



In order for the Office of Victim Services to discuss or share any of the information and records compiled for your claim with your representative (attorney or otherwise), we require the following authorization to be completed by the claimant and notarized:

Representative's Authorization by Office of Victims Services (OVS) Claimant

Pursuant to New York State Executive Law, §633 and Public Officers Law §96, I:

Name of OVS Claimant
(Please print)

OVS Claim Number

hereby authorize:

Name of Representative

Address of Representative

Phone Number of Representative

to act as my representative in the above mentioned OVS claim. This authorization is to allow the New York State Office of Victims Services to share my information and records compiled for this claim with the above authorized representative. This authorization shall be valid until revoked by me in writing.

Signature of OVS Claimant

Date

State of New York)

) ss.:

County of _____)

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

NOTARY PUBLIC

EXCEPTIONS TO PERSONAL INJURY

There are exceptions to victims of a crime who have **NOT** sustained a personal physical injury. The following charges must be reflected on the police report in order for a victim to be eligible under our statute.

Section 631.12

Menacing 2 degree (PL 120.14) (2) or (3)
Menacing 1 degree (PL 120.13)
Harassment 2 degree (PL 240.26) (2) or (3)
Harassment 1 degree (PL 240.25)
Aggravated Harassment 2 degree (PL 240.30) (4)
Aggravated Harassment 1 degree (PL 240.31) (2)
Criminal Contempt 1 degree (PL 215.51) (b) (ii) or (iv) or (PL 215.51) (c)
Stalking 4,3,2 or 1 degree (PL 120.45, 120.50, 120.55 or 120.60)

ELIGIBLE FOR:

Loss of Earnings or Support
Essential Personal Property
Security Devices
Transportation for court in connection with the prosecution of the crime (with proper documentation)
Counseling
Occupational or Job Training
Moving expenses

Section 631.11

Unlawful Imprisonment 1 degree (PL 135.10)
Kidnapping 2 or 1 degree (PL 135.25)

ELIGIBLE FOR:

Loss of Earnings or Support
Counseling
Transportation for court in connection with the prosecution of the crime (with proper documentation)

Section 631.8

Elderly (over 60) or Disabled victim

ELIGIBLE FOR:

Essential Personal Property
Transportation for necessary court appearances or prosecution (with proper documentation)
Counseling commencing within one year from the date of crime

Victims under the age of 18 (child victim) or witnesses to a physical injury crime are eligible under our statute for all Personal Injury benefits.

When a victim is claiming for Crime Scene Clean up, a personal physical injury **MUST** have occurred except for child victims.



NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
 40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001
 MICHAEL J. DOWLING
 Commissioner

AUTHORIZATION FOR INFORMATION

I, _____, residing at
 Subject of, or Other Person Named in a Report
 _____, being the subject
 Address

of, or other Person named in a report of suspected child abuse or maltreatment made to the New
 York State Central Register of Child Abuse and Maltreatment on _____,
 Date

as case number SCR # _____, hereby authorize the New York
 State Central Register of Child Abuse and Maltreatment to furnish all documentation concerning
 the report contained within the New York State Central Register of Child Abuse and
 Maltreatment, (and) (or) provide information regarding the status of such report to:

THE NEW YORK STATE OFFICE OF VICTIM SERVICES

 Name
 _____, on
 Address

my behalf in accordance with the Child Protective Services Act of 1973.

 Signature

On this _____ day of _____, 2_____, before me
 personally came _____ to me
 Subject of, or Other Person Named in a Report

known and known to be the same person(s) described in and who executed the within statement,
 and ___ he duly acknowledges to me that ___ he executed the same.

 Notary Public

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER



Andrew M. Cuomo
GOVERNOR



STATE OF NEW YORK
EXECUTIVE DEPARTMENT
OFFICE OF VICTIM SERVICES
www.ovs.ny.gov

Tina M. Stanford, Esq.
DIRECTOR

Claim#:
Crime Date:
Claimant:
Victim:

Dear Claimant:

Based on the law that governs the Office of Victim Services (OVS), in order for the OVS to award benefits the criminal justice record must show that the crime was reported to a criminal justice agency within one week after the occurrence of the crime. However, the OVS may award benefits if good cause is shown for the delay.

According to the criminal justice agency records, the complaint report was filed more than one week after the occurrence of the crime.

Please use the space provided below to explain the delay for filing the criminal complaint report:

(Claimant Signature)

____/____/_____
(Date)



NEW YORK STATE EXECUTIVE DEPARTMENT
OFFICE OF VICTIM SERVICES (OVS)

AFFIDAVIT IN SUPPORT OF EXTENSION OF FILING TIME
(TO BE COMPLETED BY CLAIMANT)

NAME : _____ CLAIM NO: _____

DATE OF CRIME: _____ LOCATION OF CRIME: _____

DATE REPORTED TO POLICE: _____ DATE CLAIM FILED WITH THE OVS: _____

DATE YOU WERE INFORMED OF THE OFFICE OF VICTIM SERVICES: _____

LIST THE FACTORS WHICH CAUSED THE DELAY IN FILING THE CLAIM BEYOND THE STATUTORY ONE YEAR FILING PERIOD:

Signature of Claimant

_____/_____/_____
Date

State of New York

County of _____

On this _____ day of _____, 20____, before me, the undersigned Notary Public in and for the

State of _____ personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity and by his/her signature on the instrument (s)he executed the instrument.

Notary Public

Seal/Stamp

PLEASE RETURN TO THE LOCATION BELOW



New York State
Office of Victim Services
1 Columbia Circle, Ste 200
Albany, NY 12203
(518) 457-8727

Claim Number:

NEW YORK STATE OFFICE OF VICTIM SERVICES		ATTENDING PHYSICIAN'S REPORT	
1. NAME OF INJURED VICTIM (Last, first, middle)		2. HOME MAILING ADDRESS (Number, street, city, state, zip code)	
3. DATE OF CRIME (Mo; day, year)		4. DOES THE VICTIM HAVE MEDICAL COVERAGE? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, which plan)	
5. WHAT HISTORY OF CRIME RELATED INJURY DID THE VICTIM GIVE YOU?			
6. WHAT IS YOUR DIAGNOSIS (Include results of x-rays, laboratory tests, etc?)			
7. DOES THE VICTIM HAVE A HISTORY OF A PRE-EXISTING SIMILAR MEDICAL CONDITION OR A PRIOR INJURY TO THE AFFECTED BODY AREA? IF SO, PLEASE EXPLAIN.			
8. DID THE INJURY EXACERBATE PRE-EXISTING CONDITIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, HOW LONG WILL THE EXACERBATION LAST?			
9. PLEASE IDENTIFY THE PERCENTAGE OF TREATMENT RELATED TO THIS CRIME.			
10. ARE THE SERVICES RENDERED RELATED TO THE CRIME RELATED INJURIES AS DESCRIBED IN SECTION 5? <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. IS THE VICTIM IN NEED OF MEDICATION DUE TO THE CRIME RELATED INJURIES? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, LIST ON BACK			
12. DID INJURY REQUIRE HOSPITALIZATION? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, DATE OF ADMISSION (Mo, day, year) DATE OF DISCHARGE		13. IS ADDITIONAL HOSPITALIZATION REQUIRED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. CRIME RELATED OPERATIONS (If any, describe type)		15. DATE OF OPERATIONS PERFORMED (Mo, day, year)	
16. WHAT IS THE FREQUENCY AND DURATION OF RECOMMENDED TREATMENT:		17. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?	
18. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?			
19. DATE OF FIRST EXAMINATION (Mo, day, year)	20. DATES OF TREATMENT (Mo, day, year)		21. DATE OF DISCHARGE FROM TREATMENT (Mo, day, year)
22. DO YOU BELIEVE THE VICTIM WAS DISABLED DUE TO THE CRIME RELATED INJURIES? <input type="checkbox"/> Yes <input type="checkbox"/> No	23. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo, day, Year) TOTAL DISABILITY: FROM TO PARTIAL DISABILITY: FROM TO		24. DATE VICTIM ABLE TO RESUME (Mo, day, year) LIGHT WORK REGULAR WORK
25. IF VICTIM IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? <input type="checkbox"/> Yes <input type="checkbox"/> No . If YES, FURNISH DATE ADVISED			
26. IF VICTIM IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS/HER PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE/SHE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.			
27. IS MEDICAL AND/OR VOCATIONAL REHABILITATION INDICATED? <input type="checkbox"/> Yes <input type="checkbox"/> No			

LIST MEDICATIONS PRESCRIBED FOR CRIME RELATED INJURIES FROM BOX 11

THE OFFICE OF VICTIM SERVICES (OVS) WILL REVIEW AND DETERMINE THE REASONABLENESS OF RELATED MEDICAL EXPENSES SUBMITTED TO THE (OVS) FOR PAYMENT. PLEASE KEEP IN MIND THAT OUR (OVS) IS THE PAYER OF LAST RESORT. CONSEQUENTLY, ALL EXISTING INSURANCE WHICH THE CLAIMANT HAS MUST BE EXHAUSTED PRIOR TO SUBMISSION TO THE (OVS).

DATE OF SERVICE	PLACE OF SERVICE *	FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		CHARGES			
		CPT PROCEDURE CODE	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)				
28. SIGNATURE OF PROVIDER (I certify that the statement on the reverse applies to this bill and is made a part hereof.)			30. HAS CLAIMANT PAID ANY PART OF THE BILL? <input type="checkbox"/> Yes <input type="checkbox"/> No		31. TOTAL CHARGE	32. AMOUNT PAID	33. BALANCE DUE
29. DATE: _____			34. PROVIDER SOC. SEC. NO.		35. PROVIDER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER		
36. YOUR PATIENT'S ACCOUNT NO.			37. PROVIDER TAX I.D. NO.				
* 1 - INPATIENT HOSPITAL 2 - OUTPATIENT HOSPITAL 3 - DOCTOR'S OFFICE 0 - OTHER LOCATIONS		4 - PATIENT'S HOME 5 - DAY CARE FACILITY (PSY) 6 - NIGHT CARE FACILITY (PSY) A - INDEPENDENT LABORATORY		7 - NURSING HOME 8 - SKILLED NURSING FACILITY 9 - AMBULANCE B - OTHER MEDICAL/SURGICAL FACILITY			

PLEASE NOTE: ALL BILLS FOR SURGICAL PROCEDURES MUST HAVE ACCOMPANYING OPERATIVE REPORTS.

HAVE YOU MADE APPLICATION FOR SERVICES TO:

BLUE SHIELD	YES <input type="checkbox"/> NO <input type="checkbox"/>	MEDICAID	YES <input type="checkbox"/> NO <input type="checkbox"/>
WORKER'S COMPENSATION	YES <input type="checkbox"/> NO <input type="checkbox"/>	ANY INSURANCE COMPANY	YES <input type="checkbox"/> NO <input type="checkbox"/>
MEDICARE	YES <input type="checkbox"/> NO <input type="checkbox"/>		

IF "YES" TO ANY, PLEASE STATE THE FOLLOWING:

OTHER INSURANCE COMPANY

NAME AND ADDRESS _____

POLICY NUMBER _____

AMOUNT REC'D _____

NAME AND ADDRESS _____

POLICY NUMBER _____

AMOUNT REC'D _____

COUNSELING ELIGIBILITY

PERSONAL INJURY CLAIMS

VICTIM: Aged 18 and over

ELIGIBLE: Victim, Spouse, Child, and Stepchild

VICTIM: Aged under 18

ELIGIBLE: Parents, Stepparent, Grandparent, Guardian, Brother, Sister, Stepbrother or Stepsister, Spouse, Child, Stepchild.

DEATH CLAIMS

VICTIM: Any age

ELIGIBLE: Surviving Spouse, Grandparent, Parent, Guardian, Siblings, Stepsiblings, Stepparent, Child or Stepchild.

EMOTIONAL INJURY - NO PERSONAL INJURY SUSTAINED

VICTIM: Elderly (60 or older) or disabled (prior to date of crime)

ELIGIBLE: Victim (counseling must begin within 1 year of the crime)

VICTIM: Under 18 including a child reported missing more than 7 days, a child victim of Stalking, Unlawful Imprisonment 1st, Kidnapping 1st and Kidnapping 2nd

ELIGIBLE: Victim, Parent, Stepparent, Grandparent, Guardian, Brother, Sister, Stepbrother and Stepsister

VICTIM: Over 18 a victim of "Stalking" crimes, Unlawful Imprisonment 1st, Kidnapping 1st and 2nd

ELIGIBLE: Victim Only

Andrew M. Cuomo
GOVERNOR



Tina M. Stanford, Esq.
DIRECTOR

STATE OF NEW YORK
EXECUTIVE DEPARTMENT
OFFICE OF VICTIM SERVICES
www.ovs.ny.gov

MENTAL HEALTH TREATMENT REPORT – OUTPATIENT

DATE OF REPORT: _____

CLAIMANT/VICTIM INFORMATION:

NAME: _____ CLAIM NO.: _____

ADDRESS: _____

DATE OF BIRTH: _____

SEX: ___ MALE ___ FEMALE

TELEPHONE: () _____

DATE OF CRIME: _____ MARITAL STATUS: _____

DATE TREATMENT BEGAN: / / CONTINUING: ___ YES ___ NO TERMINATED: / /

DIAGNOSIS (USE D.S.M. IV)

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

I PLEASE RESPOND TO ALL ITEMS – USE ADDITIONAL PAGES IF NECESSARY

1. State the claimant/victim's initial reasons for seeking treatment. Describe how and when the condition was first manifested. Summarize previous treatment efforts, if any.
2. Please describe, in detail, the relationship between the crime and the need for treatment.



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

3. Does the claimant/victim have a history of a pre-existing psychiatric disorder? Yes No.
If yes, please describe that disorder, reasons(s) for treatment, type(s) of treatment and date(s).
4. What percent of the current mental health treatment is causally related to the date of crime for which this claim is based? Check the percentage that applies or indicate another percentage. **This must be completed.**
 0% 25% 50% 75% 100% Other: _____
5. In your opinion, would the claimant/victim be in treatment if it weren't for the crime?
6. Describe the claimant/victim's current condition. Include the duration and severity of functional impairments and stress factors and the period of disability from employment.
 Date disability began: / /
 Date disability ended: / /
7. Please describe current causally related treatment goals and estimated duration of treatment to achieve stated goal:

II COMPONENTS OF TREATMENT PLAN

1. Psychotherapy: Specify types, frequency and length of sessions (if group therapy, also give number of patients in group).

2. Medication: Please list only causally related medications that are needed as a direct result of the crime.

3. Adjunctive therapies: (e.g. physical or occupational therapy). Specify type, frequency and duration.

4. If psychotherapy sessions are more than two (2) per week provide rationale.

III Other remarks or additional detail that would assist professional reviewer in understanding this claim.

IV Prognosis:

SIGNATURE OF PROVIDER

DATE

PROVIDER INFORMATION

NAME: _____

LICENSE #: _____

ADDRESS: _____

AGENCY: _____

SOCIAL SECURITY #: _____

TELEPHONE #: () _____

NEW YORK STATE EXECUTIVE DEPARTMENT
OFFICE OF VICTIM SERVICES

MEDICAL INSURANCE UPDATE REPORT
(TO BE COMPLETED BY CLAIMANT)

CLAIMANT NAME:

CLAIM NUMBER:

Are you now receiving or currently applying for any medical insurance coverage? Yes ___ No ___

Complete the following table for each person receiving benefits under this claim. Please include current and pending insurances.

Insurance	Company Name	Policy No.	Effective Date	Persons Covered
Blue Cross				
Blue Shield				
Medicare				
Medicaid				
Major Medical				
Union				
HMO				
Veteran's Admin.				
Workers Comp.				
Dental Insurance				
Vision Benefits				
Prescription Drug Program				
No Fault/MVAIC				
Other Insurance				

If your insurance coverage has terminated or changed since you were awarded benefits, **you must submit a termination of benefit statement from your former insurance carrier, and if applicable, a statement, or copy of your benefit card from your new insurance carrier listing the effective date of coverage.**

I hereby certify that the above information is true and correct to the best of my knowledge. I also understand that knowingly submitting falsified information to the Office of Victim Services is a crime.

Payments may be delayed if this form is not received within thirty (30) days.

Claimant's Signature

Date





NEW YORK STATE OFFICE OF
VICTIM SERVICES

WORKERS' COMPENSATION AUTHORIZATION

I hereby authorize the New York State Workers' Compensation Board to provide the New York State Office of Victim Services, or its representatives, any and all information with respect to any claim made relating to an incident for which a claim has been made to the Office of Victim Services.

(SIGNATURE OF CLAIMANT)

(DATE)

State of New York

County of _____

On this _____ day of _____ 20_____, before me, the

undersigned Notary Public in and for the State of _____

personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that (s)he executed the same in his/her capacity and by his/her signature on the instrument (s)he executed the instrument.

Notary Public

Seal/Stamp



NEW YORK STATE EXECUTIVE DEPARTMENT
OFFICE OF VICTIM SERVICES

CLAIM NO: _____

EMPLOYMENT QUESTIONNAIRE
(TO BE COMPLETED BY EMPLOYER)

1. EMPLOYEE NAME: _____ 2. SOC. SEC.#: _____

3. EMPLOYER'S NAME: _____

4. EMPLOYER'S TELEPHONE #: _____

5. DATE EMPLOYED _____ JOB TITLE _____

6. THE AMOUNTS LISTED BELOW SHOULD BE THE VICTIM'S NORMAL WEEKLY EARNINGS OR AVERAGE WEEKLY EARNINGS:

DAYS WORKED PER WEEK _____

GROSS EARNINGS \$ _____

FED INCOME TAX \$ _____

STATE INCOME TAX \$ _____

CITY INCOME TAX \$ _____

SOCIAL SECURITY \$ _____

MEDICARE \$ _____

OTHER DEDUCTIONS \$ _____

NET EARNINGS \$ _____ PER WEEK

7. DATE OF CRIME: 3/4/2011

8. TIME LOST (AS A RESULT OF INJURIES) FROM _____ TO _____

WAS THE VICTIM PAID DURING LOST TIME? YES _____ NO _____

WAS VACATION TIME OR SICK LEAVE USED FOR PAYMENT? YES _____ NO _____

SPECIFY OTHER LEAVE USED: _____

ARE LEAVE ACCRUALS ACCUMULATIVE? YES _____ NO _____

9. ARE BENEFITS AVAILABLE THROUGH COMPANY FOR REIMBURSEMENT FOR MEDICAL EXPENSES OR LOSS OF EARNINGS, SUCH AS BLUE CROSS, BLUE SHIELD, WORKERS' COMPENSATION, DISABILITY BENEFITS, GROUP INSURANCE, ETC.

YES _____ NO _____

IF YES, PLEASE STATE: TYPE OF BENEFIT, PAYER, AMOUNT PAID, DATES PAYMENT IN EFFECT.

DISABILITY CARRIER _____ AMT. PD. _____ PERIOD _____

MEDICAL INSURANCE CARRIER: _____

UNION BENEFITS? NAME OF UNION: _____

LIFE INSURANCE: _____

OTHER: _____

(NAME OF PERSON WHO COMPLETED THE FORM)

(AUTHORIZED SIGNATURE)

DATE: _____

TITLE: _____



STATE OF NEW YORK
EXECUTIVE DEPARTMENT

OFFICE OF VICTIM SERVICES
FINANCIAL RESOURCES STATEMENT

Claimant's Name: _____

Claim #: _____

You must fill out ALL sections on the form. If none, enter zero (0).

I. <u>INCOME</u>	DESCRIPTION	NAME OF INVESTMENT OR PAYER	MONTHLY INCOME
FROM			
Salary, Wages			
Pensions			
Annuities			
Savings, Rents			
Social Security			
Public Funds			

II. <u>ASSETS</u>	DESCRIPTION	NAME - LOCATION - OR PAYER	AMOUNT VALUE
Savings			
Stocks, Bonds			
Proceeds from Life Insurance			
Real Property (house, etc.)			

III. <u>LIABILITIES</u>	DESCRIPTION	LENDING INSTITUTION	BALANCE OWED	MONTHLY PAYMENT
Mortgage				
Rent				
Loans				
Personal Loans				
Other				

IV. **REASONABLE MONTHLY LIVING EXPENSES NOT INCLUDING RENT/MORTGAGE**

\$ _____

{this figure should include school tuition, child support, and alimony}

How many dependants do you have? _____

I affirm that the information provided above is true.

_____ Date

_____ Claimant's Signature

Claim#:
Crime Date:
Claimant:
Victim:

Dear

I have been assigned to your claim that you filed with the Crime Victim Board for benefits. Before a determination can be made on your claim, it will be necessary for you to provide the Board with the information I have **listed** below. The information must be received at the below address **within 30 days** following the date of this letter. After **30 days** your claim will be reviewed for a decision.

Any enclosed forms must be fully completed and the originals submitted. True copies may be submitted for any other documents that are requested.

Please submit the following:

- Late CVB Filing Affidavit (Form attached)
- Late Police Filing Affidavit (form enclosed).
- A fully completed Financial Resource Form (form attached)
- Please call me at your earliest convenience. Thanks
- You have provided us all the necessary information that you can to process the claim. We are waiting for additional information to arrive from other sources in order to complete your claim. We will contact you if we need any additional information.
- Name and telephone number for the detective who investigated this case and, if the perpetrator has been arrested, the Assistant District Attorney who is handling the prosecution of the perpetrator
- A copy of the supporting deposition
- A copy of the Family Court Offense Petition
- Crime: No Arrest indicated: Please submit the name and telephone number for the detective who is investigating this case. If the perpetrator has been arrested, please submit the name and telephone number of the Assistant District Attorney who is handling the court case.
- A copy of your Order of Protection
- A copy of your application for the Order of Protection (Accusatory Instrument)
- The exact date of crime. _____
- A correct police complaint, Incident or U.F. 61 No: _____
- A correct Police department/Precinct No. _____
- A fully completed Child Protective Service authorization (form attached)
- Please submit your copy of the police / criminal justice agency report.

- A copy of the signed Family Court Disposition.
- A letter explaining your exact location (street and nearest cross street) at the time of the attack and your reason for being there.
- A letter explaining your exact location (street and nearest cross street) at the time of the attack and your reason for being there.
- Estimates from three reputable moving companies or the itemized moving bill, your new mailing address, and a statement from your treating physician/counselor or a letter from the DA indicating the necessity of the move
- An itemized shelter bill with a benefit/denial statement from the Dept. of Social Services
- Security device: you must supply a statement from a treating physician, a treating counselor or a letter from the DA indicating the necessity of a security system, three (3) cost estimates from reputable companies, or an itemized installation bill
- Death Certificate of Victim
- Final itemized funeral bill
- Signed funeral contract
- Statements of Life Insurance or Death Benefits Received from any source.
- Cancelled checks, receipts or other proof if you paid any out-of-pocket expenses
- The bills for repair or replacement of stolen or damaged essential property, along with the insurance statement
- Make all claims to your homeowner/renters or automobile insurance policy first
- List of clothing lost or damaged during the crime and the estimated cost of each item
- Your receipt or estimate for replacement of eyeglasses and applicable insurance benefit or denial statement
- If you are disabled and receiving SSI payments, please submit a Social Security/Disability award letter or a letter from your physician indicating your disability at the time of the crime
- Do you have a home phone? ___ Yes ___ No. If no, please submit a replacement receipt for your cell phone along with a monthly billing statement.
- Are you 60 years of age or older? Yes _____, No _____: If yes, proof of age is needed. Proof can be a copy of one of the following: your Medicare card, a valid driver's license or birth certificate
- Crime scene clean-up/securing a crime scene your receipts for repair or removal of damages and your homeowners/renters insurance benefits statements, if applicable
- A letter stating you were held responsible for the loss
- A notarized letter from your landlord stating you were held responsible for the loss.
- Birth Certificate of Claimant and/or Dependents.
- A copy of victim's birth certificate
- A copy of your marriage certificate
- A copy of Social Security decision, or SSI Insurance and SSS
- NYS Disability Benefits Decision
- If you are disabled and receiving SSI payments, please submit a Social Security/Disability award letter or a letter from your physician indicating your disability at the time of the crime
- Taxi/livery driver questionnaire (form enclosed)
- Doctor's Letter stating disability period
- Employment Questionnaire which must be completed by employer (form attached)

- A copy of your last filed federal income tax return
- Attorney - Affidavit of Services and itemized fees requested
- Your completed Representation Authorization form (form attached)
- Two notarized affidavits, one from the claimant and the third party. It should state that the payment by the third party was meant as a loan to the claimant. The third party needs to include their social security number for payment purposes.
- Proof of Guardianship documentation - signed court papers
- Court transportation: Your letter requesting mileage reimbursement along with a letter from DA outlining dates, and necessity of your appearance in court. If public transportation was used, indicate the type and amount (e.g., bus \$1.25). If a taxi was used, include a copy of your receipt
- Power of Attorney documentation
- HIPAA form(s) which must be completed by claimant for each provider (form attached)
- Health Insurance Form which must be completed by the claimant (form attached)
- Itemized Medical bills related to the crime, including counseling
- Cancelled checks, receipts or other proof if you paid any out-of-pocket expenses
- Your Medicaid Decision or copy of card
- Statements of Benefits paid or denied by Medicare
- Statements of Benefits paid or denied by medical insurance coverage and copy of card.
- A completed Doctors Form which must be completed by doctor (form attached)
- A complete Dental Form which must be completed by dentist (form attached)
- Mental Health Treatment Report to be completed by the treating therapist
- Medical transportation: Your letter requesting mileage reimbursement along with your itemized bills or letter from your medical provider(s) listing the crime-related dates of service. If public transportation was used, indicate the type and amount (e.g., bus \$1.25). If a taxi was used, include a copy of your receipt
- Invalid Diagnostic code submitted.
- Statements of Benefits paid or denied by No-Fault or MVIAC
- A copy of current registration for the vehicle
- A copy of current registration for the vehicle
- Make all claims to your homeowner/renters or automobile insurance policy first
- A current insurance statement or declaration page showing coverage and deductible amounts for the vehicle
- Workers' Compensation Authorization (form enclosed)
- A copy of the Workers' Compensation Board Decisions
- Since your injury arose out of the course of employment, you must file a claim with the Workers Compensation Board. You can contact them at: 100 Broadway Menands, NY 12241, or at the following toll free number: 1-866-750-5157
- Rescue workers and volunteers need to submit a letter from designated leader/squadron head along with copies of your Workers Compensation

decisions.

- Copies of your Workers Compensation decisions, if at work or at a work related event.
- A letter explaining your exact location (street and nearest cross street) at the time of the attack and your reason for being there.

Your claim number is: . Please, put this number on all correspondence.

If you were employed and lost more than one week of work, you must apply for NYS disability benefits through your employer.

If you feel it is important to personally meet with the Specialist assigned to your claim, please call the Specialist at the telephone number provided and schedule an appointment. Otherwise, to communicate with your assigned Specialist, you may contact them by phone or mail at the address below.

Sincerely,

Crime Victim Specialist II



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:

- 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
- 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.
- 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.
- 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.
- 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.
- 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 Office of Victim Services - 1 Columbia Circle, Ste 200, ALBANY, NY 12203	
9(a). Specific information to be released: <input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____ <input type="checkbox"/> 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. <input type="checkbox"/> Other: _____ <div style="text-align: right;">Include: <i>(Indicate by Initialing)</i> _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information</div>	
Authorization to Discuss Health Information (b) <input type="checkbox"/> By initialing here _____ I authorize _____ Name of individual health care provider to discuss my health information with my attorney, or a governmental agency, listed here: <div style="text-align: center;">NEW YORK STATE OFFICE OF VICTIM SERVICES</div> (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.

Date: _____

Signature of patient or representative authorized by law.

- 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

ELIGIBILITY

- You are the victim of a crime who has sustained personal physical injury
- A victim of unlawful imprisonment in the first degree
- A victim of a kidnapping in the first or second degree
- You are an elderly (60 or older), or disabled victim of a crime who has suffered a loss or damage to articles of essential personal property
- You are the surviving spouse, parent, grandparent, stepparent, child, stepchild or person dependent upon the victim who died as a direct result of a crime
- You are the person who has paid or incurred the burial expenses of an innocent victim who died as a direct result of a crime. (limited to burial expenses only)
- You are a child victim of or witness to a crime (under 18) or his/her parent, guardian or sibling
- If you are eligible but under the age of 18 or incompetent, the claim application may be filed in your behalf by a relative, guardian, conservator, committee or attorney
- You are a victim of a stalking offense
- You are a victim of trafficking – Labor Trafficking pl 135.35 and/or Sexual Trafficking pl 230.34

Compensation Benefits Include:

- Expenses for medical or other related services not covered by other insurance or benefit programs
- Lost earnings or loss of support up to \$600 per week and up to a total maximum of \$30,000 for the victim and parents of hospital minors
- Burial expenses up to \$6,000
- Occupational rehabilitation expenses
- Counseling services
- The cost of repair or replacement of essential personal property lost, damaged or destroyed as the direct result of a crime up to \$500 (\$100 Cash)
- Transportation expenses for necessary court appearances in connection with the prosecution of the crime
- The cost of residing at or utilizing the services of a domestic violence shelter
- For the victim of a crime who has acted as a Good Samaritan, the cost of lost damaged or destroyed property up to \$5,000. (A victim of a crime acts as a good Samaritan when attempting to prevent a crime, lawfully apprehend the perpetrator of a crime, or assist a police officer in making an arrest)
- The cost of reasonable burial expenses without regard to the financial difficulty of the survivors when a police officer or firefighter dies from injuries received in the line of duty as a direct result of a crime
- Crime scene cleanup expenses and/or securing a crime scene up to \$2,500
- Attorney fees for representation before the Board, to a maximum of \$1,000.
- Moving expenses up to 2,500

Filling out an application for multiple children

- A child that is a witness to a physical injury crime is a victim in their own right.
- A child present in the household during a crime may or may not be a victim.
- This determination is best made by a Crime Victim Specialist during claim investigation.
- Complete a claim application for each child victim.
- When required, an application may be completed and copied for each child, but must be signed individually.

How do I access the OVS's Statute (Article 22)?

Article 22 can be found on the NYS Crime Victims Board website. Type <http://www.ovs.ny.gov> and you will be connected to the website from there you will click on Legal Information and when this page pulls up you will see a link to Article 22. Click onto this link and Article 22 will populate and you may access the document by clicking on the section you need.

Where can I locate the OVS's brochures?

Brochures also can be found on the NYS Crime Victims Board website. Type <http://www.ovs.ny.gov> and you will be connected to the website from there you will click on Forms and Publication. Then you will click on Brochures where you will find the brochures listed below.

- 2009 English Restitution Brochure
- 2009 Spanish Restitution Brochure
- A Guide to Crime Victim Compensation in New York State
- Rights of Crime Victims

EMERGENCY AWARD PROCEDURES

For: HIV/Antibiotics/pain medication/Eyeglasses

NEED:

- Claim Application
- Copy of Police Report or report from other acceptable agency or Detective's name & telephone number *
- Copy of Prescription
- Cost estimate from pharmacy or store, including Store Number and Store Tax ID

*For HIV medications, if a police report was not filed and a FRE exam was performed, in addition to the above information excluding the police report, we will also need verification of the FRE. (E.g. Medical Records, FRE confirmation letter or Discharge Summary)

Loss of Earnings/Support

- Claim Application
- Copy of Police Report or other acceptable agency
- Employment Questionnaire
- Doctor's letter of disability

Moving Expenses/Storage, Lock Replacement, Crime Scene Clean-up or Security Device

- Claim Application
- Copy of Police Report or other acceptable agency
- If the cost exceeds \$500, cost estimates from two reputable companies (moving, storage or travel) with the Tax ID # of the provider of the winning bid
- If the cost is less than \$500, an itemized bill or estimate for relocation, moving or storage expenses with the Tax ID# of the provider
- A statement from DA/ADA, treating counselor, treating physician indicating the necessity of the relocation/move/storage
- Exact address of the victim's destination

Definition of Treating Counselor

A "treating counselor" is a licensed counselor/therapist who may be from a victim assistance program (whether funded by OVS or not). If a "treating counselor" is unlicensed but works under someone licensed, then the program can provide a signed statement from the licensed counselor or therapist.

Definition of Treating Physician

A treating physician can be a Medical Doctor, a licensed Physician's Assistant or a licensed Nurse Practitioner.

Funeral Expenses

- Claim Application
- Copy of Police Report or other acceptable agency
- Copy of the Death Certificate
- Copy of the signed funeral contract
- Provider's Tax ID #

No Emergency Awards are given for Essential Personal Property

FOR ANY E.A. REQUESTS, YOU SHOULD FIRST CONTACT YOUR NEAREST OVS ADVOCATE

Albany – (518) 485-9104

Lunida Gresham

Buffalo – (716) 847-7996

Brain Stearns

NYC - (718) 923- 4366

Sandra Mobley

PERSONAL PHYSICAL INJURY CLAIM

INFORMATION REQUESTED OF CLAIMANT:

Medical and Psychotherapy expenses:

- Itemized bills
- Insurance explanation of benefit or denial statements
- Medicaid Decision listing the dates of Medicaid coverage, if applicable
- Workers Compensation Decision if the crime occurred at work or was work related
- No-Fault or MVAIC benefit or denial statements if the crime was automobile related
- Birth Certificate if the victim is a child and the parent is filing the claim
- Proof of custody or guardianship if the victim is a child and a person other than the parent is filing a claim
- Proof of conservatorship or guardianship if a claim is filed for an adult victim and the claimant is someone other than the victim
- Financial Resources form
- Proof of out-of-pocket expenses paid by the claimant such as cancelled checks or receipts
- Receipt or three estimates for installation of security device
- Homeowners or renters insurance statement if applicable for installation of security device
- A statement from the victim's counselor, physician or the District Attorney recommending the need for a security device
- Receipt or three estimates for moving expenses
- A statement from the victim's counselor, physician, or the District Attorney recommending the need to move
- Domestic Violence shelter expenses with Social Services benefit/denial statement

Loss of Earnings (for victim):

- Doctor's statement listing the victims disability period
- Copy of the claimants last Federal Income Tax Return filed if the Claimant is self-employed
- NYS Disability Benefits Decision if the victim is disabled for more than one week
- Workers Compensation Decision if the crime occurred at work or was work related
- No-Fault of MVAIC benefit or denial statements if the crime was automobile related
- Social Security Decision if the victim is permanently disabled or will be disabled for more than one year due to the crime
- Employment Questionnaire
- Financial Resources form

Loss of Earnings (parents of minor victim):

- Employment Questionnaire & proof of no salary reimbursement (leave accruals etc.)
- Medical records for proof of emergency, in-patient, or residential facility treatment to victim

Transportation Expenses for Prosecution:

- Receipt or estimate for transportation cost
- Copy of the Subpoena or a statement from the DA requiring the victim to appear in court

Crime Scene Clean-up or Securing a Crime Scene:

- Receipts or estimates for crime scene clean-up or repair of damages necessary for securing a crime scene
- Insurance benefits statements from homeowners or renters insurance for possible coverage of damages

Essential Personal Property:

- The items claimed must be reported to the police
- Receipts and/or estimates must be submitted

ESSENTIAL PERSONAL PROPERTY CLAIM WITH NO PHYSICAL INJURY

INFORMATION REQUESTED OF CLAIMANT:

- Proof of Disability if the Victim is disabled. Acceptable proof includes but not limited to a doctor's statement, copy of Medicare card, SSI or SSD Statement.
- Proof of Age if the Victim is 60 years or older. Acceptable proof includes, but is not limited to birthday or age listed on the police report, copy of Medicare Card, Birth Certificate or Drivers License.
- Birth Certificate if the Victim is under the age of 18.
- If a victim is robbed of \$2,000 or above, the victim may be asked for proof of source of funds.

Transportation Expenses for Prosecution:

- Receipt or estimate for transportation cost
- Copy of the Subpoena or a statement from the DA requiring the victim to appear in court

TRANSPORTATION FOR PROSECUTION/MEDICAL TREATMENT

PROSECUTION TRANSPORTATION EXPENSE PROCEDURES

The OVS may reimburse claimants for transportation expenses incurred for necessary court appearances in connection with the prosecution of the crime.

If private automobile is utilized for court transportation, the maximum allowable the Board can approve is the state mileage per diem rate that is in effect at the time the expense is incurred, plus any toll and parking expenses if dated receipts are submitted. The starting point address and the court destination address must be submitted. The round trip mileage must be included. (Please note: gasoline expenses are included in the per diem rate and can not be reimbursed separately.)

If public transportation is utilized, (train, bus or taxi), dated receipts must be submitted.

NOTE: Verification from the District Attorney listing the date the claimant is required to be in court must be submitted when requesting transportation expenses for payment. (A copy of the subpoena or a letter from the DA is acceptable)

MEDICAL TRANSPORTATION EXPENSES PROCEDURES

The OVS may reimburse claimants for medical transportation expenses incurred due to causally related medical treatment.

If private automobile is utilized for medical transportation, the maximum allowable the Board can approve is the state mileage per diem rate that is in effect at the time the expense is incurred, plus any toll and parking expenses if dated receipts are submitted. The starting point address and the medical provider destination address must be submitted. The round trip mileage must be included. (Please note: gasoline expenses are included in the per diem rate and can not be reimbursed separately.)

If public transportation is utilized (train, bus or taxi) dated receipts must be submitted.

Physician verification of service dates must be submitted when requesting transportation expenses for payment. Physician verification may include an itemized bill listing date(s) of service or a physician statement verifying service date(s).

DEATH CLAIM

NO EPP ON DEATH CLAIMS

If a claim is for \$5,000 or above, financial difficulty must be proven. This includes Funeral Directors who have taken on the responsibility for burial expenses.

INFORMATION REQUESTED OF CLAIMANT:

Funeral Expenses:

- Copy of the funeral contract showing the signature of the responsible party
- Death Certificate
- Burial benefit statement received from any source. Example: No-Fault if crime was automobile related - Workers Compensation if crime was work related. In addition, Social Security \$255.00 death benefits available to spouses and minor children, and any private insurance coverage that carries a burial benefit.
- Receipts or bills for other funeral expenses
- Financial Resources form

Loss of Support:

- Marriage Certificate
- Birth Certificates of victims dependent children
- Proof of Guardianship of victims dependent children if other than a parent is filing for loss of support
- Social Security benefit statement showing monthly allowance
- No-Fault benefit statement if the crime was automobile related
- Workers Compensation decision if the crime was work related
- Copy of the victims last Federal Income Tax Return filed if the victim was self-employed at the time of death
- Employment Questionnaire
- Financial Resources form

Medical and Psychotherapy Expenses:

- Itemized medical bills incurred by the victim prior to death in cases where the spouse or parent of a dependent child is the claimant
- Birth Certificates of victims children if the children seek therapy
- Birth Certificate of the victim if the victim's parents seek therapy
- Other proof of relationship may be requested such as a marriage certificate when proof of step-family members is necessary
- Itemized psychotherapy bills for eligible family members
- Insurance benefits statements for both the victim's medical expenses and the eligible family members' therapy expenses
- Financial Resources form

Transportation Expenses for Prosecution:

- Receipt or estimate for transportation cost
- Copy of the Subpoena or a statement from the DA requiring the claimant to appear in court

Crime Scene Clean Up or Securing a Crime Scene:

- Receipts or estimates for crime scene clean up or repair of damages necessary for securing a crime scene
- Insurance benefits statements from homeowners or renters insurance for possible coverage of damages

Burial Chart

Outlined below is a burial expense history chart for compensation of crimes that occurred on and after August 1, 1966.

\$6,000 for crimes occurring on and after 11/1/96, claims submitted by any person who incurs such costs;

\$2,000 for crimes occurring on and after 6/12/91 until 10/31/96, claims submitted by any person who incurs such costs;

\$2,500 for crimes occurring on and after 8/1/85 until 6/11/91, claims submitted by any person who incurs

such costs;

\$1,500 for crimes occurring on and after 7/30/83 until 7/31/85, claims submitted by any person who incurs

such costs;

\$1,500 for crimes occurring on and after 6/15/82 until 7/29/83, claims submitted by family members;

\$1,500 for crimes occurring on and after 6/16/68 until 6/14/82, claims submitted by a surviving spouse,

parent or child;

\$1,000 for crimes occurring on and after 8/1/66 until 6/15/68, claims submitted by a surviving spouse or

child.

General Guidelines for Additional Medical Payments

1. In order to receive additional medical payments, your decision must include the following language: *The Claimant may send to the Additional Medical Unit any additional medical/counseling expenses that the claimant has incurred because of this crime, that are not covered by insurance or some other source, for consideration and payment by OVS.*
2. All correspondence and associated attachments (bills, receipts, Explanation of Benefits statements etc.) **must include your claim number.**
3. All medical services for which you are seeking payment must be provided by a licensed health care provider whose profession is recognized by New York State.
4. **Insurance Generally:** The Office of Victim Services (OVS) is the payer of last resort. This means any other medical insurance coverage you have must be exhausted or denied by your insurance carrier prior to submitting your bills to OVS for payment. (*See the related information on Explanation of Benefits noted below for required documentation of insurance benefits.*) Insurances may include:
 - Union coverage,
 - Medicaid,
 - Medicare,
 - Workers' Compensation (if you were victimized at work), and/or
 - No-Fault/MVIC coverage (if you were victimized in a motor vehicle accident).
5. **Insurance Coverage:** You must provide the Office of Victim Services with documentation of your insurance coverage. If you had insurance coverage on the date of the crime or became eligible for coverage after the crime, insurance statements are required for each date of service. **If your insurance coverage is:**
 1. **Terminated:** you must submit an insurance discontinued coverage statement from your insurance company showing the date that your insurance was discontinued.
 2. **Changed:** you must submit the insurance discontinued coverage statement from your original insurance carrier and a statement from your new insurance carrier showing the date the new coverage went into effect.
 3. **New:** you must submit a statement from your insurance carrier showing the date the coverage went into effect.

Documentation Necessary to Have a Medical Bill Paid

In order to have a bill paid, the bill and all supporting documentation must be submitted to the Office of Victim Services at the same time as a single package.

Items necessary for OVS to pay a bill include:

1. Itemized bill on provider letterhead

The itemized bill must include:

- Each date of service
- Each service rendered (i.e. counseling, office visit, x-ray etc.)
- Cost of each treatment
- The medical providers tax id number
- All pages of the insurance statement

2. Insurance Explanation of Benefits (EOB, if applicable)

An Explanation of Benefit must:

- Be submitted for each service provider
- Cover each date of service
- Be submitted for services either paid or denied by your insurance coverage

3. Medical Documentation: Documentation to show the causal relationship between the crime and the medical treatment you receive must be provided. This documentation may include a:

- Attending Physician Report
- Physician's Narrative Report
- Hospital Records for Dates of Service on Submitted Bill
- Dental Claim Form
- Mental Health Treatment Report (requested by CVB annually)
- Medication Report
- Office Notes
- Letter of Medical Necessity from Doctor
- PT/OT/Massage/Acupuncture Documentation:
 - Prescription from prescribing physician showing duration and frequency of treatment
 - Progress notes for each date of service

4. Proof of Payment if you have paid out-of-pocket:

- Cancelled checks
- Receipts
- Other proof of payment
- For medications:
 - prescription receipt showing medication name, date filled, prescribing doctor and cost
- For transportation expenses,
 - List of appointment dates on provider letterhead
 - Dated receipts for tolls, if applicable
 - Dated receipts for parking, if applicable

NOTE: If any of the above required items are missing, any materials submitted will be returned.