



OFFICE OF VICTIM SERVICES

*Focusing on a brighter future*

**SECTION ONE - VICTIM INFORMATION**

Name of victim (last, first, middle) Home telephone Work telephone

Address Cell telephone Age

City State Zip Birth date Sex

Primary language of victim

Would you like to be contacted via email?  Yes  No Email \_\_\_\_\_

**SECTION TWO - CLAIMANT INFORMATION** *(Complete if different from victim)*

Name of claimant (last, first, middle) Home telephone Work telephone

Address Cell telephone Age

City State Zip Birth date Sex

Primary language of claimant

Would you like to be contacted via email?  Yes  No Email \_\_\_\_\_

Claimant relationship to victim:

- child  spouse  parent  grandchild  grandparent  spouse's parent  stepparent
- brother  sister  half brother  half sister  step child  adopted child  administrator
- party to a civil union  other (ie. DCF case worker) \_\_\_\_\_

**SECTION THREE - CONTACT PERSON** *(Person to contact if victim/claimant cannot be reached)*

Name of contact person (last, first, middle)		Relationship to claimant	
Address		City	State Zip
Home telephone	Work telephone	Cell telephone	

**SECTION FOUR - ATTORNEY REPRESENTATION** *(Complete only if represented by an attorney for this application)*

Name of attorney (last, first, middle)		Name of firm	
Address		City	State Zip
Work telephone	Fax	Juris number	

**SECTION FIVE - CRIME INFORMATION** *(Please fill out this section as completely as possible)*

Type of crime:  assault  sexual assault  robbery with injury  dui  hit and run  other \_\_\_\_\_

Briefly describe the crime:

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Date of crime	Address where crime occurred
Date crime was reported to police	Police department to which crime was reported
Police department incident number	Name(s) of assisting officer(s)

Was the crime reported to the police within five days?  yes  no (If not, please explain)

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Has an arrest(s) been made?  yes  no  unknown \_\_\_\_\_  
Name of offender(s), if known

Has the offender(s) been arraigned in court?  yes  no  unknown \_\_\_\_\_  
If yes, court location Docket number



## SECTION SEVEN - EMPLOYMENT INFORMATION

Were you employed at the time of the crime?  yes  no If yes, are you applying for wage loss compensation?  yes  no  
If yes, complete the following section (if self-employed, see SECTION SEVEN A).

Name of employer			Telephone	
Address			Hours worked per week	
City	State	Zip	Wage per hour	Tips, bonuses per week
Dates absent from work due to crime related injuries		From	To	Total hours absent

If you have missed more than one week of work, please provide a doctor's statement verifying length of time you were unable to work.

Name of doctor			Telephone	
Address		City	State	Zip

In order for OVS to consider any salary loss, please check any source listed below from which you received financial support.

sick leave	<input type="radio"/> yes <input type="radio"/> no	Workers Compensation	<input type="radio"/> yes <input type="radio"/> no	other (please list)
vacation	<input type="radio"/> yes <input type="radio"/> no	unemployment compensation	<input type="radio"/> yes <input type="radio"/> no	_____
union/fraternal insurance	<input type="radio"/> yes <input type="radio"/> no	Social Security disability	<input type="radio"/> yes <input type="radio"/> no	_____
disability benefits	<input type="radio"/> yes <input type="radio"/> no	state Medicaid/city public assistance	<input type="radio"/> yes <input type="radio"/> no	_____

## SECTION SEVEN A - SELF-EMPLOYMENT INFORMATION

If you were self-employed at the time of the crime, please submit a copy of your tax return and documentation (W-2 form, 1099 form, etc.) for the year before the crime. If you have missed more than one week of work, please provide a doctor's statement verifying length of time you were unable to work.

Name of doctor			Telephone	
Address		City	State	Zip

In order for OVS to consider any salary loss, please check any source listed below from which you received financial support.

Workers Compensation	<input type="radio"/> yes <input type="radio"/> no	disability benefits	<input type="radio"/> yes <input type="radio"/> no	other (please list)
unemployment compensation	<input type="radio"/> yes <input type="radio"/> no	Social Security disability	<input type="radio"/> yes <input type="radio"/> no	_____
union/fraternal insurance	<input type="radio"/> yes <input type="radio"/> no	state Medicaid/city public assistance	<input type="radio"/> yes <input type="radio"/> no	_____



## SECTION ELEVEN - STATEMENT OF FACTS AND AUTHORIZATION

The undersigned certifies that the information herein is true to his or her best knowledge, information and belief and hereby authorizes any hospital, physician(s) or other person(s) who attended, examined, or rendered services to \_\_\_\_\_ (victim's or family member's name), any employer(s) of the victim, any police or other municipal authority or agency, or public authorities including state and federal revenue services, any insurance company or organization having knowledge thereof, to furnish to the OVS or its representative any and all information with respect to the incident leading to the victim's personal injuries and the victim's or family member's application made for compensation. A photocopy of this authorization will be considered as effective and valid as the original.

I, \_\_\_\_\_, authorize OVS to disclose any information in its possession, including confidential information, to the offices of the Court Support Services Division, the State's Attorney, the Attorney General and to private attorneys retained by OVS or the victim, and to communicate freely with any of the foregoing when such disclosure and communications are necessary pursuant to General Statutes sections 54-208(e), 54-212 and 54-215.

Further, I understand that OVS may be entitled to receive proceeds that an offender has been ordered to pay the victim as restitution ordered by the State of Connecticut's criminal court system. This is in accordance with General Statutes section 54-215.

I understand that any recovery of my losses from the offender resulting from a civil action that I have brought entitles OVS to reimbursement of two-thirds of any compensation awarded to me and that OVS shall have a lien on the recovery pursuant to General Statutes section 54-212. I understand that I must notify OVS of the filing of any such civil action within thirty days of the filing of the action in court.

Further, I understand that pursuant to General Statutes section 54-212, OVS shall be subrogated to any cause of action I have against the offender. A civil action may be brought on behalf of OVS by the Attorney General or by a private attorney hired by OVS. OVS shall furnish me with a copy of the action within thirty days of the filing of the action in court.

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**Applicant signature** (Parent or guardian must sign if victim is a minor or an incompetent adult)      **Date**

**Please return completed form to:**

Office of Victim Services  
225 Spring Street  
Wethersfield, CT 06109

**Contact OVS at:**

1-888-286-7347 (Toll-free compensation line - CT only)  
860-263-2761  
[www.jud.ct.gov/crimevictim](http://www.jud.ct.gov/crimevictim)