



RICHARD CORDRAY

OHIO ATTORNEY GENERAL

OHIO VICTIMS OF CRIME COMPENSATION PROGRAM APPLICATION FOR COMPENSATION

*If you or your family members
are innocent victims of a violent crime,
financial assistance may be available.*



For more information, call:
(614) 466-5610

Toll-Free Numbers:

For specific case information:
(800) 582-2877

For general information:

(877) 584-2846 (877-5VICTIM)

www.OhioAttorneyGeneral.gov

WHO IS ELIGIBLE?

The Ohio Victims of Crime Compensation Program helps victims with certain out-of-pocket expenses that arise when people are physically injured, emotionally harmed or killed because of violent crime. Program costs are paid from criminal fines and not by Ohio's taxpayers.

If the following are true, you may be eligible for help from this program.

- The application is being filed within two years of the date of the crime. Victims who were minors at the time of the crime can file for compensation between ages 18-20 and under certain circumstances may be able to file later.
- The crime was reported within 72 hours (unless there is good cause for delay) and the victim cooperated with requests of law enforcement.
- The victim and claimant did not commit a criminal act that caused or contributed to the injuries.
- The victim has incurred expenses that are not fully covered by certain other sources.

WHO IS NOT ELIGIBLE?

- The offender.
- A victim or claimant who has engaged in a felony offense of violence or drug trafficking within 10 years prior to the crime that caused the injury or during the pendency of the claim.
- A victim or claimant who has been convicted of a felony within 10 years prior to the crime that caused the injury or during the pendency of the claim.
- A claimant who has been convicted of a child endangering or domestic violence offense within 10 years prior to the crime that caused the injury or during the pendency of the claim.
- An adult victim who was injured while incarcerated and serving a sentence.

WHAT ARE SOME COSTS THAT MAY BE PAID?

- Medical and related expenses
- Counseling for the victim and immediate family members of victims for specific crimes (up to \$2,500 each, a maximum \$7,500 per claim).
- Lost wages from not being able to work.
- Replacement services.
- Crime scene cleanup/repair for personal security (up to \$750).
- Evidence replacement (up to \$750).
- Funeral expenses (up to \$7,500).

ARE THERE LIMITS ON COMPENSATION?

- Compensation cannot be provided for pain and suffering, or for stolen, damaged or lost property.
- Compensation is not provided for expenses payable by collateral sources (e.g., insurance, worker's compensation benefits or restitution).
- The total award must be \$50 or more before payment can be made.

*Please enclose the application in
an envelope, seal and mail to:*

OFFICE OF OHIO ATTORNEY GENERAL
RICHARD CORDRAY

Crime Victims Assistance and Prevention
150 E. Gay St., 25 Fl.
Columbus, OH 43215-9554

OHIO VICTIMS OF CRIME COMPENSATION PROGRAM

APPLICATION FOR CRIME VICTIM COMPENSATION

Please Type or Print Using Blue or Black Ink

After an application has been filed, the law may provide for payment of an emergency award of up to \$2000 to qualified claimants who, because of the crime, will suffer undue hardship without immediate economic relief, and if a final award is likely.

THIS DOCUMENT IS A PUBLIC RECORD. EXCEPT FOR INFORMATION THAT IS PROTECTED BY STATE OR FEDERAL LAW, INFORMATION YOU PROVIDE ON THIS APPLICATION IS SUBJECT TO PUBLIC DISCLOSURE UPON REQUEST.

SECTION 1: VICTIM INFORMATION

Person injured or killed as a result of the crime. If more than one victim, a separate application is required for each victim.

Victim's Name (First / Middle Initial / Last) _____

Street Address _____ City _____ County _____

State _____ Zip Code _____ Email _____

Social Security No. _____ Date of Birth _____

Victim is/was: a. male female b. single married separated divorced widowed

Has the victim been arrested for, or convicted of, any felony, domestic violence, or child endangering offenses within 10 years prior to the injury, or since the injury? Yes No

Has the victim lived in any state other than Ohio in the 10 years preceding the crime? Yes No

If yes, list each state and indicate when the victim lived there. _____

Home Telephone No. () _____ Work Telephone No. () _____ Cell Telephone No. () _____

SECTION 2: CLAIMANT INFORMATION (If different than victim.)

Claimant cannot be a minor.

Claimant's Name (First / Middle Initial / Last) _____

Street Address _____ City _____ County _____

State _____ Zip Code _____ Email _____

Social Security No. _____ Date of Birth _____

Relationship to Victim _____

Claimant is: a. male female b. single married separated divorced widowed

Has the claimant been arrested for, or convicted of, any felony, domestic violence, or child endangering offenses within 10 years prior to the injury, or since the injury? Yes No

Has the claimant lived in any state other than Ohio in the 10 years preceding the crime? Yes No

If yes, list each state and indicate when claimant lived there. _____

Home Telephone No. () _____ Work Telephone No. () _____ Cell Telephone No. () _____

SECTION 3: CRIME INFORMATION

Date of crime _____ Date crime reported _____

Did crime happen while on the job? Yes No

Location/Address where crime occurred _____ City _____ County _____

State _____

If not reported within 72 hours, please explain why: _____

Law enforcement agency crime reported to _____

Suspected Offender(s) and Address(es) *Use additional sheet if necessary.* _____

Description of crime: Homicide Assault Robbery Sexual Assault Domestic Violence Other _____

What were the victim's injuries? _____

Did the victim die as a result of the crime or crime related injuries? Yes No Date of Death _____

SECTION 4: COMPENSATION REQUESTED

Check all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> Medical and related expenses | <input type="checkbox"/> Counseling expenses for victim | <input type="checkbox"/> Travel/lost wages to attend criminal justice proceedings when a victim is deceased. |
| <input type="checkbox"/> Lost wages | <input type="checkbox"/> Crime scene cleanup | <input type="checkbox"/> Future loss of support/care for dependents of a deceased victim |
| <input type="checkbox"/> Clothing/items held as evidence by law enforcement | <input type="checkbox"/> Replacement services (Paying someone to do what the victim would do such as house cleaning, child care, errands, etc.) | |
| <input type="checkbox"/> Protection order fees | <input type="checkbox"/> Counseling expenses for immediate family members | |
| <input type="checkbox"/> Funeral and burial | | |

SECTION 5: VICTIM'S FIRST MEDICAL TREATMENT

Name, address, and dates of service for victim's first medical treatment (doctor or hospital, whichever was first)

Doctor / Hospital _____
Street Address _____ City _____ County _____
State _____ Zip Code _____ Date(s) Treated _____

SECTION 6: HOUSEHOLD INCOME

If seeking payment of hospital bills, the following information is needed to determine eligibility for the Hospital Care Assurance Program.

How many are in the household? _____ What was the annual household income at the time of the hospitalization? \$ _____

SECTION 7: INSURANCE AND BENEFIT INFORMATION

All bills must be submitted to insurance or benefit plans before compensation can be considered.

Were there insurance or benefit plans to cover expenses at the time of the crime? Yes No At present? Yes No

If yes, check all boxes that apply and give details in the space provided.

- | | | |
|---|---|---|
| <input type="checkbox"/> Insurance Plan | <input type="checkbox"/> Employers / Union Group | <input type="checkbox"/> Workers' Compensation |
| <input type="checkbox"/> Auto Insurance | <input type="checkbox"/> Homeowner's Insurance | <input type="checkbox"/> Restitution or money from the offender |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private Accident Health Plan | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medicare | | |

Name of Insurance Company/Benefit Plan _____ Member Telephone No. () _____
Street Address or P. O. Box _____
City _____ State / Zip _____
Policy Holder's Name _____ Policy Holder's Social Security No. _____
Policy No. _____ Group No. _____

SECTION 8: EMPLOYMENT INFORMATION

Complete if filing for loss of earnings.

Employed at time of the injury? Yes No

Employer Email Address _____
Employer / Business Name _____ Telephone No. () _____
Street Address _____ City _____ County _____
State _____ Zip Code _____
Dates absent from work due to crime-related injuries _____
Name of doctor certifying time off from work _____ Doctor's Telephone No. () _____
Street Address _____ City _____ County _____
State _____ Zip Code _____

Did you receive:

- | | | |
|---|---|---|
| <input type="checkbox"/> Sick Pay | <input type="checkbox"/> Workers' Compensation | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Union or Fraternal Plan benefits | <input type="checkbox"/> Food Stamps / Cash Grant | <input type="checkbox"/> Other (Please specify) |

Signature required on reverse side.

SECTION 9: FUNERAL EXPENSES

Complete if filing for funeral expenses. Check all that apply.

Funeral Home Name and Complete Address _____

Social Security Death Benefits available? Yes No Life Insurance? Yes No

SECTION 10: ALL MINOR DEPENDANTS OF DECEASED VICTIMS

Use additional sheets if needed.

Name	Date of Birth	Social Security No.	Name and Address of Guardian

SECTION 11: ATTORNEY AND/OR VICTIM ASSISTANCE PROGRAM

To submit an application, an attorney is not required. If an attorney does help, he/she must sign the application. An attorney cannot charge an applicant for his/her representation and must submit fees to the Ohio Victims of Crime Program.

Has a private attorney represented you in filing this claim? Yes No

in suing the offender or a third party? Yes No

in an insurance claim? Yes No

in obtaining a civil protection order? Yes No

Attorney's Name _____ Email _____

Street Address _____ City / State / Zip Code _____

Work Telephone No. () _____ Fax No. () _____ Cell No. () _____

Attorney's Signature _____ Attorney's Social Security No. or Tax ID No. _____

Name of Victim Assistance Program that helped with this application _____

Email _____

Street Address _____ City / State / Zip Code _____

Telephone No. () _____

SECTION 12: SUBROGATION, AUTHORIZATION, AND SIGNATURE
YOU MUST BE 18 YEARS OF AGE OR OLDER TO SIGN THE APPLICATION.

Have you requested restitution? Yes No Court _____ Result _____

Have you made a claim for any governmental benefits? Yes No From Whom _____

Have you contacted an attorney to sue or make claim regarding this incident? Yes No Attorney's Name _____

Have you filed a claim with any insurance company regarding this incident? Yes No Insurance Claim No. _____

Mailing Address for Insurer _____

I understand that if I get money from any other source to cover the same expenses paid through the Crime Victims Compensation Program, I must reimburse the state of Ohio that amount of money. (R.C. 2743.72)

I hereby authorize any person (including any physician, medical facility, or health care provider), employer 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 failing to provide my Social Security number may significantly impede the processing of my claim. 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.

I understand that the information I have provided is being relied upon as truthful and accurate. By signing below, I swear or solemnly affirm under penalty of law that all information provided by me or on my behalf is true and accurate to the best of my knowledge and belief.

Signature of person seeking compensation (or signing as the legal guardian of a minor) _____ Date of Signature

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

CLAIM NO.: _____

PATIENT'S NAME: _____

SOCIAL SECURITY NO.: _____

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 **THE PATIENT'S ENTIRE RECORD**, excluding 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, employer organizations, Ohio Department of Job and Family Services, Child Support, law enforcement, or governmental agency, upon request to release and is to be provided 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 (excluding tax information or medical information). 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 Ohio 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 failing to provide my Social Security number may significantly impede the processing of my claim.

I understand that the Ohio 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/APPLICANT'S SIGNATURE _____ DATE _____

APPLICANT'S RELATIONSHIP TO VICTIM _____

**Do not write in this space-For Internal Use Only
Claim Number:**

Signature required above.

AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES

CLAIM NO.: _____

PATIENT'S NAME: _____

SOCIAL SECURITY NO.: _____

DATE OF BIRTH: _____

ADDRESS: _____

CLAIMANT'S NAME: _____

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

The information is to be disclosed by any covered entity, including employer(s), physicians, medical facilities, health care providers, mental health care providers, insurance companies, billing departments, health care clearinghouses, health plans, pharmaceutical entities, and is to be provided by 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 patients 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 Ohio 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 Ohio Attorney General is not a covered entity and is not subject to 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 RELATIONSHIP TO VICTIM _____

**Do not write in this space-For Internal Use Only
Claim Number:**

Signature required above.