PERSONAL INJURY COMPENSATION APPLICATION

JD-VS-8PI 10/16

OFFICE OF VICTIM SERVICES

Focusing on a brighter future

We are here to help. If you have any questions about filling out this application or the Victim Compensation Program, please call us toll-free at 1-888-286-7347. Please know that it is important that you tell us if your contact information changes. If we cannot reach you, your claim may be closed or you may miss important deadlines set by state law.

SECTION 1 – VICTIM INFORMATION

The victim is the person who was physically injured because of the crime. Parents and legal guardians of a minor child (under 18 years old) and legal guardians or conservators of an incapacitated adult must also fill out Section 3. A separate application must be filled out for each victim who was physically injured.

Name of victim (last, first, middle) _____ Birth date _____ Age _____

Address _____ City _____ State _____ Zip _____

Home telephone _____ Work telephone _____ Cell phone _____ Email _____

Primary language spoken _____ Gender: ☐ Female ☐ Male ☐ Other _____

SECTION 2 – CLAIMANT INFORMATION

The claimant is the person who has expenses because of the crime. If the victim and the claimant are the same person, you do not have to fill out this section. Parents and legal guardians of a minor child (under 18 years old) and legal guardians or conservators of an incapacitated adult must also fill out Section 3.

Name of claimant (last, first, middle) _____ Birth date _____ Age _____

Address _____ City _____ State _____ Zip _____

Home telephone _____ Work telephone _____ Cell phone _____ Email _____

Primary language spoken _____ Gender: ☐ Female ☐ Male ☐ Other _____

Relationship to victim:

☐ child ☐ spouse ☐ parent ☐ grandchild ☐ grandparent ☐ spouse's parent ☐ stepparent ☐ brother

☐ sister ☐ half-brother ☐ half-sister ☐ stepchild ☐ adopted child ☐ party to a civil union ☐ other _____

FOR OFFICE USE ONLY Claim Number Claims Examiner

SECTION 3 – PARENT/LEGAL GUARDIAN/CONSERVATOR INFORMATION

This section is for parents and legal guardians of children under 18 years old and legal guardians or conservators of an incapacitated adult. If you have your own expenses because of the crime, please fill out another application and list yourself as the claimant. (A copy of the court order naming you as the legal guardians or conservators must be provided.)

Name of parent/legal guardian/conservator (last, first, middle) _____ Relationship: ○ Natural/adoptive parent ○ Legal guardian ○ Conservator

Address _____ City _____ State _____ Zip _____

Home telephone _____ Work telephone _____ Cell phone _____ Email _____

Primary language spoken _____ Gender: ○ Female ○ Male ○ Other _____

SECTION 4 – ATTORNEY REPRESENTATION

Please check if an attorney is representing you on this application, a civil lawsuit, or both and provide the attorney's contact information. ○ Representing me on this application ○ Representing me in a civil lawsuit

Name of attorney (last, first, middle) _____ Name of firm _____

Address _____ City _____ State _____ Zip _____

Work telephone _____ Fax number _____ Juris number _____ Email address _____

SECTION 5 – CONTACT PERSON (person to contact in case we can't reach you)

Name of contact person (last, first, middle) _____ How do you know the contact person? _____

Address _____ City _____ State _____ Zip _____

Home telephone _____ Work telephone _____ Cell phone _____ Email _____

SECTION 6 – STATISTICAL INFORMATION

How did you find out about the Victim Compensation Program?

- ○ community advocate
- ○ family member
- ○ friend/acquaintance
- ○ hospital
- ○ Infoline 211
- ○ Internet
- ○ medical provider
- ○ mental health provider
- ○ Office of Adult Probation
- ○ OVS victim services advocate
- ○ OVS web page
- ○ police
- ○ poster/brochure
- ○ private attorney
- ○ prosecutor/state's attorney
- ○ public service announcement
- ○ telephone book
- ○ other _____

Statistics are voluntary but needed for federal reporting requirements.

- ○ american indian/alaskan native
- ○ asian
- ○ black/african american
- ○ hispanic
- ○ native hawaiian/pacific islander
- ○ other
- ○ white
- ○ unknown

Was the victim disabled before the crime? ○ yes ○ no

SECTION 7 – CRIME INFORMATION

If the crime was a sexual assault, please do not fill out this section but answer the questions in Section 7a. This section must be filled out for all other crimes.

Type of crime: ❍ assault ❍ robbery with injury ❍ dui ❍ hit and run ❍ other _____

Briefly describe the crime and physical injuries: _____

Date of crime | Address and city where crime happened

Date crime was reported to police | Police department crime was reported to

Police department incident number | Name of police officer investigating the crime

Was the crime reported to the police within 5 days? ❍ yes ❍ no (If no, please explain)

Was someone arrested for the crime? ❍ yes ❍ no ❍ unknown

Name of person(s) arrested, if known

Did the person(s) arrested go to court? ❍ yes ❍ no ❍ unknown

If yes, court location | Docket number, if known

SECTION 7a – SEXUAL ASSAULT CRIMES

Date of crime | Address and city where crime happened

Did you go to a hospital for a sexual assault medical examination and evidence collection? ❍ yes ❍ no

If yes, name of hospital or healthcare facility | Date of examination

Please check which professional you told about the sexual assault:

- ❍ alcohol and drug counselor
- ❍ clinical social worker
- ❍ counselor
- ❍ emergency medical services provider
- ❍ employee of Department of Children and Families
- ❍ marriage and family therapist
- ❍ mental health professional
- ❍ nurse (advanced practice, practical, or registered)
- ❍ physician or physician assistant
- ❍ police officer
- ❍ psychologist
- ❍ resident physician or intern at a Connecticut hospital
- ❍ sexual assault or domestic violence counselor
- ❍ surgeon

Name of the person you told about the assault | Title | Date you told that person

Address | City | State | Zip

Telephone number

SECTION 8 – CRIME EXPENSES

Please list all of the hospitals, doctors, dentists, counselors, ambulance services, radiology services, and others who provided treatment or services because of the crime and list the prescriptions (drugs and eyeglasses) you were given because of it (attach additional pages, if needed) and include copies of any crime related bills.

Provider	Telephone	Address	City	State	Zip

SECTION 9 – EMPLOYMENT INFORMATION

Please fill out this section if you were employed or self-employed at the time of the crime and are applying for lost wages. If self-employed, attach a copy of your tax return and W2 or 1099 form for the year of the crime. If you have not filed your taxes before completing this application, forward the information for the year before the crime happened. Please note that we can only consider taxable income. We will contact your employer for dates absent, salary, and benefit information. If you have a concern about this, please call us. If you missed more than 1 week of work, please provide a doctor's note.

Name of employer _____ Contact name _____ Telephone number _____

Address _____ City _____ State _____ Zip _____

Hours worked per week _____ Wage per hour _____ Tips, bonuses per week _____

Dates absent because of crime related injuries or care to victim _____

Name of treating doctor or hospital _____ Telephone number _____

Address _____ City _____ State _____ Zip _____

SECTION 10 – INSURANCE & OTHER FINANCIAL RESOURCES

This section must be filled out. Answer each numbered question by checking yes or no. If you answer yes, review the financial resources listed under that question and answer yes or no. If you answer yes, provide the information requested. You must contact us if any of the financial resources checked as no become available in the future.

1. Do you or will you have Medical, Mental Health, and/or Prescription Expenses? ○ **Yes** ○ **No**

Financial Resources	*Yes*	*No*	*Insurance Name*	*Address*	*Telephone*	*Member No.*
Dental Insurance	○	○				
Department of Social Services (Medical)	○	○				
Health Insurance (Primary)	○	○				
Health Insurance (Secondary)	○	○				
Medicare	○	○				
Veterans Administration	○	○				
Workers' Compensation (Crimes while at work)	○	○				

2. Do you have Crime Scene Cleanup expenses? ○ **Yes** ○ **No**

Financial Resources	*Yes*	*No*	*Insurance Name*	*Address*	*Telephone*	*Policy No.*
Homeowners Insurance	○	○				
Renters Insurance	○	○				

3. Do you have or will you have Lost Wages? ○ **Yes** ○ **No**

Financial Resources	*Yes*	*No*	*Insurance Name*	*Address*	*Telephone*	*Member/Policy No.*
Department of Social Services (Financial)	○	○				
Disability Insurance	○	○				
Life Insurance with Disability Rider	○	○				
Police/Firefighters Insurance	○	○				
Police Association of Connecticut	○	○				
Social Security Disability	○	○				
Workers' Compensation (Crimes while at work)	○	○				
Unemployment Compensation	○	○				

4. Did the incident involve a Motor Vehicle? ○ **Yes** ○ **No**

Financial Resources	*Yes*	*No*	*Insurance Name*	*Address*	*Telephone*	*Policy/Claim No.*
At the time of the crime, did you have auto insurance?	○	○				
If you did not have auto insurance at the time of the crime, did you live with a relative who had auto insurance?	○	○				
Did you file a claim against the other driver's auto insurance?	○	○				
Did you receive an auto insurance settlement?	○	○				

5. You must check yes or no for each of the sources listed below.

Other Sources of Income	*Yes*	*No*	*Court Location and Docket Number*
Did the court order restitution?	○	○	
Did you or will you file a lawsuit?	○	○	

	Yes	*No*	*Insurance Name*	*Address*	*Telephone*	*Policy/Claim No.*
Did you or will you file a Dram Shop Liability Claim?	○	○				
Other	○	○				

SECTION 11 – STATEMENT OF FACTS & AUTHORIZATION

I certify that the information in this application for victim compensation is true to the best of my knowledge, information, and belief, and I give permission to any hospital, physician(s) or other person(s) who attended, examined, or gave services to any employer(s) of the victim or claimant, any police or other municipal authority or agency, or public authorities including state and federal revenue services, any insurance company or organization having knowledge of the incident to give to the Office of Victim Services (OVS) or its representative any and all information regarding the incident leading to the victim's physical injuries and the victim's or claimant's application for compensation. A copy of this authorization will be considered as effective and valid as the original.

I give permission to OVS to disclose any information in its records, including confidential information, to the offices of the Court Support Services Division, the State's Attorney, the Attorney General, and to private attorneys retained by OVS or the victim, and to communicate freely with them when necessary (Sections 54-208(e), 54-212, and 54-215 of the Connecticut General Statutes).

I understand that I must notify OVS if I file a lawsuit against whoever is responsible for the injury for which OVS paid the award within 30 days of the filing of the action in court. If I recover money from the lawsuit, either by a judgment or by settlement, I understand that OVS is entitled by law to 2/3 of the amount OVS paid. (Section 54-212 of the Connecticut General Statutes). If I have filed a lawsuit, I agree to provide a copy of the writ, summons, and complaint to OVS immediately.

I understand that OVS will have the right to bring a lawsuit in my name against whoever is responsible for the injury for which the money was paid. I also understand that if OVS recovers money from the lawsuit, OVS is entitled by law to keep 2/3 of the amount paid, plus costs and interest. OVS will pay me any balance over that amount (Section 54-212 of the Connecticut General Statutes).

I understand that if I receive money from any other sources, including payments from state or municipal agencies, insurance benefits, or workers' compensation as a result of the criminal incident, OVS is entitled by law to 2/3 of the amount OVS paid (Section 54-212 of the Connecticut General Statutes).

I understand that if the court orders restitution to the victim for expenses paid by OVS, OVS is entitled to receive full reimbursement, unless the court orders differently (Section 54-215 of the Connecticut General Statutes).

I also understand that my providers may be reimbursed directly for debts that I owe.

Print your name	**Signature**	**Date**

*The adult victim/claimant, the parent/legal guardian/conservator of a minor child (under 18 years old), or the legal guardian of an incapacitated adult **must sign** this application. Applications that are not signed will be returned.*

Please mail, fax, or email the completed application to: Office of Victim Services, 225 Spring Street, 4th Floor, Wethersfield, CT 06109; Fax: 860-263-2780; Email: OVS@jud.ct.gov

Contact OVS at: 1-888-286-7347 (toll-free), 860-263-2761 (office), www.jud.ct.gov/crimevictim (Web site)

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