BC-VOC-100-A (Rev 8/01)

Clear Form

Family Member or Dependent Victim

Application For Crime Victim Compensation

*(Please type or print clearly in ink and use additional paper if needed)*Personal Information

For Board or JP Use Only
Primary Claim Number
Claim Number
Current Location

Personal Information

Applicant's Name (First, Middle, Last): _____

Street Address: _____ Date of Birth: _____

City/State/Zip: _____ Social Security Number: _____

Relationship to Victim: _____ Gender: Male ❑ Female ❑

Daytime Telephone: _____

Victim's Name: _____ Victim's Social Security Number: _____

*From the date of the crime to the present, has the **Applicant** been in prison, on probation, or on parole because of a felony? Yes ❑ No ❑*

YOUR Name (First, Middle, Last): _____

(If the applicant is a minor or incapacitated)

Your Street Address: _____ Your Date of Birth: _____

City/State/Zip: _____ Your Social Security Number: _____

Your Relationship to Applicant: _____ Your Gender: Male ❑ Female ❑

Daytime Telephone: _____

Crime Information

Date of Crime: _____ Case/Crime Report Number: _____

Describe Injuries: _____ Type of Crime *(Crime Code, if known)*: _____

Person(s) who committed the crime (Suspect), if known (First, Middle, Last): _____

Loss Information

Check the expenses/losses for which you are seeking compensation from the Victim Compensation Program. You must attempt to recover your losses from any/all other source(s).

Mental Health Treatment or Counseling ❑ Support Loss for Dependants of a Deceased or Disabled Victim ❑

Other (specify): _____

Employer Information *(Applicants Employer)*

Employer's Business Name: _____ Contact Person _____ Telephone _____

Street Address: _____ City/State/Zip: _____

Provider Information *(List Service Providers)*

NAME	STREET ADDRESS/CITY/STATE/ZIP	TELEPHONE NUMBER

(Use additional paper, if needed, and attach copies of bills, if available)

Reimbursement/Recovery Information *(Check all insurance/recovery sources that may apply)*

Health ❑ Medi-Cal ❑ Medicare ❑ Auto ❑ Workers Compensation ❑ Homeowners/Renters ❑ None ❑

Name of Insurance Company: _____ Policy No: _____ Telephone No.: _____

Name of Insured: _____ Social Security Number of Insured: _____

Have you file a civil law suit or insurance action for this crime? Yes ❑ No ❑ Undecided ❑

Attorney's Name: _____ Telephone No.: _____

Other Potential Sources of Reimbursement/Recovery: _____

(Use additional paper, if needed)

Representative Information

Representative ***for this Application*** [Victim/Witness (V/W) Assistance Center, Attorney, or Other]

Name of Representative: _____ Telephone No.: _____

V/W Name & Code No: _____ If Attorney, State Bar No.: _____

Representative's Signature: _____ Date: _____

Information Release *(This release must be signed and dated for compensation consideration)*

I give permission to any hospital, clinic, doctor, dentist, or mental health provider; any funeral director or similar person; any employer; any policy or governmental agency, including the Department of Justice, the State Franchise Tax Board, and Federal Internal Revenue Service; any insurance company; or any other person or agency; to provide information relating to this application, including medical, mental health, and felony conviction records to the Victims Compensation Program or its representatives. I understand the information will be used to determine compensation benefits, and that only information needed to make a decision about compensation will be requested by the Victim Compensation Program.

I understate a photocopy or FAX (facsimile) of this signed form is as valid as the original, and that my signature gives permission for release of all information specified on this permission form.

I understand the Victims Compensation Program or its representatives may pursue restitution from a convicted offender in this matter to recover monies paid to me or on my behalf by the program and by filing this application I have authorized the program to use information contained in this application and subsequent claim files to pursue restitution from the convicted offender.

Do you want to be notified by the program if a restitution hearing is going to be conducted by the court? Yes ❑ No ❑

I agree that the Victims Compensation Program or its representatives may provide information about this application to any representative named on this application, governmental agency, or any medical, dental, mental health, or funeral and/or burial provider of services and may pay the provider directly if payment of these services is approved.

I declare under penalty of perjury under the laws of the State of California *(Penal Code Section 72, 118, & 129)* that I have read all the questions and the completed application and, to the best of my information and belief, all my answers are true, correct, and complete. I further understand if I have provided any information that is false, intentionally incomplete, or misleading, I may be found liable under *Government Code Section 12651* for filing a false claim and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fined up to ten thousand dollars ($10,000).

Signed: _____ Date: _____

(Victim's signature. Parent or guardian must sign if victim is a minor, deceased, or incapacitated.)

My promise to the Victims Compensation Program

(This promise must be signed and dated for compensation consideration)

As required by California law, I will contact and repay the Victims Compensation Program if I receive any payments from the offender, a civil lawsuit, any insurance policy, or any other government or private agency to cover expenses for which I have already received payment from this Program. I understand that I may be responsible for repaying the Victims Compensation Program any amounts for which it is later determined I was not eligible. I will notify the Victims Compensation Program if I hire an attorney to represent me in any action related to this crime or if I pursue any action on my own.

Any money I receive from the Victims Compensation Program for moving/relocation expenses, improving home security, or for modifying a home or vehicle for a disabled victim will be used only for those purposes. If I am a victim of domestic violence receiving moving/relocation expenses, I will not tell the offender my home address nor allow the offender on the premises at any time, or I will seek a restraining order against the offender.

Signed: _____ Date: _____

(Victim's signature. Parent or guardian must sign if victim is a minor, deceased, or incapacitated.)

How did you find out about the Victims Compensation Program?

Police ❑ Sheriff ❑ Highway Patrol ❑ District Attorney ❑ Medical Provider (Name): _____
Victim/Witness Center ❑ Children's Protective Services ❑ Mental Health Provider (Name): _____
Media (TV, Radio, Newspaper, etc.) ❑ Victim Service Programs ❑ 1-800-VICTIMS ❑

Federal Reporting Information

*The following voluntary **victim** information is used for statistical purposes only to comply with Federal Regulations.*

Is the Victim Disabled? Yes ❑ No ❑ Was the Victim Disabled Prior to the Date of the Crime? Yes ❑ No ❑
Ethnicity of Victim: African American ❑ Asian/Pacific Islander ❑ Caucasian ❑ Hispanic ❑ Native American ❑
Other (Specify): _____

Mail To:
Victim Compensation & Government Claims Board
PO Box 3036
Sacramento, California 05812-9915

VCP Customer Services Unit
1-800-777-9229