Victims Compensation Assistance Program
Office of Victims' Services
CLAIM FORM

pennsylvania
VICTIMS COMPENSATION ASSISTANCE PROGRAM

FOR OFFICIAL USE ONLY	
Claim #	

In most cases the maximum award may not exceed $35,000

Check as many as apply.

☐ Personal Injury **Most types of expenses have a monetary limit** ☐ Death ☐ Stolen Benefit Cash

Sections 1, 2, and 3 must be completed for all claims.

SECTION 1. VICTIM INFORMATION

Victim's Name				
☐ Male ☐ Female	Date of Birth MM/DD/YY / /	Age at Time of Crime	Marital Status	Social Security #
Current Street Address				County
City	State	Zip Code	Safe Daytime Telephone # ( )	Other Safe Telephone # ( )
Employer at Time of Crime	Street Address			
City	State	Zip Code	Employer Telephone # ( )	

SECTION 2. CLAIMANT INFORMATION

If victim is the claimant, write "SAME."
If someone other than the victim is filing, complete the entire section.

Relationship to Victim _____ **(Check all that apply)**

☐ Parent of a minor child ☐ Legal guardian of victim (Attach guardianship papers) ☐ Person responsible for funeral expenses
☐ Person financially responsible for victim ☐ Person filing for crime scene cleanup ☐ Person filing for counseling expenses

Claimant's Name	Current Street Address		
City	State	Zip Code	County
☐ Male ☐ Female	Date of Birth MM/DD/YY / /	Safe Daytime Telephone # ( )	Other Safe Telephone # ( )	Social Security #
Name of Employer	Street Address		
City	State	Zip Code	Employer Telephone # ( )

SECTION 3. CRIME INFORMATION

Date of Crime MM/DD/YY / /		Date Reported to Police or Date PFA Filed MM/DD/YY / /	
Location of Crime (street name and number if known)	City	County	State
Did it happen at work? ☐ Yes ☐ No	Was this crime related to domestic violence? ☐ Yes ☐ No If PFA Order was filed, attach copy.	Did the crime involve a motor vehicle? ☐ Yes ☐ No	
Name of Police Department	Police Incident #	**If Not Reported to Police Within 72 Hours Attach Explanation**	

Name of Person(s) Who Committed Crime (if known)

_____ ☐ Adult ☐ Juvenile _____ ☐ Adult ☐ Juvenile

Briefly describe crime and injuries.

_____

_____

_____

_____

_____

SECTION 4. MEDICAL EXPENSES

Monetary limits apply.
If filing for medical expenses, attach the following:

ALL ITEMIZED MEDICAL BILLS RELATED TO CRIME. Medical bills must be in the name of the claimant and each bill **must** show name, address and telephone number of the provider and dates and type of service.

Medical expenses could include hospital, doctor, ambulance, dentist, medications, medical supplies, and physical therapy.

If victim is covered by an insurance plan or medical assistance, he/she must utilize authorized participating providers.

All bills must be submitted to your insurance or benefit plan before submitting to the Program.

Were you covered by insurance at the time of the crime? ☐ Yes ☐ No Are you covered by insurance now ? ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, please list the type(s) of insurance or benefit plan(s) you have: _____

ATTACH INSURANCE STATEMENTS OF ALL PAYMENTS AND/OR REJECTIONS FOR CORRESPONDING BILL(S).

SECTION 5. COUNSELING EXPENSES

Complete if filing for counseling expenses.
Monetary limits apply.

Are counseling expenses being filed for the victim?
☐ Yes ☐ No If yes, provide all itemized counseling bills related to the crime (must be in the name of the claimant).

Are counseling expenses being filed for a person other than the victim?
☐ Yes ☐ No If yes, complete the remainder of this section in its entirety.

Under which categories? (check all that apply)

☐ Family member _____ (relationship to the victim)
☐ Individual residing in the victim's household
☐ Person who discovered the homicide victim
☐ Dependent(s) or minor siblings of victim requesting counseling expenses
☐ Engaged to victim
☐ Witness of a violent crime_____

Name _____ Date of Birth MM/DD/YY __/__/__ Relationship to Victim _____

Name _____ Date of Birth MM/DD/YY __/__/__ Relationship to Victim _____

Name _____ Date of Birth MM/DD/YY __/__/__ Relationship to Victim _____

If additional dependents or minor siblings, please attach a separate sheet.

ATTACH ALL ITEMIZED COUNSELING BILLS RELATED TO CRIME (must be in the name of the claimant).
(Each bill **must** show name, address and telephone number of the provider and dates and type of service.)

SECTION 6. LOSS OF EARNINGS

Complete if victim or claimant is filing for loss of earnings.
Monetary limits apply.

As a result of the crime:

Did you miss work and lose pay due to crime-related injuries? ☐ Yes ☐ No
Did you miss work and lose pay due to court appearances? ☐ Yes ☐ No
Did you miss work and lose pay due to trauma related to a homicide? ☐ Yes ☐ No

Dates absent from work. MM/DD/YY:

FROM __/__/__ THRU __/__/__

Physician certification is only needed when filing for loss of earnings due to injury.
VCAP will request certification from a physician, dentist, or psychologist certifying the dates you were unable to work as a result of the injury.

Name of Physician, Dentist or Psychologist Certifying Disability

Name		
Address		Telephone # ( )
City	State	Zip Code

If you receive any of the following because of the injury, please attach benefit statements showing dates, types, and payment amounts.

Workers' Compensation
Disability Pay
Heart and Lung Act
Vacation/Annual, Sick and/or Personal Pay
Supplemental Security Income/Social Security Disability Income
Other Benefits_____

Provide copies of the following:

Two pay stubs immediately prior to the crime incident **OR** a printout from your employer covering these pay periods. If you are unable to provide this information, please provide copies of your W-2 statements **OR** most recently filed IRS tax returns including all schedules.

If self-employed, please provide copies of your most recently filed IRS tax returns, including all schedules.

SECTION 7. STOLEN BENEFIT CASH

Complete if filing for stolen benefit cash. If earnings from employment are your main source of income, you are not eligible for this benefit.
Monetary limits apply.

Type(s) of Benefit(s). The benefit(s) must be your main source of income.

☐ Social Security Retirement ☐ Supplemental Security Income ☐ Retirement/Pension(s) ☐ Disability
☐ Social Security Disability Income ☐ Social Security Survivor Benefits ☐ Court Ordered Child/Spousal Support

Amount of Cash Stolen

$ _____

Is this benefit(s) your main source of income?	☐ Yes	☐ No	(Attach a copy of your benefit statement(s) which apply to month of crime.)
Do you have homeowner's or renter's insurance?	☐ Yes	☐ No	(Attach a copy of your benefit statement(s) which apply to month of crime.)
Are you required to file IRS tax returns?	☐ Yes	☐ No	(If yes, attach copies including all schedules.)

SECTION 8. FUNERAL EXPENSES

Complete if filing for funeral expenses
Monetary limits apply.

ATTACH COPIES OF ITEMIZED FUNERAL BILLS AND/OR RECEIPTS (must be in the name of the claimant)
(Each bill must show name, address and telephone number of the provider and dates and type of service.)

Was there a Social Security death benefit?	☐ Yes	☐ No	(If yes, attach a copy of the benefit statement.)
Was there a Life Insurance policy on the victim?	☐ Yes	☐ No	(If yes and claimant is beneficiary, attach a copy of the benefit statement(s).)

SECTION 9. LOSS OF SUPPORT

This section is for death claims only. Complete if filing for loss of support.
Monetary limits apply.

Provide copies of the following:

1. If filing for the reimbursement of court ordered child/spousal support, please attach a copy of the court order.
2. If not filing for the reimbursement of court ordered child/spousal support, please provide the victim's most recently filed IRS tax returns, including all schedules. If unavailable, copies of the victim's W-2 statements **OR** last two pay stubs, **OR** a printout from the employer covering these pay periods.
3. Social Security benefit statement(s) for claimant and/or dependents.
4. Statement(s) for any benefit(s) received as a result of the death, such as life insurance, veteran's benefit(s), pension survivors benefit(s), or other benefit statement(s).
5. Birth certificates for dependent children.
6. If someone other than the parent is filing as a claimant, submit guardianship papers for minor child(ren).

Dependent's Name	Date of Birth MM/DD/YY	Relationship to Victim
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

The employer information in Section 1 on Page 1 is required to file for loss of support unless you are filing for the reimbursement of court ordered child/spousal support.

RELOCATION, CRIME SCENE CLEANUP, AND TRANSPORTATION BENEFITS

In addition to the benefits described in Sections 4 through 9, you may also be eligible for benefits listed below.
Monetary limits apply.

- Relocation (for a victim who, as a result of an eligible crime, needs to relocate due to their immediate safety and/or health):
  A claim may be filed for temporary or permanent relocation expenses for a victim and individuals residing in their household. Expenses may include rent, storage, moving costs, utility connection fees, tolls, parking, mileage and lodging.
- Crime Scene Cleanup:
  This benefit is to pay for expenses related to the reasonable and necessary costs of cleaning a crime scene in a private residence. This means to remove blood or stains caused by bodily fluids, foods, paint or other material used to deface property as a direct result of the crime, or dirt or debris caused by the processing of the crime scene. Eligible expenses may include the cost of cleaning supplies purchased for cleaning the scene, the cost of necessary equipment purchased or rented, and/or the cost of professional labor for cleaning the crime scene.
- Transportation:
  Travel for eligible individuals to obtain medical care (including pharmacies and counseling), to attend or participate in criminal justice or Protection From Abuse proceedings, for making funeral/burial arrangements, accompanying the body/remains to an alternate location for interment, or attending funeral services, may be eligible for travel expenses.

For additional information on these benefits and other eligible expenses, or if you need assistance in filing a compensation claim, please contact a Victim Service Program in your county, your county District Attorney's Office, or call the Victims Compensation Assistance Program at (717) 783-5153 or toll free at (800) 233-2339.

REPRESENTATION BY OTHERS

Who referred you to the Victims Compensation Assistance Program?
☐ Hospital ☐ Prosecutor ☐ Poster/Brochure
☐ Police ☐ Victim Service Program ☐ Other (identify)

ATTORNEY INFORMATION

Are you represented in this matter by an attorney
In filing a claim? ☐ Yes ☐ No
In a civil lawsuit? ☐ Yes ☐ No
In an insurance action? ☐ Yes ☐ No

Name of Attorney

Street Address

City | State | Zip Code

Telephone # | Fax # (if known)

VICTIM SERVICE PROGRAM INFORMATION

Did a Victim Advocate assist you in completing this form?
☐ Yes ☐ No

Name of Victim Service Program to receive copies of claim correspondence

Name of Victim Advocate who assisted in filing this claim form

Street Address

City | State | Zip Code

Telephone # | Fax # (if known)

VICTIM STATISTICAL INFORMATION

The following information is used for statistical purposes only.
The submission of information for this section is strictly voluntary.

Race
☐ White ☐ Black ☐ Hispanic ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Other

Country of Birth _____

Do you have a disability?
☐ Yes ☐ No If yes, nature of disability ☐ Physical ☐ Mental ☐ Developmental

ACKNOWLEDGEMENT AND REIMBURSEMENT AGREEMENT

This Acknowledgement and Reimbursement Agreement must be signed before the claim verification process will begin.

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 30 days from the date of the decision. I must prove the exact amount of my losses before the Program will consider awarding compensation from the Crime Victims 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 under Section 11.1303 of the Crime Victims Act. 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 under 18 Pa. C.S. 4904.

I understand that the Crime Victims Compensation Fund is the payer of last resort. I specifically agree to inform the Program of and repay to the Commonwealth 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, including any award for pain and suffering. 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**

AUTHORIZATION TO OBTAIN INFORMATION

This authorization must be signed before the claim verification process will begin.

I hereby authorize in accordance with the privacy regulations under HIPPA (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 (print 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 Office of Victims' Services, Victims Compensation Assistance Program, any and all information in their possession with respect to the crime that is the basis for this claim. Copies of this authorization may be used in place of the original.

X _____ _____

Claimant's Signature **Date**

Victims Compensation Assistance Program

Mailing Address
P.O. Box 1167
Harrisburg, PA 17108-1167

Street Address
3101 North Front St.
Harrisburg, PA 17110

Phone and Fax Numbers
(800) 233-2339
(717) 783-5153
(717) 787-4306 (FAX)

www.pacrimevictims.com