BC-VOC-100 (Rev 03/04)

For Board or JP Use Only
Claim Number:
User ID:

Victim Application For Crime Victim Compensation

(Please type in all information and use additional paper if necessary)

Personal Information

Crime Victim Information: (Please enter addresses and phone numbers where it is safe to be contacted)

VICTIM'S Name (First, Middle Initial, Last): _____

Mailing Address: _____ Date of Birth: _____

City/State/Zip: _____ Social Security Number _____

Daytime Telephone No: ( ) _____ Victim's Gender: ☐ Male ☐ Female

If Victim is deceased, Date of Death: _____

From the date of the crime to the present, has the victim been in prison, on probation, or on parole because of a felony?

☐ Yes ☐ No

Information on the person filling out this form if the victim is a minor, incapacitated, or deceased:

Name (First, Middle Initial, Last): _____

Mailing Address: _____ Date of Birth: _____

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

Daytime Telephone: ( ) _____ Your Gender: ☐ Male ☐ Female

Your Relationship to Victim: _____

Crime Information

Law Enforcement, CPS, or Agency the crime was reported to: _____

Location of Crime: _____ Date of Crime: _____

Case/Crime Report Number _____ Date Crime Reported: _____

Type of Crime (Crime Code, if known): _____

Describe Injuries: _____

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

Information About Expenses

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).

☐ Medical or Dental Expenses for the Victim
☐ Mental Health Treatment or Counseling
☐ Lost Income
☐ Loss of Support for Dependents of a Deceased or Disabled Victim
☐ Funeral and/or Burial Expenses
☐ Crime Scene Cleanup (homicide only)
☐ Home or Vehicle Modifications for a Disabled Victim
☐ Home Security Improvements
☐ Moving or Relocation Expenses
☐ Job Retraining for a Disabled Victim

Each person applying for compensation from this Program must file a separate application.

Does a **family member** or other **dependent** need an application? ☐ Yes ☐ No If yes, how many? _____

Did the **victim** miss work as a result of crime-related injuries? : ☐ Yes ☐ No

Do you wish to apply for an emergency award (advance payment)? ☐ Yes ☐ No
Emergency awards are based on substantial hardship and immediate need.

Employer Information *(Victim's Employer)*

Employer's Business Name: _____

Contact Person: _____ Telephone Number: ( )

Street Address: _____ City/State/Zip: _____

Is or Was the Victim self-employed? ☐ Yes ☐ No

About Your Expenses *(List hospitals, counselors, funeral homes or other bills)*

Name of Service Provider 1.: _____

Street Address: _____ Telephone Number ( )

City/State/Zip: _____

Name of Service Provider 2.: _____

Street Address: _____ Telephone Number ( )

City/State/Zip: _____ *Use additional paper if needed*

Insurance Information *(Check all insurance or recovery sources that may apply)*

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

Insurance Company Name: _____ Policy No.: _____ Telephone Number: ( )

Insurance Company Address _____

Name of Insured: _____ Social Security No. of Insured: _____

Have you filed a civil lawsuit or insurance action for this crime? ☐ Yes ☐ No ☐ Undecided

Attorney's Name: _____ Telephone Number: ( )

Attorney Address _____

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: _____ Representative Telephone Number: ( )

Address: _____

Relationship to Victim: _____

V/W Center Name & Code No.: _____

For Attorneys

State Bar No.: _____ Federal Tax ID: _____

Are you requesting payment? ☐ Yes ☐ No

Representative's Signature: _____ Date: _____

How did you find out about the Victim Compensation Program?

☐ Police ☐ Victim/Witness Assistance Center ☐ Victim Service Programs

☐ Sheriff ☐ Children's Protective Services ☐ Media (TV, Radio, Newspaper, etc.)

☐ Highway Patrol ☐ Adult Protective Services ☐ 1-800-VICTIMS

☐ District Attorney ☐ Mental Health Provider (name): _____

☐ Medical Provider (name): _____

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 (name):

Victim Name:	(Board Use Only) Claim No.

Information Release *(This release must be signed & 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 the 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 Victim Compensation Program or its representatives. I understand the information will be used to determine compensation benefits, and only information needed to make a decision about compensation will be requested by the Victim Compensation Program.

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

I understand the Victim Compensation Program or its representatives may pursue restitution from the convicted offender in this matter to recover monies paid to me on my behalf by the program and that 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.

I agree that the Victim 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 Sections 72, 118, and 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 found 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.)

Printed Name: _____

My Promise to the Program *(This promise must be signed & dated for compensation consideration)*

As required by California law, I will contact and repay the Victim Compensation Program if I receive any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private agency to cover expenses for which I have already received payment from this Program. I understand I may be responsible for repaying the Victim Compensation Program any amount for which it is later determined that I was not eligible. I will notify the Victim 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 Victim 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.)

Printed Name: _____

Mail To:

Victim Compensation & Government Claims Board
PO Box 3036
Sacramento, California 95812-9915

Clear Form

Print

For VCP Customer Services Unit

1-800-777-9229

Hearing impaired, please call the California Relay Service at 1-800-735-2929

www.victimcompensation.ca.gov