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

CRIME VICTIM COMPENSATION APPLICATION

Post Office Box 7951
Madison, WI 53707-7951
(608) 264-9497 or 1-800-446-6564 (Toll-free)
WI Statutes Chapter 949

CLAIM NO: _____

DATE RECEIVED:

(For Office Use Only)

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. ☐ Female ☐ Male ☐ _____

3. Date of Birth (MM-DD-YY)

Age at time of the crime
☐ 0-12 ☐ 13-17 ☐ 18-24 ☐ 25-59 ☐ 60 and older

4. Last Four Digits of Victim's Social Security Number
XXX – XX - ___ ___ ___ ___

5. Mailing Address

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. ☐ Yes ☐ No

13. Is the victim/applicant represented by a personal attorney due to this crime:
In filing this application? ☐ Yes ☐ No
In a civil lawsuit? ☐ Yes ☐ No
In an insurance action? ☐ Yes ☐ No

14. Name of Attorney

Telephone ( )

Street Address

E-mail

City

State

Zip Code

15. ***The following information is used for statistical purposes only and is needed to comply with federal regulations***

A. Disabled
Before Crime: ☐ Yes ☐ No
After Crime: ☐ Yes ☐ No

B. Race/Ethnicity:
☐ White/Caucasian ☐ Asian
☐ Black/African American ☐ Hispanic/Latino
☐ American Indian/Alaskan Native ☐ Multiracial
☐ Hawaiian/Other Pacific Islander ☐ Other

Do you need an interpreter? ☐ Yes ☐ No

Please specify the language: _____

C. How did you learn about the Compensation Program? (Check all that apply)

☐ Law Enforcement ☐ Attorney ☐ Probation or Parole ☐ Friend ☐ Poster or Brochure
☐ District Attorney ☐ Sexual Assault Program ☐ Newspaper ☐ Relative ☐ Public Service Announcement
☐ Victim/Witness Program ☐ Domestic Abuse Program ☐ Funeral Director ☐ Hospital ☐ Other

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

1. Person's Name

2. Date of Birth (MM-DD-YY)

3. Relationship to Victim

4. Mailing Address

5. City

6. State

7. Zip Code

8. Home Telephone ( )

9. Cell Phone ( )

10. E-mail

I prefer to be contacted by e-mail. ☐ Yes ☐ 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 ☐ Yes ☐ No

SECTION 3: CRIME INFORMATION

1. Type of Crime (Check all that apply)

☐ Homicide ☐ Attempted Homicide ☐ Assault/Battery
☐ Domestic Violence ☐ Child Physical Abuse ☐ Child Sexual Abuse
☐ Hit and Run of Pedestrian, Bicycle or Buggy ☐ Sexual Assault ☐ Robbery
☐ Drunk Driving / DUI ☐ Other _____

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	5. Zip Code	6. County

7. Date of Crime	8. Date Crime Reported	9. Law Enforcement Agency to which crime was reported	Officer's Name

If crime date is approximate, provide details.

10. Offender(s) Name(s):

11. 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):

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:

☐ Employers/Union Group ☐ Workers' Compensation ☐ Medical Assistance/Title 19 ☐ Homeowners Insurance
☐ Veterans' Benefits ☐ County Assistance ☐ Victim/Spouse/Parent Insurance ☐ Badger Care
☐ Lawsuit ☐Disability ☐ Medicare ☐ Other (describe) _____

SECTION 7: CRIMES INVOLVING MOTOR VEHICLES

Did the victim have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company and policy limits:
Did the driver have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company and policy limits:
Did the offender have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company and policy limits:

SECTION 8: EMPLOYMENT INFORMATION

Complete the section **ONLY** if the victim/parent was employed at the time of injury.

1a. Did the victim or deceased victim miss time from work immediately following the crime?

☐ Yes ☐ No ☐ Unknown

1b. Did the parent or applicant of a minor victim or deceased victim miss work immediately following the crime?

☐ Yes ☐ No ☐ Unknown

2a. Is the victim/parent self-employed?

☐ Yes ☐ No

2b. May we contact your employer?

☐ Yes ☐ 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