DAVE YOST
OHIO ATTORNEY GENERAL

OHIO VICTIMS OF CRIME COMPENSATION PROGRAM

Application for Supplemental Compensation

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

For more information, call:
Ohio Victims of Crime
Compensation Program
Attorney General's Office
30 E. Broad St. 23rd Floor
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

OHIO VICTIMS OF CRIME COMPENSATION PROGRAM
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. ◯ male ◯ female b. ◯ single ◯ married ◯ separated ◯ divorced ◯ widowed

Has the victim lived in any state other than Ohio in the past 10 years? ◯ Yes ◯ 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. ◯ male ◯ female b. ◯ single ◯ married ◯ separated ◯ divorced ◯ widowed

Has the claimant lived in any state other than Ohio in the past 10 years? ◯ Yes ◯ 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? $_____

SECTION 4: MEDICAL TREATMENT AND OTHER CRIME-RELATED EXPENSES

EXPENSES NOT CONSIDERED IN ORIGINAL APPLICATION

Provide name, complete address, telephone number, and date(s) of service for each provider of service or expense.

Name/ Address/ City/ State/ Zip	(Area Code) Telephone No.	Date(s) of Service

SECTION 5: INSURANCE AND BENEFIT INFORMATION

ALL BILLS MUST BE SUBMITTED TO THE INSURANCE OR BENEFIT PLAN BEFORE COMPENSATION IS CONSIDERED.

Does the victim have any insurance or benefit plan to cover the listed expenses? ◯ Yes ◯ No

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

☐ Employers/Union Group ☐ Medicare ☐ Worker's Compensation ☐ Homeowner's Insurance

☐ Insurance Plan ☐ Medicaid ☐ Private Accident Health Plan ☐ Auto Insurance

☐ Other ☐ Restitution or money from the offender

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

(Application continues on reverse side.)

SECTION 6: EMPLOYMENT INFORMATION (Complete for additional work loss since the original application.)

Employer/ Business Name	(Area Code) Telephone No.	
Street Address	City	State/Zip
Additional date(s) absent from work due to crime-related injuries		
Name of doctor certifying length or time off from work	Doctor's Street Address	
Doctor's (Area Code) Telephone No.	City/State/Zip	
Did you receive: ☐ Sick pay ☐ Worker's Compensation ☐ Disability ☐ Union or Fraternal Plan ☐ Food Stamps/ Cash Grant ☐ Other (please specify)		

SECTION 7: FUNERAL EXPENSES (Complete if filing for funeral expenses)

Funeral Home Name and Complete Address		
Was there:	Social Security Death Benefit? ◯ Yes ◯ No	
	Life Insurance? ◯ Yes ◯ No	

SECTION 8: REPRESENTATION

An attorney is not required to submit the application. If an attorney does help, he/she must sign the application. The attorney cannot charge for representation.

Attorney's Name	
Street Address	City/ State/ Zip
(Area Code) Telephone No.	Fax Number
Attorney's Signature	Attorney's Social Security No. or Tax ID No.

SECTION 9: SUBROGATION, AUTHORIZATION AND SIGNATURE

I understand that if I get money from any other source to cover the same expenses I get compensation for, I have to reimburse the state of Ohio that amount of money.

I hereby 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 providing my Social Security number is voluntary, and that it may be used to obtain the aforementioned reports, documents, records and information necessary to verify my eligibility for an award of compensation. I further 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.

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

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, 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 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: