

Below is an application for crime victim compensation. Please print this page and mail it to the following address:

Crime Victim Compensation Program
100 Court Avenue, Suite 100
Des Moines, Iowa 50319

You can also fax the application to (515) 281-8199. Or you can call (515) 281-5044 or 1-800-373-5044 and file an application by telephone.

**APPLICATION FOR CRIME VICTIM COMPENSATION
(PLEASE PRINT CLEARLY)**

Victim's Name _____

Type of Crime _____

Address _____

(Note: The Crime Victim Compensation Program will send mail to this address. If you do not want mail sent to your home address, please provide an alternative mailing address.)

City/State _____ Zip _____

Phone (____) _____ Daytime phone number (____) _____

Your name _____

Your relationship to victim _____ (If victim is a minor or deceased)

Victim's date of birth ____/____/____

Social Security# _____

Parents SS # if the victim is a minor _____

Law enforcement agency crime reported to _____

Case no. _____

Location of crime _____

Investigating Officer _____

Date of crime _____ Date crime reported _____

Date crime discovered _____

Name of person who committed
crime _____

Does the victim have children or other dependents? ____ yes ____ no

Did the victim miss work as a result of crime related injuries? ____ yes ____ no

Does the victim wish to apply for an emergency award for lost wages or personal payments on crime related medical bills? ____ yes ____ no

(Employer's Business Name)

(contact person / phone number)

(street address / city / state / zip)

Check the expenses for which you are seeking compensation:

_____ lost wages due to crime related injuries

_____ lost wages to attend court proceedings

_____ loss of support / care for dependents of a deceased victim or those unable to work more than 60 days

_____ medical expenses for the victim

_____ medical expenses for homicide victim survivor

_____ dental

_____ counseling for the victim

_____ counseling for spouse, children, parents, siblings or persons living in a victim's household

_____ counseling for homicide victim survivors

_____ funeral and burial

_____ clean-up of a crime scene

_____ clothing held as evidence

Insurance Information ___ Car ___ Medicaid / Medicare ___ Workers Comp ___ Health ___ None

Name, Address & Policy

Are you represented by a private attorney in a civil lawsuit or insurance action?

___ yes ___ no ___ not at this time

Attorney's Name _____

Phone No _____

Street Address _____

City / State / Zip _____

The following information is used for statistical purposes only. It is needed to comply with Federal Regulations.

Disabled _____ yes _____ no
Gender _____ Female _____ Male
Age _____ 17 and under _____ 18-63 _____ 64 and over
Race _____ white _____ black _____ hispanic
_____ other (please list other)
Who referred you? ___ Police / Sheriff ___ Co. Attorney ___ Media ___ Hospital
___ Victim Services ___ Other

YOU MUST READ AND SIGN BELOW AS NEEDED

Describe injuries _____

List name of doctors, clinics hospitals, dentists, ambulance, etc. (send bill copies if available, use more paper for list if needed) Please include name, address, city, state, zip and telephone number.

INFORMATION RELEASE

I give permission to any hospital, clinic, doctor, insurance company, employer, person or agency to give needed information, including medical records and test results which may include drug and alcohol screen, to the Crime Victim Compensation Program of the Iowa Department of Justice. This release does not authorize records protected under 42 CFR, Iowa Code Chapter 228 or Iowa Code section 141.23(3).

I understand the information will be used to determine compensation benefits, and that only information needed to make a decision about compensation benefits will be requested by the Compensation Program.

I understand that Iowa and Federal laws require the Compensation Program to keep any confidential information it receives confidential. I understand this information release is valid for one year from the date of my signature and that I can cancel this release by writing to the Compensation Program at any time, except if any information has already been received and used it is not subject to cancellation.

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

signed _____

date _____

(Applicant signature--parent or guardian must sign if victim is a minor)

REPAYMENT AND SUBROGATION AGREEMENT

Form must be signed to receive compensation

I understand that Iowa law requires me to contact and repay the Compensation Program if I receive payments from the offender, a civil lawsuit, an insurance program, or any other government or private agency after I receive payment from the Compensation Program. I also agree to notify the Compensation Program if I hire an attorney to represent me in any action related to this crime. I certify the information in this application is true and correct to the best of my knowledge. I understand my signature says I agree to all statements specified in this agreement.

signed _____

date _____

(Applicant signature--parent or guardian must sign if victim is a minor)