



MIKE DEWINE

★ OHIO ATTORNEY GENERAL ★

OHIO VICTIMS OF CRIME COMPENSATION PROGRAM

Application for Supplemental
Compensation

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

For more information, call:

Ohio Victims of Crime
Compensation Program
Attorney General's Office
150 E. Gay St., 25th Fl.
Columbus, OH 43215
(614) 466-5610

Toll-Free Numbers:

For Specific Case Information
(800) 582-2877

For General Information
(877) 584-2846 (877-5VICTIM)

Also visit us at

www.ohioattorneygeneral.gov

ELIGIBILITY CHECKLIST FOR SUPPLEMENTAL APPLICATION

If you answer “yes” to all these questions, you may be eligible for help from this program.

- The claimant has incurred additional economic loss.
- The supplemental application is being filed within five years of The last decision by the Attorney General, a Court of Claims panel of commissioners, or judge of the Court of Claims.
- The claimant has previously been determined eligible to receive an award of reparations by the Attorney General or Court of claims.
- The claimant and the victim have maintained eligibility from the time of the previous decision.
- The maximum amount of \$50,000 has not yet been paid on the claim.

WHO CAN GET HELP?

The Ohio Victims of Crime Compensation Program helps victims with certain out-of-pocket expenses caused when people are physically injured, emotionally harmed, or killed by violent criminal acts. Program costs are paid entirely by criminal fines and not by Ohio’s taxpayers.

WHO IS NOT ELIGIBLE?

- ✓ The Offender.
- ✓ Anyone who engaged in a felony 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.
- ✓ Anyone injured while incarcerated and serving a sentence.

WHAT ARE SOME COSTS THAT MAY BE PAID?

- ✓ Medical and related expenses.
- ✓ Counseling for family members of victims for specific crimes (up to \$2,500 each.) Maximum \$7,500 per claim.
- ✓ Wages lost from not being able to work.
- ✓ Replacement services.
- ✓ Crime scene clean-up/repair for safety (up to \$750).
- ✓ Evidence replacement (up to \$750).
- ✓ Funeral expenses up to \$7,500

ARE THERE LIMITS ON COMPENSATION?

- ✓ Yes. Compensation cannot be paid for stolen, damaged, or lost property, or for pain and suffering.
- ✓ Compensation is not paid for costs payable by other source.
- ✓ The total award must be \$50 or more before payment is made.



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SUPPLEMENTAL COMPENSATION APPLICATION

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.

(Please Type or Print Using Blue or Black Ink)

ORIGINAL CLAIM NUMBER: V _____ - _____

SECTION 1: VICTIM INFORMATION

Victim's Name (First/Middle Initial/ Last) _____	
Street Address _____	
City _____	County _____ State _____ Zip _____
Social Security # _____ Date of Birth _____	
Victim is/was: a. <input type="radio"/> male <input type="radio"/> female	b. <input type="radio"/> single <input type="radio"/> married <input type="radio"/> separated <input type="radio"/> divorced <input type="radio"/> widowed
Has the victim been arrested for, or convicted of, any felony within 10 years prior to the injury, or since the injury? <input type="radio"/> Yes <input type="radio"/> No	
Has the victim lived in any state other than Ohio in the past 10 years? <input type="radio"/> Yes <input type="radio"/> No If yes, list each state _____	
Home Phone (____) _____	Work Phone (____) _____

SECTION 2: CLAIMANT INFORMATION (If different than victim)

Claimant's Name (First/Middle Initial/ Last) _____	
Street Address _____	
City _____	County _____ State _____ Zip _____
Social Security # _____ Date of Birth _____ Relationship to victim _____	
Claimant is/was: a. <input type="radio"/> male <input type="radio"/> female	b. <input type="radio"/> single <input type="radio"/> married <input type="radio"/> separated <input type="radio"/> divorced <input type="radio"/> widowed
Has the claimant been arrested for, or convicted of, any felony within 10 years prior to the injury, or since the injury? <input type="radio"/> Yes <input type="radio"/> No	
Has the claimant lived in any state other than Ohio in the past 10 years? <input type="radio"/> Yes <input type="radio"/> No If yes, list each state _____	
Home Phone (____) _____	Work Phone (____) _____

SECTION 3: HOUSEHOLD INCOME

If seeking payment of hospital bill(s), 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? \$ _____

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

ORIGINAL CLAIM NUMBER: V ____ - ____

PATIENT'S NAME:
DATE OF BIRTH:
SOCIAL SECURITY NUMBER:
ADDRESS:
CLAIMANT'S NAME:

I, _____, hereby voluntarily authorize the disclosure of information from my health record. I authorize the disclosure or use of **MY 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 psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS and AIDS-related conditions.

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.

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.

VICTIM'S/CLAIMANT'S SIGNATURE

DATE

CLAIMANT'S RELATION TO VICTIM

Do not write in this space – For Internal Use Only

Claim Number: