CRIME VICTIM COMPENSATION PROGRAM APPLICATION INFORMATION

An application may be filed by, or on behalf of, a person who was injured or died as a result of the crime. The Program may help with certain expenses such as medical or mental health bills or other losses directly related to the crime and covered by the Program. **Personal property losses including cash, or "pain and suffering" claims cannot be reimbursed by the Program.**

WHAT TO DO

- Please print clearly in ink. Separate applications must be completed for each injured victim.
- Enclose copies of crime-related medical bills received so far and send any other bills as they are received. The Program requires that the bills be itemized. It is the applicant's responsibility to document the losses. **If there is insurance, Medical Assistance or other coverage sources for costs of medical or mental health expenses, a provider from within the provider group or that the network will reimburse, must be used. If those sources are not used first, the Program may not be able to consider reimbursement of those costs.**
- Send the completed application to the Crime Victim Compensation Program as soon as possible. Do **not** wait until court is over or until treatment is completed.
- The application must be signed by the injured victim or by the parent or guardian if the victim is under 18 years of age. If the victim is deceased, the application may be signed by a family member or by the administrator of the victim's estate.
- Provide all information requested by the District Attorney's Office to them in a timely manner. The Crime Victim Compensation Program Application does not need to be sent there.
- Return the completed application to the address listed on the bottom of this page. The applicant will receive a letter from the Crime Victim Compensation Program acknowledging the receipt of the application. Call the Program if a letter is not received after two weeks of submitting the application. Notify the Program of any changes in address or phone number. If you have any questions, please call (608) 264-9497 or 1-800-446-6564 (Toll-free). **Keep this information sheet for your records.**

REMEMBER

- The crime must be **reported to law enforcement within 5 days of the date of the crime** and the victim must cooperate in the investigation and prosecution of any known suspects. The **application must be filed within 1 year of the date of the crime.** However, there are very limited circumstances in which this requirement may be waived. If the crime was not reported within 5-days or claim was not filed within 1 year, attach a written statement explaining the reason for the delay.
- Any money received from other sources such as restitution, lawsuits, insurance settlements, etc. **must be repaid** to the Crime Victim Compensation Program for crime related expenses paid by the Program.

Wisconsin Department of Justice
Crime Victim Compensation Program
Post Office Box 7951
Madison, WI 53707-7951
(608) 264-9497 or 1-800-446-6564 (Toll-free)

All information will be verified by the Crime Victim Compensation Program. Section 949.17 of the Wisconsin Statutes provides penalties for persons who submit fraudulent applications.

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CRIME VICTIM COMPENSATION APPLICATION

Post Office Box 7951
Madison, WI 53707-7951
(608) 264-9497 or 1-800-446-6564 (Toll-free)
WI Statutes Chapter 949

CLAIM NO: ___________________

DATE RECEIVED:

(For Office Use Only)

PLEASE BE SURE TO SIGN THE APPLICATION ON THE LAST PAGE

SECTION 1: VICTIM INFORMATION

1. Victim's First Name	Victim's Last Name	2. ☐ Female ☐ Male	3. Date of Birth

4. Social Security Number	5. Mailing Address

6. City	7. State	8. Zip Code	9. County

10. Home Telephone ( )	11. Cell Phone ( )	12. Work Telephone ( )

13. Is the victim represented by an attorney due to this crime:

in filing this application? ☐ Yes ☐ No

in a civil lawsuit? ☐ Yes ☐ No

in an insurance action? ☐ Yes ☐ No

14. Name of Attorney		
Street Address		
City	State	Zip Code

15. **The following victim information is used for statistical purposes only and is needed to comply with federal regulations**

A. Handicapped

Before Crime: ☐ Yes ☐ No

After Crime: ☐ Yes ☐ No

B. Race: ☐ White ☐ American Indian or Alaskan Native ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other

C. How did you learn about the Compensation Program? (Check all that apply)

☐ Law Enforcement	☐ Attorney	☐ Probation or Parole	☐ Friend	☐ Poster or Brochure
☐ District Attorney	☐ Sexual Assault Program	☐ Newspaper	☐ Relative	☐ Public Service Announcement
☐ Victim/Witness Program	☐ Domestic Abuse Program	☐ Funeral Director	☐ Hospital	☐ Other

SECTION 2: PERSON FILLING OUT THE APPLICATION IF VICTIM IS A MINOR, HAS A GUARDIAN, OR IF VICTIM IS DECEASED

1. Person's Name	2. Relationship to Victim

3. Mailing Address	4. City	5. State	6. Zip Code

7. Home Telephone ( )	8. Cell Phone ( )	9. Work Telephone ( )

SECTION 3: CRIME INFORMATION

1. Type of Crime (Check all that apply)

☐ Homicide ☐ Attempted Homicide ☐ Assault/Battery
☐ Domestic Violence ☐ Child Physical Abuse ☐ Child Sexual Abuse
☐ Hit and Run of Pedestrian ☐ Sexual Assault ☐ Robbery
☐ Drunk Driver / DUI ☐ Other ______________________

2. Location of Crime: Street Address	3. City	4. State	5. County

6. Date of Crime	7. Date Crime Reported	8. Law Enforcement Agency to which crime was reported	Officer's name
/ /	/ /		

9. Offender(s) Name(s):

10. Did victim know offender(s)? ☐Yes ☐No If yes, in what way?

Description of Crime (optional):

SECTION 4: MEDICAL/MENTAL HEALTH EXPENSE INFORMATION

1. Name and address of medical facility where victim was **first treated**:	2. Date of Treatment: / /

3. Mental Health Treatment received, or to be received? ☐ Yes ☐ No ☐ Unknown

SECTION 5: MISCELLANEOUS EXPENSES

Homemaker Services $ ____________ Documented Crime Scene Clean-up $ ______________________

Securing a Crime Scene $ ____________ Property held as evidence and damaged by Crime Lab testing $ ____________

Clothing/bedding held as evidence and the reasonable replacement value of each:

____________________ $____________ ____________________ $____________

____________________ $____________ ____________________ $____________

SECTION 6: INSURANCE AND BENEFIT INFORMATION

1. Was there insurance or other source of payment to cover expenses at the time of the crime? ☐ Yes ☐ No

2. Check all that apply:

☐ Employers/Union Group ☐ Workers' Compensation ☐ Medical Assistance/Title 19 ☐ Homeowners Insurance

☐ Veterans' Benefits ☐ County Welfare/GAMP ☐ Victim/Spouse/Parent Insurance ☐ Badger Care

☐ Lawsuit ☐ Disability ☐ Medicare ☐ Other (describe) ____________

SECTION 7: CRIMES INVOLVING MOTOR VEHICLES

Did the victim have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company:
Did the driver have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company:
Did the offender have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company:

SECTION 8: EMPLOYMENT INFORMATION

Complete this section **ONLY** if the victim was employed at the time of injury.

1. Did victim miss time from work immediately following the crime?

☐ Yes ☐ No ☐ Unknown

2. Is the victim self-employed?

☐ Yes ☐ No

3. Dates absent from work due to crime related injuries: From ______________________ To ______________________

4. Name of Employer	5. Employer Telephone

6. Employer Mailing Address	7. City	8. State	9. Zip Code

FOR CRIMES RESULTING IN DEATH

SECTION 9: FUNERAL/BURIAL EXPENSES

1. Funeral Home Name		2. Mailing Address	
3. City	4. State	5. Zip Code	6. Phone Number ( )

7. Life Insurance ☐ Yes ☐ No ☐ Unknown Amount: $ ____________ Beneficiary ____________________________________

SECTION 10: DEPENDENTS FINANCIALLY SUPPORTED BY VICTIM AT TIME OF DEATH

First Name Last Name	Date of Birth	Relationship to Victim

NOTE: If a claim is approved, the Program may be able to assist certain family/household members of the deceased victim with losses due to emotional/physical reactions to the death. More information can be obtained by calling the Crime Victim Compensation Program office.

AGREEMENT

- My signature below means that I certify that information on this application is true and correct.
- I agree that payments for bills may be paid directly to whom the payment is owed.
- I understand that the Crime Victim Compensation Program reimburses for costs not covered by any other source.
- I agree to notify the Crime Victim Compensation Program if a lawsuit is filed.
- I agree to repay the Crime Victim Compensation Program for all payments made if I receive money from any other source.
- I agree to refund the Crime Victim Compensation Program for all money paid by the Program if this claim is determined to be false or fraudulent.

AUTHORIZATION

I authorize and request any person having information needed by the Crime Victim Compensation Program to process my claim to release that information to the Wisconsin Department of Justice. This includes, but is not limited to, all past law enforcement records concerning me; private and governmental physicians and hospitals; local, state and federal law enforcement and prosecutors office and federal court personnel; any employer; and any private company or governmental agency that is providing or may provide medical or monetary benefits. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I authorize the Crime Victim Compensation Program to release copies of crime-related medical bills and wage information to the Office of the District Attorney for determination and documentation of restitution. I certify that I understand and agree to the above statements.

_______________________________________ Signature of Victim or Person filing Claim

_______________________ Date

RETURN COMPLETED APPLICATION TO:

Wisconsin Department of Justice
Crime Victim Compensation Program
Post Office Box 7951
Madison, WI 53707-7951
FAX (608) 264-6368

FOR ASSISTANCE CALL: In Madison (608) 264-9497
Toll Free 1-800-446-6564