MIKE DEWINE
OHIO ATTORNEY GENERAL

Crime Victim Assistance Application
Additional Claimant

Please e-mail, fax or mail this page to the Ohio Attorney General's Office.

Office of Ohio Attorney General
Ohio Victims of Crime Compensation
150 E. Gay St., 25th Floor
Columbus, OH 43215-9542

Phone: (800) 582-2877
Fax:
CrimeVictims@OhioAttorneyGeneral.gov

Temporary claim number:_____ (Sent to the point of contact's e-mail.)

Claimant's name_____
Address_____
City_____ County_____ State_____
ZIP code_____ Social Security Number_____ Date of birth_____
Relationship to victim_____
Claimant is: ___male ___female ___single ___married
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:
_____
E-mail_____ Phone number_____
Fax number_____ Cell phone number_____

Acknowledgement

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 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. 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 information I have provided is being relied upon as truthful and accurate.

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.

Claimant's signature_____

Claimant's name_____ Date_____