a result of the crime. Not all of the sections may apply to your situation; provide as much information as you have available.
- Include a police report number, if known.
- Please submit one application per crime.

Section 3. Losses Claimed

- This section collects information on what types of compensable losses you may have incurred as a result of the crime. Compensable losses are those types of losses that are covered by the Crime Victims Compensation Act.
- If you have any questions or would like to have more information on the types of expenses that are compensable, please call 1-800-228-3368, individuals with hearing or speech disabilities can reach us by using the 7-1-1 relay service.

Section 4. Medical Information and Benefits

- Complete this section only if you are applying for medical, dental or counseling expenses.
- If you are the parent, spouse, or child, applying for counseling expenses you incurred because of the crime against an injured child, spouse, or parent, fill out a separate application listing yourself as the victim.
- Counseling expenses can only be considered for payment if the counseling is provided by one of the following: licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed professional counselor or a Christian Science practitioner/nurse.

Section 5. Employment Information

- Complete this section if you are applying for lost earnings. Reimbursement is available for earnings lost due to time off recovering from the crime and attending court.
- If you are a parent, spouse, or child, applying for lost earnings for time you missed from work to care for your injured child, spouse, or parent, fill out a separate application listing yourself as the victim.

Section 6. Funeral/Burial Information & Death Benefits

- Fill out this section if you are applying on behalf of a deceased victim.
- Loss of support is provided when a crime victim was working prior to the crime, but due to his or her death is no longer able to provide monetary support or meet a legal obligation to provide monetary support.
- We require information on all of the dependents of the victim before any recommendations can be made. Include the name(s) of any dependents, date of birth, and name and phone number of legal guardian(s).

Section 7. Certification and Authorization

- The Acknowledgement of Subrogation indicates that you have read the section, understand and agree to subrogate your rights to recovery should you get restitution from the criminal case or money from a civil lawsuit. This means that if you, or any vendors on your behalf, receive money from the Crime Victims Compensation Program, you agree that if you recover money from any other source, such as from the offender or a civil suit, that you will repay the money you received from the Crime Victims Compensation Program.
- The Release of Information authorizes the Office of the Illinois Attorney General to request medical, financial and other necessary information to process your claim. The Office of the Illinois Attorney General will request only what is necessary to investigate the claim.
- Read the Certification of Application, which certifies that the information you have given in the application is true and accurate, under penalties of perjury. Make sure that you have provided the most complete and accurate available information before you sign.
- The application requests information about an attorney. However, you do not need an attorney to apply for this program.

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COMPLETE ALL SECTIONS TO THE BEST OF YOUR ABILITY.
SEE INSTRUCTIONS FOR INFORMATION ON FILLING OUT THE APPLICATION.
Required fields are denoted with a red Asterisk "*".
If you need help, call the Attorney General's Office at **1-800-228-3368**, 7-1-1 relay service.

NOTICE:
Application forms are public records, which are subject to the Freedom of Information Act just like other public records. If we receive a request for copies of records that include your application, we may be required to provide a copy of your application to the requestor. Information that would reveal your identity as an applicant is, however, exempt from disclosure and will be deleted from copies that we provide, allowing the requestor to read your application without compromising your privacy.

Office Use Only

SECTION 1. VICTIM & APPLICANT INFORMATION

Is the victim a minor, deceased, or incapacitated or do you have legal guardianship?* ☐ YES ☐ NO
If the answer is YES, please complete both Section A and B.

A. VICTIM / DECEASED VICTIM INFORMATION

Victim's Name:* _____ Date of Birth:* _____ / _____ / _____
Street Address:* _____ Apt#: _____
City:* _____ State:* _____ Zip Code:* _____
E-mail Address:* _____
Cell Phone:* (____) _____ - _____ Alternate Phone: (____) _____ -_____
Work Phone: (____) _____ - _____
☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male
☐ Genderqueer/Gender Non-Conforming (GNC) ☐ Prefer Not to Answer ☐ Not Listed
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Civil Union Partner

The following information is used for statistical purposes only according to federal regulations. Providing this information is voluntary and will not affect your application. Victim's Race: ☐ White
☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian
Other Race _____
Victim's Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Do you have a disability? ☐ Yes ☐ No, If yes, nature of disability ☐ Physical ☐ Mental ☐ Developmental.

B. APPLICANT INFORMATION, if you are applying on behalf of the Victim

Applicant's Name:* _____ Date of Birth:* _____ / _____ / _____
Street Address:* _____ Apt#: _____
City:* _____ State:* _____ Zip Code:* _____
E-mail Address:* _____
Cell Phone:* (____) _____ - _____ Alternate Phone: (____) _____ -_____
Work Phone: (____) _____ - _____

☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Genderqueer/Gender Non-Conforming (GNC)
☐ Prefer Not to Answer ☐ Not Listed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Civil Union Partner

Relationship to victim:_____

C. CONTACT INFORMATION

- Is English your preferred language? ☐ Yes ☐ No
  If no, language you are most comfortable speaking: _____
- Are you working with an advocate? ☐ Yes ☐ No If yes, please provide the following:
  Name:_____ Telephone: _____
  Organization: _____ E-mail Address: _____
- Do you consent to allow the Attorney General's Office to discuss your claim with your advocate or obtain documents required for your claim? ☐ Yes ☐ No
- Is there another person you would prefer us to contact to discuss your claim? ☐ Yes ☐ No
  Name: _____Telephone: _____
  Relationship to you: _____

SECTION 2 - CRIME AND COURT INFORMATION

A. CRIME INFORMATION

Police Report #: * _____

Date of Crime: * _____ / _____ / _____ Date Crime Reported: * _____ / _____ / _____

Street Address where crime occurred: * _____

City: * _____ County: * _____

Name of Agency/Police Department crime reported to: * _____

Briefly Describe crime: * _____

Briefly Describe injuries: * _____

Do you know the identity of the offender(s)? ☐ Yes ☐ No

- If yes, offender(s) name(s): _____
  Relationship, if any, between victim and offender(s): _____
- Was a sexual assault evidence collection kit performed at a hospital? ☐ Yes ☐ No

B. CRIMINAL CASE INFORMATION

- Was the offender arrested? ☐ Yes ☐ No ☐ Unknown
- Has the offender been charged in court? ☐ Yes ☐ No ☐ Unknown
- Were you required to testify for this case? ☐ Yes ☐ No ☐ Unknown
- What was the outcome of the criminal case? (Include criminal case number if any)
- _____
- _____
- Has restitution been ordered against the offender? ☐ Yes ☐ No, If yes, how much? $_____

C. ORDER OF PROTECTION INFORMATION

Did you obtain a Plenary Domestic Violence Order of Protection, a Civil No-Contact Order, or a Stalking No Contact order? ☐ Yes ☐ No

If yes, please enter the number: OOP#_____ CNCO#_____

When does the Order of Protection expire? _____

D. CIVIL CASE INFORMATION

- Has a civil lawsuit been filed against anyone in relation to this incident? ☐ Yes ☐ No
  Name of lawyer handling your civil suit: _____ ARDC No.: _____
  Telephone: (____) _____ - _____ E-mail Address: _____

SECTION 3 - LOSSES CLAIMED

☐ Medical/Hospital	☐ Dental	☐ Transportation	☐ Accessibility Costs
☐ Crime Scene Cleanup	☐ Counseling**	☐ Relocation Costs	☐ Temporary Lodging
☐ Tattoo Removal*	☐ Loss of Earnings	☐ Tuition	☐ Replacement Service Loss
☐ Locks	☐ Windows	☐ Clothing	☐ Bedding
☐ Prosthetic Appliances	☐ Eyeglasses/Contacts	☐ Hearing Aids	☐ Replacement Costs
☐ Loss of Support	☐ Towing and Storage	☐ Funeral/Burial	☐ Loss of Future Earnings
☐ Dependent Replacement Service Loss			

- * Available for victims of Human Trafficking only
- ** Counseling expenses must be provided by a psychiatrist, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or a Christian Science practitioner / nurse.

SECTION 4 - MEDICAL INFORMATION & BENEFITS

Please submit copies of itemized bills. All bills must be submitted to other sources of recovery available to the victim.

Medical Provider	City	Provider Phone No.	Date(s) of Services	Amount of Bill

Insurance and Other Collateral sources? ☐ Yes ☐ No
Insurance and other collateral source information. The Crime Victims Compensation Program offers reimbursement after all other sources of payment have been exhausted.
Please enter Policy and ID# information in the corresponding field.

Medical Card	Medicare	Medical Insurance

Union Insurance	Vision/Dental Insurance, etc.	Worker's Compensation

Veterans Administration	SSI or SSDI	Auto Insurance

Proceeds of Personal Injury or Other Litigation	Hospital Uninsured Patient Discount	Other Insurance

SECTION 5 - EMPLOYMENT INFORMATION

- In order to qualify for loss of earnings the victim must have been actively employed at the time of the crime.
- Are you applying for loss of earnings due to the crime? ☐ Yes ☐ No
  Please list all employment history during the six (6) months before the crime:

Name of Employer	Employer's Address	Employer's Phone No.	Victim's Net Monthly Wages (Take Home Pay)

Did you receive sick, vacation, personal time, or disability benefits from work after the crime? ☐ Yes ☐ No

Type of Benefits	Amount
Sick	$
Vacation	$
Personal	$
Disability	$
Other	$

SECTION 6 - FUNERAL/BURIAL INFORMATION & DEATH BENEFITS

A. FUNERAL AND BURIAL

Name of Funeral Home

Funeral Home Phone Number	Total Amount of Funeral Bill
	$

Name of Person(s) who have paid	Relationship to Victim	Amounts
		$
		$
		$
		$
		$

CEMETERY INFORMATION

Name of Cemetery

Cemetery Phone Number	Total Amount of Cemetery Bill
	$

Name of Person(s) who have paid	Relationship to Victim	Amounts
		$
		$
		$
		$
		$

Total Amount of Funeral/Cemetery Expenses

B. LIFE INSURANCE AND DEATH BENEFITS

- Did the victim have a life insurance policy? ☐ Yes ☐ No

Name of Insurance Company	Name of Beneficiary	Beneficiary's Phone No.	Amount Paid

C. LOSS OF SUPPORT TO DEPENDENTS

- Was the victim employed during the six (6) months before the crime? ☐ Yes ☐ No

Name of Dependent	Relationship to Victim	Date of Birth	Name/Phone Number of Legal Guardian

SECTION 7 - CERTIFICATION AND AUTHORIZATION

Acknowledgement and Subrogation: As required by the subrogation provision of the Illinois Crime Victims Compensation Act, 740 ILCS 45/17, I will contact and repay the Crime Victims Compensation Program if I receive any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private agency to cover expenses for which I receive payment from the Compensation Program. I understand that I will be responsible for repaying the Compensation Program any amount for which it is later determined that I was not eligible.

Release of Information: I hereby authorize any hospital, physician, health care provider, mental health provider, funeral director, or other person who rendered related services; any employer of the victim or applicant; any law enforcement or governmental agency; any insurance company; or any other individual company, agency or organization having relevant knowledge, to furnish any and all information in their possession with respect to the incident that is the basis for this claim to the Crime Victims Compensation Bureau of the Illinois Attorney General's Office. This information is to be used in any way necessary related to my claim for an award of compensation from the Illinois Crime Victims Compensation Program.

I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS, and AIDS-related conditions.

I understand that at any time I may revoke this authorization from the Illinois Attorney General's Office, except to the extent that action has been taken in reliance on this authorization. This authorization will expire in 3 years from the date the victim/applicant signed or when this claim is resolved.

This authorization complies with the requirements of 45 C.F.R. § 164.508, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule. A photocopy or facsimile copy of this authorization shall have the same effect as the original.

Certification of Application: I hereby certify, subject to the penalties of perjury, that all of the information that I have provided in this application is true, accurate, and complete to the best of my knowledge. I understand that if I willfully provide any information that is false, incomplete, or misleading, I may be denied benefits and/or I may be prosecuted for crimes punishable by imprisonment, a fine, or both.

_____ _____

Applicant's Signature **Date Signed**

Are you being represented by counsel for this Crime Victims Compensation Claim? ☐ Yes ☐ No

Name of Lawyer: _____ ARDC No: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: (_____) _____-_____ E-mail Address: _____

740 ILCS 45/12 prohibits the charging of fees for presenting this form to the Court of Claims.

Please return completed application and all subsequent information to:

Office of the Illinois Attorney General
Crime Victims Services Bureau
115 South LaSalle Street, 12th Floor
Chicago, IL 60603