



## Perfected Claims Checklist

Please use this checklist to help you gather all the information needed to file a Perfected Claim. If you are unable to obtain any of these documents or need assistance, please call the Perfected Claims Coordinator, Kelli Grace, at 614-995-4231 or 800-582-2877 and ask for a perfected claims team member.

Before submitting a perfected claim to the Ohio Crime Victims Compensation Program, please review the following checklist to ensure that you are providing all necessary documentation / information.

### Medical Expenses:

- Itemized copies of related medical bills listing all charges, payments and adjustments.
- An Attorney General's Office medical information report completed by each doctor that is providing on-going medical treatment (attached to this document).
- A signed and dated HIPAA compliant authorization release (attached to this document). Please check our website to see if the hospital requires a special authorization release. If so, please download, complete and include the release form with the filed application.
- ▶ If the victim was treated by a non- network provider, please include documentation showing that the victim was referred to the non-network provider.

### Victim or Family Counseling Expenses:

- A signed and dated psychotherapy release for **each** family member seeking counseling (attached to this document).
- Itemized copies of related counseling bills listing all charges, payments and adjustments.
- An Attorney General's Office mental health report completed by each provider who has provided treatment as a result of the crime (attached to this document).
- ▶ If the victim was treated by a non- network provider, please include documentation showing that the victim was referred to the non-network provider.

### Lost Wages:

- A disability statement from a medical or counseling provider.
- An Attorney General's Office employment information report, completed by the employer and copies of paychecks for 6 weeks prior to the crime (attached to this document).

**Lost Wages when an applicant is self-employed:**

- Complete tax returns for the year prior to the incident and if available, the year of the incident.
- An Attorney General's Office self-employed applicant's information form. (attached to this document).

**Replacement Services:**

- The name, address & phone number of any person(s) providing replacement services. Include a list of services provided listing the date of service and amount paid as well as documentation of the payment (i.e. cancelled checks).
- Statement from a doctor supporting the need for replacement services.

**Evidence Replacement:**

- An itemized list including the estimated value for each item held as evidence.

**Crime Scene Cleanup Expenses:**

- Contracts/receipts for cleanup expenses.

**Mileage Expenses:**

- Please provide the following for each trip; date(s), distance traveled, the complete address of the origination and destination points.

**Name of the Victim Witness Assistance Program that helped with the filing of this Perfected Claim:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State Zip: \_\_\_\_\_

Telephone Number (Area Code) \_\_\_\_\_

Email Address: \_\_\_\_\_

Signature: \_\_\_\_\_



# MIKE DEWINE

★ OHIO ATTORNEY GENERAL ★

### The Ohio Victims of Crime Compensation Program

150 E. Gay St., 25th Fl.  
Columbus, OH 43215  
Telephone: (614) 466-5610  
(800) 582-2877  
Facsimile: (614) 752-2732  
(614) 995-5412  
www.ag.state.oh.us

## MEDICAL INFORMATION REPORT

Dr. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Victim's Name: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_  
Victim's Date of Birth: \_\_\_\_\_ Claimant's Name: \_\_\_\_\_  
Victim's SSN: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Dear Doctor:

An Application for Crime Victims Compensation has been filed for reimbursement of medical expenses not covered by insurance or other sources as outlined in Chapter 2743.51, O.R.C. Enclosed is an Authorization Release. To help us determine reimbursement, if any, please provide the following information. Thank you for your cooperation. If you have questions please call 800-582-2877 (Statewide) or 614-466-5610.

**Please complete and return with itemized bill(s) to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMPORTANT INFORMATION EFFECTIVE JULY 1, 2000**

**DIRECT PAYMENT CANNOT BE MADE WITHOUT A TAX ID NO. & ITEMIZED BILL(S) SHOWING CHARGES, PAYMENTS & ADJUSTMENTS. ACCEPTING A CVC PAYMENT FOR INJURY RELATED SERVICES IS CONSIDERED PAYMENT IN FULL.**

**PATIENT HISTORY**

History Described By Patient:

**DIAGNOSIS**

Date of First Exam:

Date of Last Exam:

Diagnosis:

Victim Name: \_\_\_\_\_

Were all the injuries caused by the crime as described by patient? Yes  No   
 If no, what percentage of your services was related to the crime? \_\_\_\_\_%  
 Were there any pre-existing conditions aggravated by the crime? Yes  No   
 If yes, please describe the pre-existing condition(s):

PROGNOSIS / DISABILITY

Is/was the patient injured or emotionally distressed to the extent that they were unable to work? Yes  No   
 Dates Unable To Work: From: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 To: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 From: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 To: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Is patient still unable to work? Yes  No   
 If yes, what is the anticipated date the patient can: Return to full-time work: \_\_\_\_\_  
 Return to limited work: \_\_\_\_\_ With the following restrictions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What percentage of the patient's inability to work was a result of the crime? \_\_\_\_\_%  
 Has the patient been released from treatment? Yes  No

INSURANCE

Are you a Medicare, Medicaid or County Welfare Provider? Yes  No  [Circle all that apply]  
 Patient's Insurance Company Name and Complete Address:  
 \_\_\_\_\_  
 Insurance Policy or Case No.  
 Do you participate in a "UCR" or contract program with the above noted insurance(s) carrier? Yes  No

PHYSICIAN INFORMATION

Physician Name:  
 Provider Billing Name:  
 Provider Billing Address:  
 \_\_\_\_\_  
 Tax ID No. Phone No. Fax No.

Prepared By: \_\_\_\_\_ Date \_\_\_\_\_  
 Signature / Title



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## MENTAL HEALTH REPORT

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Victim's Name: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_  
Patient's Date of Birth: \_\_\_\_\_  
Patient's SSN: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_  
Claimant's Name: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_

Dear Sir or Madam:

An Application for Crime Victims Compensation has been filed for reimbursement of mental health expenses not covered by insurance or other sources as outlined in Chapter 2743.51, O.R.C. Enclosed is an Authorization Release. To help us determine reimbursement, if any, please provide the following information. Thank you for your cooperation. If you have questions please call 800-582-2877 (Statewide) or 614-466-5610.

**Please complete and return with itemized bill(s) to:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMPORTANT INFORMATION EFFECTIVE JULY 1, 2000**

**DIRECT PAYMENT CANNOT BE MADE WITHOUT A TAX ID NO. & ITEMIZED BILL(S) SHOWING CHARGES, PAYMENTS & ADJUSTMENTS. ACCEPTING A CVC PAYMENT FOR INJURY RELATED SERVICES IS CONSIDERED PAYMENT IN FULL.**

**CLINICAL INFORMATION**

Presenting Problem: (Be specific with respect to the original description by patient)

Explain below how the above symptoms directly related to the crime victimization?

Are you providing treatment for conditions that existed prior to the victimization? Yes  No

**If yes, session notes must accompany this report and explain below:**

Victim Name: \_\_\_\_\_

CLINICAL INFORMATION (Continued)

Are you aware of any therapy prior to your treatment? Yes  No

If yes, provide name and address of person who provided treatment.

In your opinion, is the above stated problem a direct result of the alleged crime? Yes  No

What percent of therapy is directly related to the crime? \_\_\_\_\_%

Is/was patient unable to perform any type of gainful employment as a direct result of the crime? Yes  No

Dates Unable To Work: From: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ To: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
From: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ To: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Is patient still unable to work? Yes  No

If yes, what is the anticipated date the patient can: Return to full-time work: \_\_\_\_\_

Return to limited work: \_\_\_\_\_ With the following restrictions: \_\_\_\_\_

DIAGNOSTIC INFORMATION (DSM IV) AND TREATMENT PLAN

Axis I

Axis II

Axis III

Type Of Treatment:

Individual Therapy  Family Therapy  Group Therapy

Medication Mgt.  Psychological Asses./Testing  Other

Issues to be addressed:

Frequency of Sessions:

THERAPIST INFORMATION

Are you a Medicare, Medicaid or County Welfare Provider? Yes  No  [Circle all that apply]

Therapist Name:

Provider Billing Name:

Provider Billing Address:

Tax ID No.

Phone No.

Fax No.

Prepared By:

Signature / Title

Date



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### EMPLOYMENT INFORMATION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Claim No.: \_\_\_\_\_  
Victim's Name: \_\_\_\_\_  
Claimant's Name: \_\_\_\_\_

Date of injury: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Employee's SSN: \_\_\_\_\_

### Dear Sir or Madam:

An Application for Crime Victims Compensation has been filed for consideration of lost wages as a result of a crime. We have been informed that the individual was employed or was to be employed at the time of the crime. Enclosed is an Authorization Release. Thank you for your cooperation. If you have questions please call 800-582-2877 or 614-466-5610.

Return completed form to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMPLOYMENT INFORMATION						
<b>Dates Employed:</b>	From: _____/_____/_____		To: _____/_____/_____			
<b>Job Title:</b>	_____					
<b>Check One:</b>	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Temporary		
LIST NO. OF HOURS NORMALLY SCHEDULED TO WORK PER DAY						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
EARNINGS INFORMATION						
Hourly Rate of Pay _____ W-4 Filing Status: _____ No. of Exemptions: _____ <input type="checkbox"/> Married <input type="checkbox"/> Single						
How Often Paid? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Monthly						
PROVIDE EARNINGS HISTORY FOR THREE PAY PERIODS PRIOR TO DATE OF INJURY						
Would the employee have received any salary increases? Yes <input type="checkbox"/> No <input type="checkbox"/>						
Hourly amount of Increase _____			Effective Date _____			

TIME LOST DUE TO INJURY	
Begin Date	Return Date
Begin Date	Return Date
Begin Date	Return Date
Would employee have been scheduled for work during the above period(s)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
MEDICAL DOCUMENTATION	
Is medical documentation required for absences greater than 3 days? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, give name and complete address who provided documentation: _____	
MEDICAL BENEFITS	
Please list the source(s) of benefits available through your company for medical expenses, loss of earnings or short/long term disability: [Use reverse side if needed]	
Source of Benefits: _____	
Mailing Address: _____	
Type of Benefits: _____	
Policy/Group No.: _____	
DISABILITY BENEFITS	
Source of Benefits: _____	
Mailing Address: _____	
Type of Benefits: _____	
Policy/Group No.: _____	
If sick leave was available to the employee can it be cashed in? Yes <input type="checkbox"/> No <input type="checkbox"/> Carried over? Yes <input type="checkbox"/> No <input type="checkbox"/>	
How much sick leave was available at the time of injury? _____	
How much has been paid in <i>NET</i> sick leave as a result of the injury? _____	
Employer Name:	
Employer Address:	
Telephone No.	Fax No.
Name and Title:	
Signature and Date:	

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## SELF-EMPLOYED APPLICANT'S INFORMATION

EMPLOYEE NAME		
EMPLOYEE'S SOCIAL SECURITY NO.		EMPLOYEE'S DATE OF BIRTH
<b>JOB AND INCOME INFORMATION</b>		
<b>IF THE CRIME IMPACTED THE ABILITY TO MANAGE THE BUSINESS AND CAUSE ECONOMIC LOSS</b> <b>SEND TO OUR OFFICE A COPY OF THE FOLLOWING DOCUMENTATION TO SUPPORT YOUR CLAIM:</b>		
<ol style="list-style-type: none"> <li>1. COMPLETE TAX RETURN FOR YEAR OF INJURY (INCLUDE ALL APPLICABLE SCHEDULES)</li> <li>2. COMPLETE TAX RETURN FOR YEAR PRIOR TO INJURY (INCLUDE ALL APPLICABLE SCHEDULES)</li> <li>3. W-2 FORMS OR SIMILAR DOCUMENTATION FOR EMPLOYEES HIRED TO COVER YOUR ABSENCE</li> <li>4. W-2 FORMS OR SIMILAR DOCUMENTATION FOR EMPLOYEES HIRED TO FULFILL YOUR SIGNED BUSINESS AGREEMENTS THAT YOU COULD NOT PERFORM BECAUSE OF YOUR INJURY</li> <li>5. SIGNED BUSINESS AGREEMENTS THAT YOU COULD NOT PERFORM BECAUSE OF YOUR INJURY</li> </ol>		
<b>DATES ABSENT FROM WORK DUE TO CRIME (Use Reverse Side If Needed)</b>		
FROM DATE	TO DATE	REASON FOR ABSENCE
IF STILL OFF WORK WHAT IS THE ESTIMATED DATE OF RETURN? _____ PERSON OR HOSPITAL WHO TREATED THE VICTIM / APPLICANT FIRST (Include complete address)		
<b>NAME OF A DOCTOR WHO CAN TELL US THE LENGTH OF TIME YOU WERE UNABLE TO WORK.</b>		
DOCTOR'S NAME: _____ ADDRESS (INCLUDE CITY, STATE, ZIP) _____ TELEPHONE NO. _____		
<b>CHECK ALL SOURCES THE VICTIM OR APPLICANT HAS OR WILL RECEIVE MONEY FROM</b>		
<input type="checkbox"/> OFFENDER <input type="checkbox"/> WAGE CONTINUATION PLAN <input type="checkbox"/> DISABILITY PAY OR ANY OTHER SOURCE (Name, complete address and telephone #)		

**HAVE QUESTIONS OR NEED ASSISTANCE COMPLETING THIS FORM?  
 CALL 1-800-582-2877 OR 614-466-5610**

**HELP US TO PROCESS THIS APPLICATION TIMELY BY RETURNING THIS FORM WITHIN 14 DAYS**



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## REPLACEMENT SERVICES INFORMATION FORM

Victim	Applicant	
<b>Provide copies of receipts or canceled checks</b>		
Name of Provider: _____ Mailing address, street, city / state: _____ Telephone Number: _____ Type of Service: _____ Dates of Service: _____ Amount Paid: _____		
Name of Provider: _____ Mailing address, street, city / state: _____ Telephone Number: _____ Type of Service: _____ Dates of Service: _____ Amount Paid: _____		
Name of Provider: _____ Mailing address, street, city / state: _____ Telephone Number: _____ Type of Service: _____ Dates of Service: _____ Amount Paid: _____		
Provide name and address of physician or medical provider who can certify that the replacement service was medically necessary:		



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## CO-APPLICANT GENERAL AUTHORIZATION RELEASE

CLAIM NO.: \_\_\_\_\_

VICTIM'S NAME: \_\_\_\_\_

APPLICANT'S NAME: \_\_\_\_\_

CO-APPLICANT'S NAME: \_\_\_\_\_

CO-APPLICANT'S ADDRESS: \_\_\_\_\_

CO-APPLICANT DATE OF BIRTH: \_\_\_\_\_

CO-APPLICANT SSN: \_\_\_\_\_

I hereby request to be added as an applicant to the above-referenced claim. I authorize any person (including any physician, medical facility or health care provider), organization, the Ohio Department of Job and Family Services, the appropriate county Department of Job and Family Services or Child Support Enforcement Agency (for purposes of child support enforcement), law enforcement agency or government agency, upon request, to release to the Ohio Attorney General, the Court of Claims of Ohio, or to my attorney, a copy of any report, document, record, criminal record or other information (including tax information or returns, or medical information) in any way relating to my claim for an award of reparations under the Ohio Victims of Crime 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 disclosure of confidential information from medical records may be protected by state or federal law. If applicable, state law (R.C.3701.243) and federal regulations (42 C.F.R. part 2) prohibit the Ohio Attorney General or the Court of Claims of Ohio from making any further disclosure of confidential information without my specific written consent or as otherwise permitted by such regulations. This authorization or a copy hereof shall be valid for a period of two years without any further consent by me.

\_\_\_\_\_  
CO-APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CO-APPLICANT'S RELATIONSHIP TO VICTIM



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## AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

**CLAIM NUMBER:** \_\_\_\_\_  
**PATIENT'S NAME:** \_\_\_\_\_  
**DATE OF BIRTH:** \_\_\_\_\_  
**SOCIAL SECURITY NUMBER:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_

**CLAIMANT'S NAME:** \_\_\_\_\_

I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from the above patient's health record. I authorize the disclosure or use of patient's ENTIRE RECORD, exclusive of psychotherapy notes.

This information is to be disclosed by any covered entity, including any physician, medical facility, health care provider, mental health care provider, insurance company, billing department, health care clearinghouse, health plan, or pharmaceutical entity, and is to be provided to the Ohio Attorney General, the Court of Claims of Ohio, or to my attorney. This information is to be used in any way necessary related to my claim for an award of reparations from the Ohio Victims of Crime 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 the covered entity from which the Attorney General seeks to obtain records may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that the Attorney General is not a covered entity and is not subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996. However, I understand that the Ohio Public Records Act (R.C. § 149.43) prohibits the Attorney General or the Court of Claims of Ohio from making any further disclosure of confidential information without my specific written consent or as otherwise permitted by such regulations.

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 release shall have the same effect as the original.

I understand that I may revoke this authorization in writing submitted at any time to the Ohio Attorney General, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate two years from the date of my signature.

\_\_\_\_\_  
VICTIM'S/CLAIMANT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CLAIMANT'S RELATION TO VICTIM

Do not write in this space – For Internal Use Only

Claim Number:



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## AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES

**CLAIM NUMBER:** \_\_\_\_\_  
**PATIENT'S NAME:** \_\_\_\_\_  
**DATE OF BIRTH:** \_\_\_\_\_  
**SOCIAL SECURITY NUMBER:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_

**APPLICANT'S NAME:** \_\_\_\_\_

I, \_\_\_\_\_, authorize the disclosure of information from the above my/patient's health record. I authorize the disclosure or use of the patient's PSYCHOTHERAPY NOTES.

This information is to be disclosed by any covered entity, including physicians, medical facilities, health care providers, mental health care providers, insurance companies, billing departments, health care clearinghouses, health plans, or pharmaceutical entities, and is to be provided to the Ohio Attorney General, the Court of Claims of Ohio, or to my attorney. This information is to be used in any way necessary related to my/the patient's claim for an award of reparations from the Ohio Victims of Crime 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 the covered entity from which the Attorney General seeks to obtain records may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that the Attorney General is not a covered entity and is not subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996. 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 release shall have the same effect as the original.

I understand that I may revoke this authorization in writing submitted at any time to the Ohio Attorney General, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate two years from the date of my signature.

\_\_\_\_\_  
VICTIM'S/APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
APPLICANT'S RELATION TO VICTIM