



## OFFICE OF VICTIM SERVICES

*Focusing on a brighter future*

We understand that this is a very difficult time for you and your family. We are here to help. If you have any questions about filling out this application or the 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**

Name of victim (last, first, middle)	Birth date	Age
Address	City	State Zip
Gender: <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Other _____		

**SECTION 2 - CLAIMANT INFORMATION**

The claimant is the person who has expenses 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. If you are applying for loss of support for minor child(ren) of the victim, please fill out Section 3 and Section 8.

Name of claimant (last, first, middle)	Birth date	Age	
Address	City	State Zip	
Home telephone	Work telephone	Cell phone	Email
Primary language spoken	Gender: <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> 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  
 designated decision maker  other \_\_\_\_\_

*An adult claimant, the parent/legal guardian of a minor child (under 18 years old), or the legal guardian or conservator of an incapacitated adult **must sign** Section 13 of this application. Applications that are not signed will be returned.*

### 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. (Legal guardians or conservators must provide a copy of the court order.)

Name of parent, legal guardian, or conservator (last, first, middle)		How are you related to the claimant?	
Address	City	State	Zip
Home telephone	Work telephone	Cell phone	Email
Primary language spoken		Gender: <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> 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?

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

Statistics are voluntary and needed for federal reporting requirements.

- |  |                             |  |                                |
|--|-----------------------------|--|--------------------------------|
| <input type="radio"/> american indian/alaskan native   | <input type="radio"/> asian | <input type="radio"/> black/african american | <input type="radio"/> hispanic |
| <input type="radio"/> native hawaiian/pacific islander | <input type="radio"/> other | <input type="radio"/> white                  | <input type="radio"/> unknown  |



## SECTION 9 - COUNSELING/MEDICAL/PRESCRIPTION EXPENSES

Please fill out this section if you have or will have counseling, prescription, and/or medical expenses because of the crime. List the hospitals, doctors, counselors, ambulance services, and others who provided treatment or services that were not covered or fully covered (for example, you had co-pays) by insurance or other financial resources. Please include any copies that you have of receipts showing your payments, itemized bills, and/or pharmacy printouts for prescription expenses.

Provider	Telephone	Address	City	State	Zip

## SECTION 10 - COURT RELATED EXPENSES

Please fill out this section if you have or will have expenses for attending court proceedings. The relatives of the victim that are eligible for this benefit are defined in state law (Section 54-201 (4) of the Connecticut General Statutes). Please check your relationship to the victim below. If your relationship is not listed, you are not eligible for this benefit.

- child (natural, step, and adopted)    spouse    parent    grandchild    grandparent  
 spouse's parent    stepparent    brother (natural and half)    sister (natural and half)

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

Are you applying for lost wages to attend court proceedings?  yes  no (If yes, please fill out below.)

Employer name	Contact name	Telephone number

Address	City	State	Zip

## SECTION 11 - FUNERAL EXPENSES (Maximum benefit \$5,000)

Please fill out this section if you have or will have funeral expenses and attach a copy of the death certificate. Please also include any copies that you have of receipts showing your payments or an itemized bill from the funeral home.

Was an estate opened in probate court?  yes  no  don't know

If you checked yes above, are you the administrator or the executor of the estate?

- yes (please attach a copy of the probate court's appointment order)  
 no (please apply to the estate for reimbursement of funeral expenses)

Name of funeral home	Contact name	Telephone number

Address	City	State	Zip

## SECTION 12 - 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

<i>Financial Resources</i>	<i>Yes</i>	<i>No</i>	<i>Insurance Name</i>	<i>Address</i>	<i>Telephone</i>	<i>Member No.</i>
Department of Social Services (MEDICAL)	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Insurance (PRIMARY)	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Insurance (SECONDARY)	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Savings/Spending Accounts						
Flexible Spending Account	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Reimbursement Account	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Health Savings Account	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Medicare	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Veterans Administration	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____

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

<i>Financial Resources</i>	<i>Yes</i>	<i>No</i>	<i>Insurance Name</i>	<i>Address</i>	<i>Telephone</i>	<i>Policy No.</i>
Homeowners Insurance	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Renters Insurance	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____

**3. Do you or will you have Funeral Expenses?**     Yes     No

<i>Financial Resources</i>	<i>Yes</i>	<i>No</i>	<i>Insurance Name</i>	<i>Address</i>	<i>Telephone</i>	<i>Policy No.</i>
Department of Social Services (FUNERAL)	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Did the victim have burial or funeral insurance?	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Workers' Compensation (CRIMES WHILE AT WORK)	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____

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

<i>Financial Resources</i>	<i>Yes</i>	<i>No</i>	<i>Insurance/Provider Name</i>	<i>Address</i>	<i>Telephone</i>	<i>Policy/Claim No.</i>
At the time of the crime, did the victim have auto insurance?	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
If the victim did not have auto insurance at the time of the crime, did the victim live with a relative who had auto insurance?	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Did you file a claim against the other driver's auto insurance?	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____
Did you receive an auto insurance settlement?	<input type="radio"/>	<input type="radio"/>	_____	_____	_____	_____

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

<i>Other Sources of Income</i>	<i>Yes</i>	<i>No</i>	<i>Court Location and Docket Number</i>
Was restitution ordered by the court?	<input type="radio"/>	<input type="radio"/>	_____
Did you or will you file a lawsuit?	<input type="radio"/>	<input type="radio"/>	_____
			<i>Insurance/Provider Name      Address      Telephone      Policy/Claim No.</i>
If the victim had life insurance, are you the beneficiary?	<input type="radio"/>	<input type="radio"/>	_____
Did you or will you file a Dram Shop Liability claim?	<input type="radio"/>	<input type="radio"/>	_____
Other	<input type="radio"/>	<input type="radio"/>	_____
Other	<input type="radio"/>	<input type="radio"/>	_____

## SECTION 13 - 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 \_\_\_\_\_ and \_\_\_\_\_, 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 death and the 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 claimant, 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 or death 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 or death 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 claimant 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.

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**Applicant signature**

**Date**

*The parent, guardian, or conservator **must sign** if the claimant is a minor or incompetent adult. Applications that are not signed will be returned.*

**Please mail, fax, or e-mail the completed application to:** Office of Victim Services, 225 Spring Street, 4th Floor, Wethersfield, CT 06109; Fax: 860-263-2780; E-mail: [OVS@jud.ct.gov](mailto:OVS@jud.ct.gov).

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

The Judicial Branch of the State of Connecticut complies with the Americans with Disabilities Act (ADA). If you need a reasonable accommodation, in accordance with the ADA, contact a Judicial Branch employee or an ADA contact person listed at [www.jud.ct.gov/ada/](http://www.jud.ct.gov/ada/).