



OFFICE OF VICTIM SERVICES

*Focusing on a brighter future*

**SECTION ONE - VICTIM INFORMATION**

\_\_\_\_\_  
Name of victim (last, first, middle)

\_\_\_\_\_  
Last known address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Age

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Birth date

**SECTION TWO - CLAIMANT INFORMATION**

\_\_\_\_\_  
Name of claimant (last, first, middle)

\_\_\_\_\_  
Home telephone

\_\_\_\_\_  
Work telephone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Age

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Birth date

\_\_\_\_\_  
Cell telephone

\_\_\_\_\_  
Primary language of claimant

Would you like to be contacted via email?  yes  no Email \_\_\_\_\_

Claimant relationship to victim (you may check more than one relationship if applicable):

- child
- spouse
- parent
- grandchild
- grandparent
- spouse's parent
- stepparent
- brother
- sister
- half brother
- half sister
- step child
- adopted child
- administrator
- designated decision maker
- party to a civil union
- other (ie. DCF case worker) \_\_\_\_\_

### SECTION THREE - LOSS OF SUPPORT

Are you applying for Loss of Support Compensation?  yes  no (If yes, please complete below.)

For a child, attach or send a copy of the child's birth certificate. For a spouse, attach or send a copy of the marriage certificate.

Attach additional page if necessary.

Dependent's Name	Address (Street, City, State, Zip)	Relationship to Victim	Birth date (mm/dd/yyyy)	Guardian (if minor)

### SECTION FOUR - CONTACT PERSON (Person to contact if claimant cannot be reached)

Name of contact person (last, first, middle)		Relationship to claimant		
Address		City	State	Zip
Home telephone	Work telephone	Cell telephone		

### SECTION FIVE - ATTORNEY REPRESENTATION (Complete only if represented by an attorney for this application)

Name of attorney (last, first, middle)		Name of firm		
Address		City	State	Zip
Work telephone	Fax	Juris number		

**SECTION SIX - CRIME INFORMATION** *(Please fill out this section as completely as possible)*

Type of crime:  homicide  dui  hit and run  other \_\_\_\_\_

Briefly describe the crime:

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Date of crime \_\_\_\_\_ Address where crime occurred \_\_\_\_\_

Date crime was reported to police \_\_\_\_\_ Police department to which crime was reported \_\_\_\_\_

Police department incident number \_\_\_\_\_ Name(s) of assisting officer(s) \_\_\_\_\_

Was the crime reported to the police within five days?  yes  no (If not, please explain)

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Has an arrest(s) been made?  yes  no  unknown \_\_\_\_\_  
Name of offender(s), if known \_\_\_\_\_

Has the offender(s) been arraigned in court?  yes  no  unknown \_\_\_\_\_  
If yes, court location \_\_\_\_\_ Docket number \_\_\_\_\_

**SECTION SEVEN - COUNSELING/MEDICAL INFORMATION**

Are you applying for compensation of unreimbursed mental health counseling and/or medical expenses?  yes  no

List all providers that gave treatment, include mental health counselors, pharmacies (for prescriptions), doctors, hospital and ambulance. Attach additional page if necessary. If available, please attach copies of bills.

Provider's Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_

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Will there be additional treatment?  yes  no  unknown

If yes, provider's name \_\_\_\_\_

## SECTION EIGHT - INSURANCE & OTHER COLLATERAL SOURCE INFORMATION (for claimant)

Have bills been paid or will bills be paid by any of the following sources?

yourself	<input type="radio"/> yes <input type="radio"/> no	Veterans' Administration	<input type="radio"/> yes <input type="radio"/> no
private health insurance	<input type="radio"/> yes <input type="radio"/> no	Workers' Compensation	<input type="radio"/> yes <input type="radio"/> no
Medicare	<input type="radio"/> yes <input type="radio"/> no	other (please list) _____	
State Medicaid	<input type="radio"/> yes <input type="radio"/> no		

\_\_\_\_\_  
Name of primary medical insurer Telephone Policy number

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Name of secondary medical insurer (if applicable) Telephone Policy Number

\_\_\_\_\_  
Address City State Zip

*Please note: If you have checked yes to any of the above, medical and mental health counseling bills must be submitted to that source before OVS can consider reimbursement.*

## SECTION NINE - FUNERAL EXPENSES

Are you applying for compensation for funeral expenses?  yes  no (If yes, please complete below.)

If an estate has been opened, attach or send a copy of the Probate Court's Appointment of the Named Fiduciary. Attach or send the funeral bill and a copy of the death certificate (original death certificate not required).

\_\_\_\_\_  
Name of Funeral Home Telephone

\_\_\_\_\_  
Address City State Zip

Have any funeral expenses been paid or will any funeral expenses be paid by any of the following sources?  yes  no

Burial Insurance	<input type="radio"/> yes <input type="radio"/> no	Veterans' Benefits/Insurance	<input type="radio"/> yes <input type="radio"/> no
Life Insurance	<input type="radio"/> yes <input type="radio"/> no	Other	<input type="radio"/> yes <input type="radio"/> no
Public Assistance	<input type="radio"/> yes <input type="radio"/> no	_____	

*Please note: If you have checked yes to any of the above, funeral bills must be submitted to that source before OVS can consider reimbursement.*

## SECTION TEN - COURT RELATED BENEFITS

Are you an eligible relative of the victim?  yes  no

Eligible relatives, defined by General Statutes section 54-201(4), are spouse, parent, grandparent, stepparent, child, including natural born, step and adopted, grandchild, brother, sister, half brother, half sister, or spouse's parents.

Are you applying for mileage or travel expenses to attend court proceedings?  yes  no

Are you applying for wage loss compensation to attend court proceedings?  yes  no (If yes, please complete below.)

\_\_\_\_\_  
Claimant's Employer

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Employer's Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Date(s) absent from work to attend court proceeding(s).

## SECTION ELEVEN - RESTITUTION AND CIVIL ACTION

Did the crime involve motor vehicles?  yes  no (If yes, please provide your automobile insurance policy declaration pages.)

Did the court order the defendant to make restitution?  yes  no

Have you filed or do you intend to file a civil action?  yes  no (If yes, please complete below.)

\_\_\_\_\_  
Name of attorney (last, first, middle)

\_\_\_\_\_  
Name of firm

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Work telephone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Juris number

## SECTION TWELVE - STATISTICAL INFORMATION

How did you find out about the crime victims' compensation program?

- |   |  |   |   |
|---|--|---|---|
| <input type="radio"/> community advocate  | <input type="radio"/> hospital               | <input type="radio"/> Office of Adult Probation | <input type="radio"/> private attorney            |
| <input type="radio"/> family member       | <input type="radio"/> Infoline/211           | <input type="radio"/> OVS victim advocate       | <input type="radio"/> prosecutor/state's attorney |
| <input type="radio"/> friend/acquaintance | <input type="radio"/> medical provider       | <input type="radio"/> OVS webpage               | <input type="radio"/> public service announcement |
| <input type="radio"/> funeral home        | <input type="radio"/> mental health provider | <input type="radio"/> police                    | <input type="radio"/> telephone book              |
|   |  | <input type="radio"/> poster/brochure           | <input type="radio"/> other _____                 |

Submission of your information regarding race/ethnic background or disabilities is voluntary.

- white  black/African American  hispanic  native Hawaiian/pacific islander  
 american indian/alaskan native  asian  other  unknown

## SECTION THIRTEEN - STATEMENT OF FACTS AND AUTHORIZATION

The undersigned certifies that the information herein is true to his or her best knowledge, information and belief and hereby authorizes any hospital, physician(s), funeral director or other person(s) who attended, examined, or rendered services to \_\_\_\_\_ and \_\_\_\_\_, any employer(s) of the victim/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 thereof, to furnish to OVS or its representative any and all information with respect to the incident leading to the victim's death and the claimant's application made for compensation. A photocopy of this authorization will be considered as effective and valid as the original.

I, \_\_\_\_\_, authorize OVS to disclose any information in its possession, 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 claimant, and to communicate freely with any of the foregoing when such disclosure and communications are necessary pursuant to General Statutes sections 54-208(e), 54-212 and 54-215.

Further, I understand that OVS may be entitled to receive proceeds that an offender has been ordered to pay the claimant as restitution ordered by the State of Connecticut's criminal court system. This is in accordance with General Statutes section 54-215.

I understand that any recovery of my losses from the offender resulting from a civil action that I have brought entitles OVS to reimbursement of two-thirds of any compensation awarded to me and that OVS shall have a lien on the recovery pursuant to General Statutes section 54-212. I understand that I must notify OVS of the filing of any such civil action within thirty days of the filing of the action in court.

Further, I understand that pursuant to General Statutes section 54-212, OVS shall be subrogated to any cause of action I have against the offender. A civil action may be brought on behalf of OVS by the Attorney General or by a private attorney hired by OVS. OVS shall furnish me with a copy of the action within thirty days of the filing of the action in court.

\_\_\_\_\_  
**Claimant signature** (Parent or guardian must sign if claimant is a minor or an incompetent adult)

\_\_\_\_\_  
**Date**

**Please return completed form to:**

Office of Victim Services  
225 Spring Street  
Wethersfield, CT 06109

**Contact OVS at:**

1-888-286-7347 (Toll-free compensation line - CT only)  
860-263-2761  
[www.jud.ct.gov/crimevictim](http://www.jud.ct.gov/crimevictim)