MIKE DEWINE

★ OHIO ATTORNEY GENERAL ★

OHIO VICTIMS OF CRIME COMPENSATION PROGRAM

Application for Supplemental Compensation

If you or your family members are innocent victims of a violent crime, financial assistance may be available.

For more information, call:

Ohio Victims of Crime
Compensation Program
Attorney General's Office
150 E. Gay St., 25th Fl.
Columbus, OH 43215
(614) 466-5610

Toll-Free Numbers:
For Specific Case Information
(800) 582-2877
For General Information
(877) 584-2846 (877-5VICTIM)
Also visit us at
www.ohioattorneygeneral.gov

ELIGIBILITY CHECKLIST FOR SUPPLEMENTAL APPLICATION

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

- ☐ The claimant has incurred additional economic loss.
- ☐ The supplemental application is being filed within five years of The last decision by the Attorney General, a Court of Claims panel of commissioners, or judge of the Court of Claims.
- ☐ The claimant has previously been determined eligible to receive an award of reparations by the Attorney General or Court of claims.
- ☐ The claimant and the victim have maintained eligibility from the time of the previous decision.
- ☐ The maximum amount of $50,000 has not yet been paid on the claim.

WHO CAN GET HELP?

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 entirely by criminal fines and not by Ohio's taxpayers.

WHO IS NOT ELIGIBLE?

- ✓ The Offender.
- ✓ Anyone who engaged in a felony of violence or drug trafficking within 10 years prior to the crime that caused the injury or during the pendency of the claim.
- ✓ A victim or claimant who has been convicted of a felony within 10 years prior to the crime that caused the injury or during the pendency of the claim.
- ✓ A claimant who has been convicted of a child endangering or domestic violence offense within 10 years prior to the crime that caused the injury or during the pendency of the claim.
- ✓ Anyone injured while incarcerated and serving a sentence.

WHAT ARE SOME COSTS THAT MAY BE PAID?

- ✓ Medical and related expenses.
- ✓ Counseling for family members of victims for specific crimes (up to $2,500 each.) Maximum $7,500 per claim.
- ✓ Wages lost from not being able to work.
- ✓ Replacement services.
- ✓ Crime scene clean-up/repair for safety (up to $750).
- ✓ Evidence replacement (up to $750).
- ✓ Funeral expenses up to $7,500

ARE THERE LIMITS ON COMPENSATION?

- ✓ Yes. Compensation cannot be paid for stolen, damaged, or lost property, or for pain and suffering.
- ✓ Compensation is not paid for costs payable by other source.
- ✓ The total award must be $50 or more before payment is made.

OHIO VICTIMS OF CRIME COMPENSATION PROGRAM

SUPPLEMENTAL COMPENSATION APPLICATION

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.

(Please Type or Print Using Blue or Black Ink)

ORIGINAL CLAIM NUMBER: V ___ ___ - ___ ___ ___ ___ ___

SECTION 1: VICTIM INFORMATION

Victim's Name (First/Middle Initial/ Last) _____

Street Address _____

City _____ County _____ State_____ Zip _____

Social Security # _____ Date of Birth _____

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

Has the victim been arrested for, or convicted of, any felony within 10 years prior to the injury, or since the injury? ◯ Yes ◯ No

Has the victim lived in any state other than Ohio in the past 10 years? ◯ Yes ◯ No If yes, list each state _____

Home Phone (____) _____ Work Phone (___) _____

SECTION 2: CLAIMANT INFORMATION (If different than victim)

Claimant's Name (First/Middle Initial/ Last)_____

Street Address _____

City _____ County _____ State_____ Zip _____

Social Security # _____ Date of Birth _____ Relationship to victim _____

Claimant is/was: a. ◯ male ◯ female b. ◯ single ◯ married ◯ separated ◯ divorced ◯ widowed

Has the claimant been arrested for, or convicted of, any felony within 10 years prior to the injury, or since the injury? ◯ Yes ◯ No

Has the claimant lived in any state other than Ohio in the past 10 years? ◯ Yes ◯ No If yes, list each state _____

Home Phone (____) _____ Work Phone (___) _____

SECTION 3: HOUSEHOLD INCOME

If seeking payment of hospital bill(s), 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 4: MEDICAL TREATMENT AND OTHER CRIME-RELATED EXPENSES

EXPENSES NOT CONSIDERED IN ORIGINAL APPLICATION

Provide name, complete address, telephone number, and date(s) of service for each provider of service or expense.

Name/ Address/ City/ State/ Zip	(Area Code) Telephone No.	Date(s) of Service

SECTION 5: INSURANCE AND BENEFIT INFORMATION

ALL BILLS MUST BE SUBMITTED TO THE INSURANCE OR BENEFIT PLAN BEFORE COMPENSATION IS CONSIDERED.

Does the victim have any insurance or benefit plan to cover the listed expenses? ◯ Yes ◯ No

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

☐ Employers/Union Group ☐ Medicare ☐ Worker's Compensation ☐ Homeowner's Insurance

☐ Insurance Plan ☐ Medicaid ☐ Private Accident Health Plan ☐ Auto Insurance

☐ Other ☐ Restitution or money from the offender

Name of Insurance Company/ Benefit Plan	
Street Address or P.O. Box	
City	State/Zip
Policy Holder's Name	Policy Holder's Social Security No.
Policy No.	Group No.

(Application continues on reverse side.)

SECTION 6: EMPLOYMENT INFORMATION (Complete for additional work loss since the original application.)

Employer/ Business Name	(Area Code) Telephone No.	
Street Address	City	State/Zip
Additional date(s) absent from work due to crime-related injuries		
Name of doctor certifying length or time off from work	Doctor's Street Address	
Doctor's (Area Code) Telephone No.	City/State/Zip	
Did you receive: ☐ Sick pay ☐ Worker's Compensation ☐ Disability ☐ Union or Fraternal Plan ☐ Food Stamps/ Cash Grant ☐ Other (please specify)		

SECTION 7: FUNERAL EXPENSES (Complete if filing for funeral expenses)

Funeral Home Name and Complete Address		
Was there:	Social Security Death Benefit?	○ Yes ○ No
	Life Insurance?	○ Yes ○ No

SECTION 8: REPRESENTATION

An attorney is not required to submit the application. If an attorney does help, he/she must sign the application. The attorney cannot charge for representation.

Attorney's Name	
Street Address	City/ State/ Zip
(Area Code) Telephone No.	Fax Number
Attorney's Signature	Attorney's Social Security No. or Tax ID No.

SECTION 9: SUBROGATION, AUTHORIZATION AND SIGNATURE

I understand that if I get money from any other source to cover the same expenses I get compensation for, I have to reimburse the state of Ohio that amount of money.

I hereby authorize any person (including any physician, medical facility, or health care provider), 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 providing my Social Security number is voluntary, and that it may be used to obtain the aforementioned reports, documents, records and information necessary to verify my eligibility for an award of compensation. I further 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 (R.C. 3701.243) and federal regulations (42 C.F.R. 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.

_____ _____

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

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

ORIGINAL CLAIM NUMBER: V ___ ___ - ___ ___ ___ ___ ___

PATIENT'S NAME:
DATE OF BIRTH:
SOCIAL SECURITY NUMBER:
ADDRESS:
CLAIMANT'S NAME:

I, _____, hereby voluntarily authorize the disclosure of information from my health record. I authorize the disclosure or use of **MY ENTIRE RECORD**, exclusive of 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, 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 claim for an award of reparations from the Ohio Victims of Crime Compensation Program.

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

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.

I understand that the 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. However, I understand that the Ohio Public Records Act (R.C. §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 C.F.R. §164.508, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the HIPAA Privacy Rule.

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

_____ _____

VICTIM'S/CLAIMANT'S SIGNATURE DATE

_____

CLAIMANT'S RELATION TO VICTIM

Do not write in this space – For Internal Use Only

Claim Number: