



New York State Crime Victims Board

Claim Application and Instructions

1 Columbia Circle, Suite 200
Albany, NY 12203-6383
(518) 457-8727

55 Hanson Place, Room 1000
Brooklyn, NY 11217-1523
(718) 923-4325

65 Court Street, Room 308
Buffalo, NY 14202-3406
(716) 847-7992

How to Apply for Compensation

Who can apply for compensation?

Innocent victims of crime, certain relatives, dependents and the guardian can apply to CVB (Crime Victims Board) for compensation of out-of-pocket expenses not covered by insurance or other resources.

What kinds of expenses can I get compensated for?

CVB offers compensation related to personal injury, death and loss of essential personal property.

The specific expenses CVB may cover include:

- Medical and counseling expenses
- Loss of Essential Personal Property (*up to \$500, including \$100 for cash*)
- Burial or Funeral Expenses (*up to \$6,000*)
- Lost Wages or Lost Support (*up to \$30,000*) (*Parents or guardians of hospitalized minor children may be eligible for this benefit.*)
- Transportation (court/medical)
- Occupational/Vocational Rehabilitation
- Use of Domestic Violence Shelters
- Crime scene clean-up (*up to \$2,500*)
- Good Samaritan property losses (*up to \$5,000*)

How do I ask for compensation?

Send us your completed CVB application along with copies of:

- Correspondence with insurance companies or benefits plan saying if they will cover your loss
- Medical bills
- Police reports
- Insurance cards
- Receipts for essential personal property
- Death certificate and funeral contract
- Victim's birth certificate

What if I don't have some of the papers CVB needs?

Send your application in right away. You can send the other documents later.

What if there is not enough room on the application form?

You can attach as many pages as you need to the application form.

Do I need a lawyer to file a claim to CVB?

No. But, if you hire a lawyer to help you with this claim, you can ask CVB to reimburse up to \$1,000 of the legal fees.

What if my property was lost, damaged or destroyed because of the crime?

If you are under 18, 60 or over, disabled or were injured, you may apply for benefits to replace your *essential* personal property or cash that was not covered by any other resource.

Essential means necessary for your health and welfare, like eyeglasses and clothes.

What if I move?

Write to CVB right away. Tell us your new address and phone number. Also let us know if your email address changes.

What if I have questions or need help filing a claim?

We can help you find a victim assistance program near you. Call us at: **1-800-247-8035**

Or visit our website: **www.cvb.state.ny.us**

It's best to fill out the form completely, or it may take longer to process your claim.

Who can sign the claim?

Generally, the victim must sign the claim. However, if the victim is under 18, or is physically or mentally incapable of signing, then the legal guardian (the person receiving the benefits) must fill out section 2 of the claim and sign the claim.

If the victim died, the person asking for benefits must fill out section 2 of the claim and sign the claim.

Do I have to fill out the attached HIPAA form?

Yes. Fill out one HIPAA form for **each** service provider. You can photocopy a blank form to make extra copies.

New York State Crime Victims Board
1 Columbia Circle, Suite 200
Albany, NY 12203-6383
Tel: 1-800-247-8035
TTY: 1-888-289-9747
www.cvb.state.ny.us



Application for Compensation

New York State Crime Victims Board



Read *How to Apply for Compensation* before filling out this form.
Please print. Answer all questions. *It is a crime to file a false claim!*

| Victim Assistance Program Use Only | | |
|------------------------------------|--------------|----------------|
| CVB VAP ID# | Program Name | Advocate Name |
| Program Phone () | | Advocate Email |

1 Tell us about the victim.

| | | | | | |
|---|-----------------------------|-------------|--|-----------------------------------|-----------------|
| Last Name | First Name | MI | Social Security # <input type="checkbox"/> Check here if you do not have one. _____ - ____ - _____ | Date of Birth | |
| Mailing Address: | | | | | |
| <i>Street</i> | <i>Apt. # (or P.O. Box)</i> | <i>City</i> | <i>County</i> | <i>State (or Foreign Country)</i> | <i>Zip Code</i> |
| Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other <input type="checkbox"/> Unknown | | | | | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Lives with partner | | | | | |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Was the victim disabled at the time of the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| How did you first hear about the <i>Crime Victims Compensation Program</i>? | | | | | |
| <input type="checkbox"/> Police <input type="checkbox"/> Hospital <input type="checkbox"/> District Attorney <input type="checkbox"/> Victim Assistance Program <input type="checkbox"/> Radio/TV <input type="checkbox"/> Brochure/Poster <input type="checkbox"/> Internet <input type="checkbox"/> Other | | | | | |

2 If you are *not* the victim, and are signing this claim, tell us about you. (See "Who can sign the claim?" on the instructions page.)

| | | | | | |
|------------------|-----------------------------|-------------|--|-----------------------------------|-----------------|
| Last Name | First Name | MI | Social Security # <input type="checkbox"/> Check here if you do not have one. _____ - ____ - _____ | Date of Birth | |
| Mailing Address: | | | | | |
| <i>Street</i> | <i>Apt. # (or P.O. Box)</i> | <i>City</i> | <i>County</i> | <i>State (or Foreign Country)</i> | <i>Zip Code</i> |

What is your relationship to the victim? (Check **only one**.)

Parent Spouse Child Guardian Attorney Other (Explain): _____

3 Tell us about the crime. (Check **only one**.)

The victim died because of:

- Motor Vehicle (DWI)
- Motor Vehicle (Other)
- Terrorism
- Arson
- Human Trafficking
- Other Homicide: _____

The victim was injured because of:

- Assault
- Sexual Assault
- Child Physical Abuse
- Child Sexual Abuse
- Motor Vehicle (DWI)
- Motor Vehicle (*not DWI*)
- Other (Explain): _____
- Stalking
- Kidnapping
- Terrorism
- Arson
- Robbery
- Human Trafficking

The victim lost essential personal property because of:

- Burglary/Robbery
- Motor Vehicle (DWI)
- Motor Vehicle (*not DWI*)
- Human Trafficking
- Other (Explain): _____
- Arson

Where did the crime happen? (Check **only one**.) Work Owned residence Apt. Bldg. Public Street

Subway/Bus Parking Lot Restaurant/Bar School/School grounds Shopping Mall Other (Explain): _____

Was this a domestic violence crime? Yes No Unknown

Was the victim driving a livery cab when the crime happened? Yes No Unknown

Was the victim's property lost or damaged while trying to prevent or stop a crime against someone else or while helping the authorities stop the crime? Yes No

Crime Report #: _____ **Police or criminal justice agency reported to:** _____

County where crime happened: _____ Date of crime: _____ Date crime was reported: _____

If more than 7 days between the date of crime and date the crime was reported, explain why: _____

If more than 1 year between the date of crime and the date you are filing this claim, explain why: _____

Describe the crime in your own words: _____

4 Tell us about the suspect. Suspect's name (if you know): _____

- Has the suspect been arrested for this crime? Yes No
 Has the suspect been prosecuted for this crime? Yes No Pending
 Does the suspect live in the same house as the victim
 OR is the suspect a member of the victim's family? Yes No
 Has the court issued an order of protection in this case?.. Yes No (If Yes, attach a copy.)
 Did the court order the suspect to pay restitution? Yes (Amount \$ _____) No Pending

5 Tell us about your expenses related to this crime. (Check all that apply.)

- Medical Medical transportation Funeral/Burial Court Transportation
 Crime Scene Cleanup Loss of Support Lost Wages DV Shelter or Moving
 Security Device/System Vocational/Rehabilitation Counseling Essential Personal Property
 Other (Explain): _____

6 List any essential personal property, like cash, eyeglasses, or clothing that needs to be replaced because of this crime. (If none, skip to 7.)

| Describe what was lost/damaged: | Cost | Describe what was lost/damaged: | Cost |
|---------------------------------|----------|---------------------------------|----------|
| 1. _____ | \$ _____ | 4. _____ | \$ _____ |
| 2. _____ | \$ _____ | 5. _____ | \$ _____ |
| 3. _____ | \$ _____ | 6. _____ | \$ _____ |

| | | |
|------------------------------------|----------------|------------------|
| Homeowner/Renter Insurance Company | Policy or ID # | Deductible \$ |
| Auto/Other Insurance Company | Policy or ID # | Deductible \$ |

— If there were no injuries and you are only asking for essential personal property benefits, skip to 15. —

7 If the victim was injured or died because of this crime, fill out below.

Describe the victim's injuries, briefly: _____

Did the victim receive any medical treatment? Yes No (If **No**, skip to section 8.)

Tell us about the health professionals who treated the victim for injuries related to this crime:

| | Name | Address | Phone # |
|-----------------------------------|-------|---------|--------------|
| First Hospital | _____ | _____ | (____) _____ |
| Other Hospital | _____ | _____ | (____) _____ |
| First Doctor (not in hospital) | _____ | _____ | (____) _____ |
| Other Doctor | _____ | _____ | (____) _____ |
| First Dentist | _____ | _____ | (____) _____ |
| Victim's Counselor | _____ | _____ | (____) _____ |

8 Tell us about the victim's dependents or others who depended on the victim for support. (If none, skip to 9.)

| | | | | |
|-----------------|---------|--|---------------|--|
| Dependent | Name | Social Security # ____ - ____ - _____ | Date of Birth | Relationship to Victim |
| | Address | | | Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Dependent | Name | Social Security # ____ - ____ - _____ | Date of Birth | Relationship to Victim |
| | Address | | | Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Dependent | Name | Social Security # ____ - ____ - _____ | Date of Birth | Relationship to Victim |
| | Address | | | Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No |

If more than 3 dependents, attach a separate sheet and check here:

9 Did anyone besides the victim receive counseling because of this crime? (If no, skip to 10.)

| | | | |
|--|------------------------|---|----------------|
| Who received counseling? | Relationship to Victim | Insurance company billed for counseling | Policy or ID # |
| Counselor's name, address and phone #: | | | |
| Who else received counseling? | Relationship to Victim | Insurance company billed for counseling | Policy or ID # |
| Counselor's name, address and phone #: | | | |

If more than 2 people received counseling because of this crime, check here and attach a separate sheet to describe.

10 List any insurance covering the victim or the victim's dependents. If no insurance, write "None" below. If you have applied but are not covered yet, write "Pending" under Policy or ID #.

| | | |
|---|----------------|--|
| Primary Insurance Company | Policy or ID # | Name of person(s) covered by this insurance: |
| Major Medical Insurance Company | Policy or ID # | Name of person(s) covered by this insurance: |
| Other Insurance (Union, Dental, Vision, etc.) | Policy or ID # | Name of person(s) covered by this insurance: |
| Medicare | Policy or ID # | Name of person(s) covered by this insurance: |
| Medicaid | Policy or ID # | Name of person(s) covered by this insurance: |
| Workers' Compensation | Policy or ID # | Name of person(s) covered by this insurance: |
| Auto Insurance | Policy or ID # | Name of person(s) covered by this insurance: |
| Other insurance | Policy or ID # | Name of person(s) covered by this insurance: |

11 Tell us about the victim's or the parent's employment and insurance for Lost Wages.

If you do not want us to contact your employer, you cannot ask to be reimbursed for Lost Wages. (Skip to 12.)

Was the victim/parent employed when the crime happened? Yes No (If No, skip to 12.)

Did the victim/parent miss work because of the crime? Yes No

Was the victim/parent self-employed? Yes No (If Yes, attach copies of last year's federal tax return and all schedules.)

Employer's Name, Address, and Phone #:

 Employer Street City State Zip Code Phone # ()

Other Employer's Name, Address, and Phone #:

 Employer Street City State Zip Code Phone # ()

Name, Address, and Phone # of doctor who certified victim could not go to work:

 Doctor Street City State Zip Code Phone # ()

Tell us about any insurance company that will cover the victim's lost time at work. (If none, write "None" below and skip to 12.)

| | | | |
|---------------------------|--------------------------|-----------------------------|---------------------------|
| 1. Unemployment Insurance | Policy or ID # or "None" | 5. Social Security Benefits | SSN ____ - ____ - ____ |
| 2. Disability Insurance | Policy or ID # or "None" | 6. SSI Benefits | SSN ____ - ____ - ____ |
| 3. Pension Plan | Policy or ID # or "None" | 7. Workers' Compensation | Policy or ID # or "None" |
| 4. Other insurance | Policy or ID # or "None" | 8. Other insurance | Policy or ID # or "None" |

12 If the victim died, fill out below if you have any burial expenses. (If not, skip to 14.)

Also, attach a copy of the funeral home contract, other bills for burial expenses, and a photocopy of the Death Certificate, if you have them.

Name of Funeral Home: _____ Phone #: () _____

Address: _____
 Street City State Zip Code

13 If the victim died, tell us about any life insurance and death benefits.

(If the victim did not die, or does not have any life insurance or death benefits, skip to 14.)

| | | | | |
|-----------------------|--------------|---------|-----------|----------------|
| | Company Name | Address | Phone # | Policy or ID # |
| Life Insurance | _____ | _____ | () _____ | _____ |
| Pension Plan | _____ | _____ | () _____ | _____ |
| Other Insurance/Plan | _____ | _____ | () _____ | _____ |
| Medicaid | _____ | _____ | () _____ | _____ |
| Workers' Compensation | _____ | _____ | () _____ | _____ |

If any other insurance or death benefits, list here: _____

Do any of these policies cover the victim's burial expenses? Yes No

Has anyone applied for the Social Security Death Benefit? Yes No

14 Tell us about your financial situation. You must fill out ALL sections below. If none, enter zero (0).

How many dependents do you have? _____

What is your total annual income (from ALL sources)? If you are not sure, estimate: \$ _____

List ALL your assets and ALL your debts below. If you are not sure, estimate.

| Your Assets – If none, enter zero (0). | | Your Debts – How much do you owe now? | |
|--|----------|---------------------------------------|---------------------------------|
| Savings, stocks, bonds | \$ _____ | | If none, enter zero (0). |
| Real Property (house, etc.) | \$ _____ | Mortgage | \$ _____ |
| Proceeds from life insurance | \$ _____ | Loans | \$ _____ |
| Other | \$ _____ | Other | \$ _____ |

15 If a private lawyer is helping with this claim, fill out below.

| | |
|------------------|-----------|
| _____ | () _____ |
| Name of Law Firm | Phone # |
| _____ | _____ |
| Lawyer's Name | Address |

16 Claimant's Authorization: I ACKNOWLEDGE that accepting an award from the Crime Victims Board (Board) creates a lien in favor of the State of New York on any recovery relating to the crime upon which this claim is based, including any judgment, settlement or order of restitution. I further authorize any funeral director, attorney, employer, police or other public authority, insurance company or any person who rendered services to the above, or having knowledge of the same, to furnish the Board or its representatives the following information: Worker's Compensation records, information relating to the crime or any injuries or death suffered as the result of the crime, and information relating to this claim. If an award is made, I authorize the Board to make payments directly to the provider of services. I also authorize the Board to share my information and records compiled for this claim with the local Victim Assistance Program (VAP) in order for the VAP to assist the Board in processing my claim and making its determination. If a private lawyer has been indicated above, I also authorize the Board to share my information and records compiled for this claim with the lawyer in order for him/her to act as my representative. I understand a separate Notice of Appearance from my lawyer will be needed in addition to this authorization.

A photocopy of this authorization shall be deemed as effective as the original.

| | |
|----------------------|-----------------|
| _____ | () _____ |
| Claimant's Signature | Daytime Phone # |
| _____ | _____ |
| Date | |

Email: _____ Language you prefer to speak: English Spanish Other _____

To process your claim, mail us the following documents. (Keep a copy for your records.)

- All bills and receipts for services listed on this form
- Your completed, signed claim form
- One completed HIPAA form for each service provider listed on this form (You can photocopy the HIPAA form.)
- Letters from any insurers denying or authorizing payment for the services listed on this form.

Remember: You must bill your insurance company or benefits plan **before** the Board can pay.

Mail your documents to:

New York State Crime Victims Board
1 Columbia Circle, Suite 200
Albany, NY 12203-6383



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

| | | |
|-----------------|---------------|------------------------|
| Patient Name | Date of Birth | Social Security Number |
| Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
NYS CRIME VICTIMS BOARD – 1 COLUMBIA CIRCLE, SUITE 200, ALBANY, NY 12203-6383

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: _____ Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:
NEW YORK STATE CRIME VICTIMS BOARD

(Attorney/Firm Name or Governmental Agency Name)

| | |
|---|--|
| 10. Reason for release of information: <i>At request of the individual for purposes of establishing eligibility for New York State Crime Victims Board benefits.</i> | 11. Date or event on which this authorization will expire: <i>This authorization will expire upon the termination of the individual's eligibility for Crime Victims Board benefits.</i> |
|---|--|

| | |
|--|---|
| 12. If not the patient, name of person signing form: | 13. Authority to sign on behalf of patient: |
|--|---|

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law. Date: _____

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**