DAVE YOST
OHIO ATTORNEY GENERAL

Ohio Victims of Crime Compensation Program

If you or your family members are victims of a violent crime, financial assistance for out-of-pocket expenses may be available

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The Ohio Victims of Crime Compensation Program helps victims with certain out-of-pocket expenses caused when people are physically injured, emotionally harmed or killed by violent criminal acts. Program costs are paid by criminal fines and not by Ohio's taxpayers.

For more information, call:
614-466-5610

Toll-free numbers:

For specific case information:
800-582-2877

For general information:
877-584-2846 (877-5VICTIM)

www.OhioAttorneyGeneral.gov

ELIGIBILITY CHECKLIST

If you answer “yes” to all these questions, you may be eligible for help from this program.

- The crime was reported and the victim cooperated with requests of law enforcement.
- The victim was not committing a criminal act that caused or contributed to the injuries (this does not apply to homicide claims).
- The victim has incurred expenses that are not fully covered by collateral sources.

WHO MAY BE ELIGIBLE?

- Victims of violent crime
- Someone who legally assumes the financial responsibility in behalf of a victim of violent crime
- For crimes resulting in death, the dependents of that victim or someone assuming the financial responsibility for that victim/family member
- In certain crimes, family members may be eligible to file their own claim

WHAT ARE SOME COSTS THAT MAY BE REIMBURSED?

- Medical and related expenses
- Wages lost as a result of attending funeral or certain court proceedings, medically unable to work or in certain cases to aid in the care or recovery of the victim
- Crime scene cleanup/repair for safety (up to $750)
- Evidence replacement for items held by law enforcement (up to $750)
- Funeral expenses (up to $7,500)

ARE THERE LIMITS ON COMPENSATION?

- Yes. Compensation cannot be paid for pain and suffering, stolen, damaged, or lost property.
- Compensation is not paid for costs payable by other sources (such as insurance or Bureau of Workers’ Compensation).
- The application must be filed within 3 years of the date of the crime.
- The total award must be $50 or more before payment is made.

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Ohio Victims of Crime Compensation Program
Application for Crime Victim Compensation

Please type or print using blue or black ink
After an application has been filed, the law may provide for payment of an emergency award of up to $2,000 to qualified claimants who, because of the crime, will suffer undue hardship without immediate economic relief and if a final award is likely.

THIS DOCUMENT IS A PUBLIC RECORD. EXCEPT FOR INFORMATION THAT IS PROTECTED BY STATE OR FEDERAL LAW, INFORMATION YOU PROVIDE ON THIS APPLICATION IS SUBJECT TO PUBLIC DISCLOSURE UPON REQUEST.

SECTION 1: VICTIM INFORMATION

Person injured or killed as a result of the crime. If more than one victim is affected, a separate application is required for each victim.

Victim's name (first/middle initial/last) _____

Street address _____ City _____ County _____

State _____ ZIP code _____ E-mail _____

Social Security number _____ Date of birth _____

Victim is/was: **a.** male ☐ female ☐ **b.** single ☐ married ☐ separated ☐ divorced ☐ widowed ☐

Home telephone ( ) _____ Work telephone ( ) _____ Cell telephone ( ) _____

SECTION 2: CLAIMANT INFORMATION *(if different than victim)*

Claimant cannot be a minor.

Claimant's name (first /middle initial /last) _____

Street address _____ City _____ County _____

State _____ ZIP code _____ E-mail _____

Social Security number _____ Date of birth _____

Relationship to victim _____

Claimant is: **a.** male ☐ female ☐ **b.** single ☐ married ☐ separated ☐ divorced ☐ widowed ☐

Home telephone ( ) _____ Work telephone ( ) _____ Cell telephone ( ) _____

SECTION 3: CRIME INFORMATION

Date of crime _____ Date crime reported _____

Did crime happen while on the job? Yes ☐ No ☐

Location/address where crime occurred _____ City _____ County _____

State _____

Law enforcement agency crime reported to _____

Suspected offender(s) and address(es). *Use additional sheet if necessary.* _____

Description of crime: Homicide ☐ Assault ☐ Robbery ☐ Sexual assault ☐ Domestic violence ☐ Other _____

What were the victim's injuries? _____

Did the victim die as a result of the crime or from crime-related injuries? ☐ Yes ☐ No Date of death _____

SECTION 4: COMPENSATION REQUESTED

Check all that apply.

- ☐ Medical and related expenses
- ☐ Lost wages
- ☐ Clothing damaged by medical treatment
- ☐ Protection order fees
- ☐ Funeral and burial
- ☐ Items held as evidence by law enforcement
- ☐ Counseling expenses for victim
- ☐ Crime scene cleanup
- ☐ Replacement services (paying someone to do what the victim would normally do such as housecleaning, child care, errands, etc.)
- ☐ Counseling expenses for immediate family members
- ☐ Travel/lost wages to attend criminal justice proceedings when a victim is deceased
- ☐ Future loss of support/care for dependents of a deceased victim
- ☐ Mileage

SECTION 5: VICTIM'S FIRST MEDICAL TREATMENT

Name, address, and date of service for victim's first medical treatment (doctor or hospital, whichever was first)

Doctor/hospital _____

Street address _____ City _____ County _____

State _____ ZIP code _____ Date(s) treated _____

If seeking payment of hospital bills, the following information is needed to determine eligibility for the Hospital Care Assurance Program.

How many are in the household? _____ What was the annual household income at the time of the hospitalization? $ _____

SECTION 6: INSURANCE AND BENEFIT INFORMATION

All bills must be submitted to insurance or benefit plans before compensation can be considered.

Were there insurance or benefit plans to cover expenses at the time of the crime? Yes ☐ No ☐ At present? Yes ☐ No ☐

If yes, check all boxes that apply and give details in the space provided.

- ☐ Health insurance plan *(Please send front and back copy of card)*
- ☐ Auto insurance
- ☐ Medicaid
- ☐ Employers/union group
- ☐ Homeowner's insurance
- ☐ Private accident health plan
- ☐ Workers' compensation
- ☐ Restitution or money from the offender
- ☐ Medicare
- ☐ Life Insurance
- ☐ Other

_____

_____

_____

Name of insurance company/benefit plan _____ Member telephone ( ) _____

Street address or P. O. box _____

City _____ State/ZIP _____

Policy holder/beneficiary's name _____ Policy holder/beneficiary's Social Security number _____

Policy no. _____ Group no. _____

SECTION 7: EMPLOYMENT INFORMATION

Complete if filing for loss of earnings. Provide copies of 6 paychecks prior to crime.

Employed at time of the injury? Yes ☐ No ☐ Employer e-mail address _____

Employer/business name _____ Telephone ( ) _____

Street address _____ City _____ County _____

State _____ ZIP code _____

Dates absent from work due to crime-related injuries _____

Name of doctor certifying time off from work _____ Doctor's telephone ( ) _____

Street address _____ City _____ County _____

State _____ ZIP code _____

Did you receive (check all that apply):

☐ Sick pay ☐ Workers' compensation ☐ Disability ☐ Union or fraternal plan benefits ☐ Food stamps /cash grant ☐ Other (please specify)

SECTION 8: FUNERAL EXPENSES

Complete if filing for funeral expenses. Check all that apply.

Funeral home name and complete address _____

_____

If you have a copy of the death certificate, please include a copy with your application.

Signature required on reverse side.

SECTION 9: ALL MINOR DEPENDENTS OF DECEASED VICTIMS

Use additional sheets if needed.

Name | Date of birth | Social Security number | Name and address of guardian

SECTION 10: ATTORNEY AND/OR VICTIM ASSISTANCE PROGRAM

Has a private attorney represented you in:

Filing this claim? Yes ☐ No ☐ Suing the offender or a third party? Yes ☐ No ☐ An insurance claim? Yes ☐ No ☐ Obtaining a civil protection order? Yes ☐ No ☐

VICTIM ASSISTANCE PROGRAM

In some cases there may be a local advocate available to help you as well. We may contact an advocate to help process your claim.

Name of victim assistance program that helped with this application _____

Street address _____

City/state/ZIP code _____

Telephone ( ) _____

E-mail _____

ATTORNEY ASSISTANCE

Attorney's name _____

Street address _____

City/state/ZIP code _____

Work telephone ( ) _____ Fax ( ) _____

Cell ( ) _____ E-mail _____

Attorney's signature _____

Attorney's Social Security or tax ID number _____

To submit an application, an attorney is not required. If an attorney does help, he/she must sign the application. An attorney cannot charge an applicant for his/her representation and must submit fees to the Ohio Victims of Crime Program.

SECTION 11: VICTIM STATISTICAL INFORMATION

For statistical purposes only. This is strictly voluntary.

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

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

SECTION 12: SUBROGATION, AUTHORIZATION, AND SIGNATURE
YOU MUST BE 18 YEARS OF AGE OR OLDER TO SIGN THE APPLICATION.

Have you requested restitution? Yes ☐ No ☐ Court _____ Result _____

Have you made a claim for any governmental benefits? Yes ☐ No ☐ From whom _____

Have you contacted an attorney to sue or make claim regarding this incident? Yes ☐ No ☐ Attorney's name _____

Have you filed a claim with any insurance company regarding this incident? Yes ☐ No ☐ Insurance claim number _____

Mailing address for insurer _____

I understand that if I get money from any other source to cover the same expenses paid through the Crime Victims Compensation Program, I must reimburse the state of Ohio that amount of money. (Ohio Revised Code Section 2743.72)

I hereby authorize any person (including any physician, medical facility or health care provider), employer organization, the Ohio Department of Job and Family Services, the appropriate county Department of Job and Family Services or Child Support Enforcement Agency (for purposes of child support enforcement), law enforcement agency or government agency, upon request, to release to the Ohio Attorney General, the Court of Claims of Ohio or to my attorney, a copy of any report, document, record, criminal record, or other information (including tax information or returns, or medical information) in any way relating to my claim for an award of reparations under the Ohio Victims of Crime Compensation Program.

I understand that failing to provide my Social Security number may significantly impede the processing of my claim. I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS and AIDS-related conditions.

I understand that disclosure of confidential information from medical records may be protected by state or federal law. If applicable, state law (Ohio Revised Code Section 3701.243) and federal regulations (42 CFR part 2) prohibit the Ohio Attorney General or the Court of Claims of Ohio from making any further disclosure of confidential information without my specific written consent or as otherwise permitted by such regulations. This authorization or a copy hereof shall be valid for a period of two years without any further consent by me.

I understand that the information I have provided is being relied upon as truthful and accurate. By signing below, I swear or solemnly affirm under penalty of law that all information provided by me or on my behalf is true and accurate to the best of my knowledge and belief.

X _____ _____

Signature of person seeking compensation (or signing as the legal guardian of a minor) **Date of signature**

This release must be signed and dated for the application to be processed.

AUTHORIZATION FOR USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES

PATIENT'S NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

VICTIM/CLAIMANT'S NAME: _____

I, _____ , authorize the disclosure of information from my/the patient's health record. I authorize the disclosure or use of the patient's **PSYCHOTHERAPY NOTES**.

The information is to be disclosed by any covered entity — including employer(s), physicians, medical facilities, health care providers, mental health care providers, insurance companies, billing departments, health care clearinghouses, health plans, and pharmaceutical entities — and is to be provided to the Ohio Attorney General, the Court of Claims of Ohio or to my attorney. This information is to be used in any way necessary related to my/the patient's claim for an award of reparations from the Ohio Victims of Crime Compensation Program.

I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS and AIDS-related conditions.

I understand that the covered entity from which the Ohio Attorney General seeks to obtain records may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that the Ohio Attorney General is not a covered entity and is not subject to privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authorization complies with the requirements of 45 CFR 164.508, HIPAA and the HIPAA Privacy Rule.

A photocopy or facsimile copy of this authorization release shall have the same effect as the original.

I understand that I may revoke this authorization in writing submitted at any time to the Ohio Attorney General, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate two years from the date of my signature.

VICTIM'S/CLAIMANT'S SIGNATURE X _____ **DATE** _____

CLAIMANT'S RELATIONSHIP TO VICTIM _____

Do not write in this space-For Internal Use Only
Claim number:

Signature required above.

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

PATIENT'S NAME: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

_____

VICTIM/CLAIMANT'S NAME: _____

I, _____ , hereby voluntarily authorize the disclosure of information from the above patient's health record. I authorize the disclosure or use of **THE PATIENT'S ENTIRE RECORD**, excluding psychotherapy notes.

This information is to be disclosed by any covered entity, including any physician, medical facility, health care provider, mental health care provider, insurance company, billing department, health care clearinghouse, health plan or pharmaceutical entity, employer organizations, Ohio Department of Job and Family Services, Child Support, law enforcement or governmental agency, upon request to release and is to be provided to the Ohio Attorney General, the Court of Claims of Ohio, or to my attorney a copy of any report, document, record, criminal record or other information (including tax information or medical information). This information is to be used in any way necessary related to my claim for an award of reparations from the Ohio Victims of Crime Compensation Program.

I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS and AIDS related conditions.

I understand that the covered entity from which the Ohio Attorney General seeks to obtain records may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that failing to provide my Social Security number may significantly impede the processing of my claim.

I understand that the Ohio Attorney General is not a covered entity and is not subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, I understand that the Ohio Public Records Act (Ohio Revised Code Section 149.43) prohibits the Attorney General or the Court of Claims of Ohio from making any further disclosure of confidential information without my specific written consent or as otherwise permitted by such regulations.

This authorization complies with the requirements of 45 CFR 164.508, HIPAA, and the HIPAA Privacy Rule.

A photocopy or facsimile copy of this authorization release shall have the same effect as the original.

I understand that I may revoke this authorization in writing submitted at any time to the Ohio Attorney General, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate two years from the date of my signature.

VICTIM'S/CLAIMANT'S SIGNATURE **X** _____ **DATE** _____

CLAIMANT'S RELATIONSHIP TO VICTIM _____

Do not write in this space. For internal use only.
Claim number:

Signature required above.