


WISCONSIN

CRIME VICTIM COMPENSATION PROGRAM APPLICATION INFORMATION

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

WHAT TO DO – KEEP THIS INFORMATION SHEET FOR YOUR REFERENCE

- **PLEASE PRINT CLEARLY.** Separate applications must be completed for each injured victim.
- Enclose **itemized** copies of crime-related medical bills. Send copies of other itemized crime-related medical bills as they are received. This Program requires that the bills be itemized.
- Crime-related medical bills must first be sent to all other payment sources available, i.e. health insurance, Medical Assistance, Badger Care or another payment source. You must use a medical provider that accepts your insurance plan. Otherwise, this Program may not be able to reimburse for those expenses.
- This Program may pay expenses incurred within 4 years of the date of the crime or until the claim reaches \$40,000 maximum, whichever comes first.
- Send the completed application to the Crime Victim Compensation Program as soon as possible. Do **not** wait until court is over or treatment is completed.
- Return the completed application to the address listed on the bottom of this page. The applicant will receive a letter or, if specified, an email from the Crime Victim Compensation Program acknowledging receipt of the application. Notify the Program of any change in address, email or phone number. If you have any questions, call the Office of Crime Victim Services at 608-264-9497 or 1-800-446-6564.

ELIGIBILITY REQUIREMENTS

Eligibility for Crime Victim Compensation:

- The crime must be reported to law enforcement within 5 days of the date of the crime or within 5 days of the time when a report could reasonably be made.
- The application must be filed within 1 year of the crime date.
- These requirements may be waived in the interest of justice. If the crime was not reported within 5 days or the application was not filed within 1 year, include a brief but detailed written reason for the delay.
- The victim must cooperate with the investigation and prosecution of the case.
- A restitution request must be made to the District Attorney’s Office if the criminal case is being prosecuted. Provide all restitution information promptly to the District Attorney’s Office as they request it.
- Parents of victims who are under the age of 18 may be eligible for lost wages and counseling expenses incurred due to the crime. Limits apply and itemized bills or documents are required.
- Adults victimized as children can apply for benefits. The program can pay eligible expenses for four years or \$40,000 maximum. Other eligibility requirements still apply.

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

- Any money received from other sources such as restitution, lawsuits, insurance settlement, etc. **must be repaid** to the Crime Victim Compensation Program for crime related expenses paid by the Program.

Wisconsin Department of Justice
Crime Victim Compensation Program
 Post Office Box 7951
 Madison, WI 53707-7951
 (608) 264-9497 or 1-800-446-6564 (Toll-free)
www.doj.state.wi.us/ocvs

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

	WISCONSIN	<h1 style="margin: 0;">CRIME VICTIM COMPENSATION APPLICATION</h1> <p style="margin: 5px 0;">Post Office Box 7951 Madison, WI 53707-7951 (608) 264-9497 or 1-800-446-6564 (Toll-free) WI Statutes Chapter 949</p>	<p>CLAIM NO: _____</p> <p>DATE RECEIVED: _____</p> <p style="text-align: right; font-weight: bold;">(For Office Use Only)</p>
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**PLEASE BE SURE TO SIGN THE APPLICATION ON THE LAST PAGE
THE APPLICATION MUST BE FILED WITHIN 1 YEAR OF THE DATE OF THE CRIME**

SECTION 1: VICTIM/DECEASED VICTIM INFORMATION

1. Victim's First Name		Victim's Last Name		2. <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> _____		3. Date of Birth (MM-DD-YY)	
4. Last Four Digits of Victim's Social Security Number XXX - XX - _____		5. Mailing Address				Age at time of the crime <input type="checkbox"/> 0-12 <input type="checkbox"/> 13-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-59 <input type="checkbox"/> 60 and older	
6. City		7. State		8. Zip Code		9. County	
10. Home Telephone ()		11. Cell Phone ()		12. E-mail		I prefer to be contacted by e-mail. <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Is the victim/applicant represented by a personal attorney due to this crime: In filing this application? <input type="checkbox"/> Yes <input type="checkbox"/> No In a civil lawsuit? <input type="checkbox"/> Yes <input type="checkbox"/> No In an insurance action? <input type="checkbox"/> Yes <input type="checkbox"/> No				14. Name of Attorney		Telephone ()	
				Street Address		E-mail	
				City		State	
15. The following information is used for statistical purposes only and is needed to comply with federal regulations						Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify the language: _____	
A. Disabled Before Crime: <input type="checkbox"/> Yes <input type="checkbox"/> No After Crime: <input type="checkbox"/> Yes <input type="checkbox"/> No		B. Race/Ethnicity: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Multiracial <input type="checkbox"/> Hawaiian/Other Pacific Islander <input type="checkbox"/> Other					
C. How did you learn about the Compensation Program? (Check all that apply)							
<input type="checkbox"/> Law Enforcement		<input type="checkbox"/> Attorney		<input type="checkbox"/> Probation or Parole		<input type="checkbox"/> Friend	
<input type="checkbox"/> District Attorney		<input type="checkbox"/> Sexual Assault Program		<input type="checkbox"/> Newspaper		<input type="checkbox"/> Relative	
<input type="checkbox"/> Victim/Witness Program		<input type="checkbox"/> Domestic Abuse Program		<input type="checkbox"/> Funeral Director		<input type="checkbox"/> Hospital	
						<input type="checkbox"/> Poster or Brochure	
						<input type="checkbox"/> Public Service Announcement	
						<input type="checkbox"/> Other	

**SECTION 2A: PARENT/LEGAL GUARDIAN INFORMATION IF VICTIM IS A MINOR; OR
APPLICANT CONTACT INFORMATION IF VICTIM IS DECEASED**

1. Person's Name		Date of Birth		2. Relationship to Victim			
3. Mailing Address			4. City		5. State		6. Zip Code
7. Home Telephone ()		8. Cell Phone ()		9. E-mail		I prefer to be contacted by e-mail. <input type="checkbox"/> Yes <input type="checkbox"/> No	

**SECTION 2B: THIS SECTION IS FOR VICTIM ADVOCATES OR VICTIM WITNESS STAFF WHO ARE
PROVIDING ASSISTANCE**

1. Name		2. Organization/Title			3. Work Phone ()		
4. Address			5. E-mail			6. Alternate Contact for Victim <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 3: CRIME INFORMATION

1. Type of Crime (Check all that apply)

<input type="checkbox"/> Homicide	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Hit and Run of Pedestrian, Bicycle or Buggy	<input type="checkbox"/> Drunk Driving / DUI
<input type="checkbox"/> Attempted Homicide	<input type="checkbox"/> Child Physical Abuse	<input type="checkbox"/> Sexual Assault	<input type="checkbox"/> Other _____
<input type="checkbox"/> Assault/Battery	<input type="checkbox"/> Child Sexual Abuse	<input type="checkbox"/> Robbery	

Did the crime involve? Domestic or Family Violence Bullying Elder Abuse Hate Crime Mass Violence

2. Location of Crime: Street Address		3. City	4. State	Zip Code	5. County
6. Date of Crime	7. Date Crime Reported	8. Law Enforcement Agency to which crime was reported		Officer's Name	

If crime date is approximate, provide details.

9. Offender(s) Name(s):

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

Description of crime (optional):

SECTION 4: MEDICAL/MENTAL HEALTH EXPENSE INFORMATION

1. Name and address of medical facility where victim was first treated :	2. Date of Treatment (MM-DD-YY):
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3. Mental Health Treatment received, or to be received? By victim? Yes No Unknown By parent? Yes No Unknown

SECTION 5: MISCELLANEOUS EXPENSES

Caretaker Services \$ _____ Documented Crime Scene Cleanup \$ _____

Securing a Crime Scene \$ _____ Modifications to home to accommodate a disability \$ _____

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

_____ \$ _____	_____ \$ _____
_____ \$ _____	_____ \$ _____

SECTION 6: INSURANCE AND BENEFIT INFORMATION

1. Was there insurance or other source of payment to cover expenses at the time of the crime? Yes No
Please attach copies of any crime-related itemized bills and explanations of benefits.

2. Check all that apply:

<input type="checkbox"/> Employers/Union Group	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Medical Assistance/Title 19	<input type="checkbox"/> Homeowners Insurance
<input type="checkbox"/> Veterans' Benefits	<input type="checkbox"/> County Assistance	<input type="checkbox"/> Victim/Spouse/Parent Insurance	<input type="checkbox"/> Badger Care
<input type="checkbox"/> Lawsuit	<input type="checkbox"/> Disability	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other (describe) _____

SECTION 7: CRIMES INVOLVING MOTOR VEHICLES

Did the victim have auto insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of company and policy limits:
Did the driver have auto insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of company and policy limits:
Did the offender have auto insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of company and policy limits:

SECTION 8: EMPLOYMENT INFORMATION

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

1a. Did the victim or deceased victim miss time from work immediately following the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2a. Is the victim/parent self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
1b. Did the parent or applicant of a minor victim or deceased victim miss work immediately following the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2b. May we contact your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

4. Name of Employer	5. Employer Telephone ()		
6. Employer Mailing Address	7. City	8. State	9. Zip Code

SECTION 9: FUNERAL/BURIAL EXPENSES

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

SECTION 10: LIFE INSURANCE

Life Insurance Yes No Unknown Amount: \$ _____ Beneficiary _____

SECTION 11: DEPENDENTS FINANCIALLY SUPPORTED BY VICTIM AT TIME OF DEATH

First Name	Last Name	Date of Birth (MM-DD-YY)	Relationship to Victim

SECTION 12: AGREEMENT AND AUTHORIZATION

AGREEMENT

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

AUTHORIZATION

I authorize and request any person having information needed by the Crime Victim Compensation Program to process my claim to release that information to the Wisconsin Department of Justice. That includes, but is not limited to all records concerning me from the following entities: child support agencies; private and governmental physicians and hospitals; all billing entities; local, state and federal law enforcement, prosecutors offices and federal court personnel; any employer(s), unemployment compensation insurance program, workers compensation program; and any private company or governmental agency that is providing or may provide medical or monetary benefits. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

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

Signature of Victim or Authorized Applicant (see below)

Date

The **victim** must sign and date the application form. If the victim is under the age of 18, the **parent** or **guardian** must sign and date the application form. If the victim is deceased or an incapacitated adult victim, the **applicant** or **legal representative** must sign and date the application form.

RETURN COMPLETED APPLICATION TO:

**Wisconsin Department of Justice
Crime Victim Compensation Program
Post Office Box 7951
Madison, WI 53707-7951
FAX: (608) 264-6368
Email: ocvs@doj.state.wi.us**

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