

CLAIM FORM

Complete and submit to:

Delaware Victims' Compensation Assistance Program
240 North James Street, Suite 203
Wilmington, DE 19804-3171

1 year waiver	yes	no
72 hour waiver	yes	no
DATE	CHAIR	

<http://www.attorneygeneral.delaware.gov/VCAP>

Please contact the DE VCAP if you need assistance completing this form (Phone)302.995.8383 (Fax)302.995.8387

SECTION 1. VICTIM INFORMATION SECTION		Name of person injured or killed as the result of the violent crime. If there was more than one victim, complete a separate claim form for each victim.			
Victim's Name (last, first, m.i.)		Date of Birth (MM/DD/YY) / /		Social Security Number	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race (optional) <input type="checkbox"/> Asian/Pacific Island <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other _____			Is Victim Deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address (including apartment #)		City		State	Zip Code
Home Phone () ()	Work Phone () ()	Cell Phone () ()	E-Mail Address		
Who referred you to the compensation program? Contact Person: _____					
<input type="checkbox"/> Hospital		<input type="checkbox"/> Police Agency		<input type="checkbox"/> Prosecutor	
<input type="checkbox"/> Victim Services DOJ		<input type="checkbox"/> Poster/Brochure/Advertisement		<input type="checkbox"/> Public Service Announcement	
				<input type="checkbox"/> Victim Services Police	
				<input type="checkbox"/> Other: _____	

SECTION 2. CLAIMANT INFORMATION		Name of person filing on behalf of a deceased victim, minor victim, or an incapacitated adult victim.			
Claimant's Name (last, first, m.i.)		Date of Birth (MM/DD/YY) / /		Social Security Number	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Victim <input type="checkbox"/> Parent <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Former Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____				
Street Address (including apartment #)		City		State	Zip Code
Home Phone () ()	Work Phone () ()	Cell Phone () ()	E-Mail Address		

SECTION 3. CRIME INFORMATION		Date of Crime / /	Date Reported to Police / /	Name of Suspect	
Relationship of suspect to victim: _____					
Name of Police Department Investigating Crime		Police Complaint Number		Investigating Officer's Name	
Location of Crime (address)		City		State	Zip Code
Type of Crime: (please check one)					
<input type="checkbox"/> Assault	<input type="checkbox"/> DWI/DUI	<input type="checkbox"/> Homicide/Murder	<input type="checkbox"/> Child Sexual Abuse		
<input type="checkbox"/> Child Physical Abuse	<input type="checkbox"/> Stalking	<input type="checkbox"/> Kidnapping	<input type="checkbox"/> Arson		
<input type="checkbox"/> Domestic Abuse	<input type="checkbox"/> Adult Sexual Abuse	<input type="checkbox"/> Robbery	<input type="checkbox"/> Burglary		
<input type="checkbox"/> Protection From Abuse (PFA) or PFA ex parte (emergency hearing)	<input type="checkbox"/> Other Please specify if other: _____				

SECTION 4. LOSS INFORMATION		Check the type of expenses/losses you are seeking for compensation. You must attempt to recover your losses from any/all other sources(s).		
<input type="checkbox"/> Medical/Dental	<input type="checkbox"/> Wage/Income Loss	<input type="checkbox"/> Funeral/Burial	<input type="checkbox"/> Mental Health Counseling	<input type="checkbox"/> Crime Scene Cleanup
<input type="checkbox"/> Mental Health Counseling (Secondary Victim)	<input type="checkbox"/> Loss of Support for Victim's Dependents	<input type="checkbox"/> Moving	<input type="checkbox"/> Relocation	<input type="checkbox"/> Temp. Housing
<input type="checkbox"/> Other Please specify if other:		Approximate amount of Loss (Must demonstrate a minimum of \$25.00 loss.) \$		
Name of Secondary Victim's (last, first, m.i.)			Relationship to Victim	
Address		Phone No.	Date of Birth (MM/DD/YY) / /	
Other Secondary Victim(s)			Relationship to Victim	
Address		Phone No.	Date of Birth (MM/DD/YY) / /	

SECTION 5. MEDICAL INFORMATION	List all Medical/Dental Providers, and/or those who have provided services to the victim and attach any medical bills you have received.		
Name of Provider	Address	Phone	Amount Due \$
Name of Provider	Address	Phone	Amount Due \$
Name of Provider	Address	Phone	Amount Due \$
Name of Provider	Address	Phone	Amount Due \$

SECTION 6. VICTIM'S EMPLOYER INFORMATION	Complete only if filing for income loss			
Name of Employer	Address	City	State	Zip Code
Telephone Number ()	Fax Number ()	Was the victim self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dates absent from work due to crime related injury From: To:		Amount of wages lost due to injuries \$		
Victim was released back to work on:	By (Name of physician)	Phone Number of Physician ()		

SECTION 7. SOURCES OF FINANCIAL ASSISTANCE	Check all that may apply				
Did the victim have insurance at the time of the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does secondary victim have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Health	<input type="checkbox"/> Auto	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> SSI
<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Disability Benefits	<input type="checkbox"/> Homeowners/Renters	<input type="checkbox"/> General Assistance	<input type="checkbox"/> None	
Provider Name:				Policy #	

ACKNOWLEDGEMENT AND REIMBURSEMENT AGREEMENTS

The Acknowledgement, Reimbursement and Authorization Agreements must be signed before the claim verification process will begin.

Certification of Application

Subject to the penalty of fine or imprisonment, the information contained in this application for a Crime Victim Compensation award is true and correct to the best of my knowledge.

Consent

I agree that any award(s) may be paid directly, at the discretion of the Delaware Victims' Compensation Assistance Program, to the person(s) owed payment.

Subrogation Agreement

I agree that I HAVE NOT and WILL NOT sign any release or participate in any settlement or compromise with any person who may be liable to me for damages as a result of the criminal act for which I am making a claim. In consideration of any award made by the AGENCY, I agree to subrogate to the AGENCY any right or cause of action to the extent of the award that I may have against any third party. I authorize the AGENCY to pursue in my name at the expense of the AGENCY recovery from any third party any sums paid to me from the VICTIM'S COMPENSATION FUND. In any suit that is brought by the AGENCY, I agree to fully cooperate and assist in any manner including executing and returning papers as required.

Repayment

If later I recover any money through legal action, restitution or otherwise, I agree to immediately repay the award(s) to the AGENCY.

Civil Lawsuit

Will there be a Civil Lawsuit in relation to this crime? Yes No Unknown

If yes, list the name and address of Attorney: _____

Appeal

I understand if I am dissatisfied with the initial decision of the Victims' Compensation Assistance Program, I may submit a written request for a Reconsideration within 15 days after the date the decision is mailed. If the claimant is dissatisfied with the Agency's final decision, the claimant, may, within 15 days after the date the decision is mailed, request a hearing before the Appeals Board. If I am not satisfied with the Appeals Board's final decision, I understand that I may appeal the decision to the Superior Court of the State of Delaware within thirty (30) days for the final decision.

Acknowledgement and Reimbursement Agreements

My signature below signifies I understand each of the following statements or points of law: The decision to approve my claim is that of the Program's. I may object to all or part of the Program's decision in writing within 15 days from the date that the decision is mailed. I must prove the exact amount of my losses before the Program will consider awarding compensation from the Crime Victim's Compensation Fund. I may file for reimbursement for additional expenses incurred relating to the crime. My claim may be denied if I do not cooperate fully with law enforcement agencies, the courts, and the Program or maintain a valid address with the Program. If I were to make a false claim, it would be a criminal offense punishable as a misdemeanor. If I were to make a false statement in this claim form with the intent to mislead the Program, it would be a criminal offense punishable as a misdemeanor. I understand that the Delaware Victims' Compensation Assistance Program is the payor of last resort. I specifically agree to inform the Program of and repay to the Delaware VCAP any funds that I may receive from any other source that has not already been considered, as a result of the crime and to the extent of the award. That is, I agree to repay any funds that I receive from the offender, any other person or source, which compensates me for the injury I suffered. I further agree that if the claim is at any time determined to be in error, false or fraudulent, I will refund to the Program all sums of money paid by the Program.

X _____ **Claimant's Signature** _____ **Date**

X _____ **Witness Verification of Signature** _____ **Date**

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 42 USC§§1320d et seq.) any hospital, physician, health care provider or other person who attended or examined (Name of Victim) _____; any funeral director or other person who rendered related services; any employer of the victim or claimant; any police or governmental agency, including state or federal taxing authorities; any insurance company; or any organization having relevant knowledge, to furnish to the Delaware Victims' Compensation Assistance Program, any and all information in their possession with respect to the incident that is the basis for this claim. Copies of this authorization may be used in place of the original.

X _____ **Claimant's Signature** _____ **Date**

X _____ **Victim's Signature (if age 18 or over)** _____ **Date**