

Ohio Victims of Crime Compensation Program

If you or your family members are victims of a violent crime, financial assistance for out-of-pocket expenses may be available

The Ohio Victims of Crime Compensation Program helps victims with certain outof-pocket expenses caused when people are physically injured, emotionally harmed or killed by violent criminal acts.

CONTACT US

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**)

Fax number: 614-752-2732 or 855-229-0600

Email address: CrimeVictimsCompensationApplications@OhioAgo.gov

30 E. Broad St., 26 Fl., Columbus, OH 43215 www.OhioAttorneyGeneral.gov

ELIGIBILITY CHECKLIST

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

- The crime was reported and the victim cooperated with requests of law enforcement.
- The victim was not committing a criminal act that caused or contributed to the injuries (this does not apply to homicide claims).
- The victim has incurred expenses that are not fully covered by collateral sources.

WHO MAY BE ELIGIBLE?

- · Victims of violent crime
- · Someone who legally assumes the financial responsibility in behalf of a victim of violent crime
- For crimes resulting in death, the dependents of that victim or someone assuming the financial responsibility for that victim/family member
- In certain crimes, family members may be eligible to file their own claim

WHAT ARE SOME COSTS THAT MAY BE REIMBURSED?

- Medical and related expenses
- Wages lost as a result of attending funeral or certain court proceedings, medically unable to work or in certain cases to aid in the care or recovery of the victim
- Crime scene cleanup/repair for safety (up to \$750)
- Evidence replacement for items held by law enforcement (up to \$750)
- Funeral expenses (up to \$7,500)

ARE THERE LIMITS ON COMPENSATION?

- Yes. Compensation cannot be paid for pain and suffering, stolen, damaged, or lost property.
- Compensation is not paid for costs payable by other sources (such as insurance or Bureau of Workers' Compensation).
- The application must be filed within 3 years of the date of the crime.
- The total award must be \$50 or more before payment is made.



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 \$2,000 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 is affected, a separate application is required for each victim. Victim's name (first/middle initial/last) ____ _____City_____County____ Street address ____ State ______ E-mail_____ Social Security number _____ _____ Date of birth____ Victim is/was: a. male ☐ female ☐ b. single ☐ married ☐ separated ☐ divorced ☐ widowed ☐) ______ Work telephone () ______ Cell telephone () ______ Home telephone (**SECTION 2: CLAIMANT INFORMATION** (if different than victim) Claimant cannot be a minor. Claimant's name (first /middle initial /last) ____ _____City _____County ____ _____ ZIP code _____ E-mail ____ _____ Date of birth_____ Social Security number ___ Relationship to victim _____ Claimant is: a. male ☐ female ☐ b. single ☐ married ☐ separated ☐ divorced ☐ widowed ☐ _____ Work telephone () _____ Cell telephone (Home telephone (**SECTION 3: CRIME INFORMATION** _____Date crime reported _____ Date of crime ____ Did crime happen while on the job? Yes ☐ No ☐ _____City_____County____ Location/address where crime occurred _____ 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 from crime-related injuries? ☐ Yes ☐ No Date of death ___

SECTION 4: COMPENSAT	ION REQUESTED						
Check all that apply.		☐ Items held as evidence by law enforcement			Counseling expenses for immediate		
☐ Medical and related expenses		☐ Counseling expenses for victim			family members		
☐ Lost wages ☐ Clothing damaged by medical treatment ☐ Protection order fees ☐ Funeral and burial		 □ Crime scene cleanup □ Replacement services (paying someone to do what the victim would normally do such as housecleaning, child care, errands, etc.) 			☐ Travel/lost wages to attend criminal justice proceedings when a victim is deceased		
				o do	☐ Future loss of support/care for dependents of a deceased victim ☐ Mileage		
				ıs L			
SECTION 5: VICTIM'S FIR	ST MEDICAL TR	FATMENT					
Name, address, and date of s			atment (doctor or l	hospital whi	ichever was fir	st)	
Doctor/hospital			•	• '	ionovon mao m		
Street address					County	,	
State ZIP code			•		-		
If seeking payment of hospital bills, the							
How many are in the household?	_				_		
now many are in the nousehold:	What was the all	iluai ilouseiloiu ilic	ome at the time of the	e nospitalizatioi	ι: φ		
SECTION 6: INSURANCE	AND BENEFIT IN	FORMATION					
All bills must be submitted to			compensation can	n be consider	red.		
Were there insurance or benefit plans		-	-		? Yes □ No □		
If yes, check all boxes that apply and	•				· · · ·		
yoo, ooo. a soxoo a.ac app.y aa	give detaile in the space	provided					
Health insurance plan (Please send front and back copy of card)	■ Employers/union g	group	■ Workers' comper	nsation		☐ Life Insurance	
			Restitution or mo	Restitution or money from the offender Other			
Medicaid	Medicare						
Name of insurance company/benefit)		
Street address or P. O. box							
City		,					
Policy holder/beneficiary's name	older/beneficiary's name Policy holder/beneficiary's Social Security number						
olicy no Group no							
SECTION 7: EMPLOYMEN	T INFORMATION						
Complete if filing for loss of ea	arnings. Provide cop	ies of 6 payche	cks prior to crime).			
Employed at time of the injury? Yes	☐ No ☐ Employer €	e-mail address					
Employer/business name				Telephone	()		
Street address			City		County		
State ZIP code							
Dates absent from work due to crime	-related injuries						
Name of doctor certifying time off fro	m work			Doctor's te	elephone ()	
Street address							
StateZIP code							
Did you receive (check all that apply):							
		Union or fro	tornal plan banafita	□ Food aton	mna /aaah grant	Other (please appoint)	
Sick pay Workers' compens	sation	U OHIOH OF HA	ternal plan benefits	☐ FOOU Star	mps /cash grant	Other (please specify)	
SECTION 8: FUNERAL EX	PENSES						
Complete if filing for funeral e	xpenses. Check all t	that apply.					
Funoral home name and samplets	ldroce						
Funeral home name and complete ac	IUI 699						

If you have a copy of the death certificate, please include a copy with your application.

Signature required on reverse side.

SECTION 9: ALL MINOR DEPENDENTS OF DECEASED VICTIMS Use additional sheets if needed. Name Date of birth Social Security number Name and address of guardian SECTION 10: ATTORNEY AND/OR VICTIM ASSISTANCE PROGRAM Has a private attorney represented you in: Filing this claim? Yes 🔲 No 🔲 Suing the offender or a third party? Yes 🗎 No 🗎 An insurance claim? Yes 🗎 No 🔲 Obtaining a civil protection order? Yes 🗀 No 🗀 ATTORNEY ASSISTANCE VICTIM ASSISTANCE PROGRAM In some cases there may be a local advocate available to help you as well. Attorney's name ___ We may contact an advocate to help process your claim. Street address Name of victim assistance program that helped with this application — City/state/ZIP code ____ Work telephone () ______ Fax () _____ Street address -_____ E-mail ____ City/state/ZIP code ____ Attorney's signature __ Telephone () ____ Attorney's Social Security or tax ID number ____ E-mail 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. **SECTION 11: VICTIM STATISTICAL INFORMATION** For statistical purposes only. This is strictly voluntary. Race: White Black Hispanic American Indian/Alaskan Native Asian/Pacific Islander Other Do you have a disability? ☐ Yes ☐ No If yes, nature of disability ☐ Physical ☐ Mental ☐ Developmental **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 number 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. (Ohio Revised Code Section 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 (Ohio Revised Code Section 3701.243) and federal regulations (42 CFR 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

This release must be signed and dated for the application to be processed.

AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES PATIENT'S NAME: __ SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: ___ ADDRESS: VICTIM/CLAIMANT'S NAME: _____ _, authorize the disclosure of information from my/the 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, and 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 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 (HIPAA). This authorization complies with the requirements of 45 CFR 164.508, 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 X ______DATE _____DATE _____ CLAIMANT'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 INFORMATION PATIENT'S NAME: ____ SOCIAL SECURITY NUMBER: ADDRESS: VICTIM/CLAIMANT'S NAME: _____ ______, 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 (including 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 (HIPAA). However, I understand that the Ohio Public Records Act (Ohio Revised Code Section 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 CFR 164.508, 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 X _____ DATE _____ DATE ____ CLAIMANT'S RELATIONSHIP TO VICTIM _____ Do not write in this space. For internal use only.

Claim number:

Signature required above.