



NON-RELATIVE CHILD WITNESS TO DOMESTIC VIOLENCE COMPENSATION

APPLICATION

JD-VS-8W 10/12

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 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. If the child is related to the victim, you may have to fill out a different application. Please call us for more information.

SECTION 1 - VICTIM INFORMATION

The victim is the person who was physically injured in a domestic violence crime. Please fill out as much of the information that you know.

Name of victim (last, first, middle)

Address

City

State

Zip

Gender: Female Male Other _____

SECTION 2 - CHILD WITNESS/CLAIMANT INFORMATION

The witness is the child (under 18 years old) who saw the incident and needs mental health counseling because of the crime. Parents and legal guardians of a minor child (under 18 years old) must also fill out Section 3.

Name of witness (last, first, middle)

Birth date

Age

Address

City

State

Zip

Home telephone

Gender: Female Male Other _____

SECTION 3 - PARENT/LEGAL GUARDIAN INFORMATION

This section is for parents and legal guardians of children under 18 years old. (Legal guardians or conservators must provide a copy of the court order.)

Name of parent or legal guardian (last, first, middle)

How are you related to the child witness?

Address

City

State

Zip

Home telephone

Work telephone

Cell phone

Email

Primary language spoken

Gender: Female Male Other _____

The parent/legal guardian of a minor child (under 18 years old) **must sign** Section 9 of this application. Applications that are not signed will be returned.

SECTION 4 - ATTORNEY REPRESENTATION

Please fill out this section if an attorney is representing you on this application.

Name of attorney (last, first, middle)

Name of firm

Address

City

State Zip

Work telephone

Fax number

Juris number

SECTION 5 - STATISTICAL INFORMATION

How did you find out about the Victim Compensation Program?

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

Statistics are voluntary and needed for federal reporting requirements.

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

SECTION 6 - CRIME INFORMATION

Please fill out this section.

Type of crime: domestic violence personal injury domestic violence homicide

Date of crime

Address and city or town where crime happened

Is the child a relative of the victim? yes no

(If yes, you may have to fill out a different application. Please call the Compensation Program toll-free at 1-888-286-7347 for more information.)

Briefly describe how the child saw the crime and the child's physical or emotional injuries from witnessing it.

SECTION 7 - COUNSELING/MEDICAL INFORMATION

Please list all of the hospitals, doctors, mental health counselors, and others who provided treatment or services to the child because he or she witnessed the crime and list the prescriptions (drugs) the child was given because of it (attach additional pages, if needed) and include copies of any crime related bills.

<i>Provider</i>	<i>Telephone</i>	<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip</i>

SECTION 8 - INSURANCE & OTHER FINANCIAL RESOURCES

This section must be filled out. Please check yes or no for each of the financial resources below that you have or may be able to get paid by. If the financial resource is not one that you can get paid by, please check no. You must contact us if any of the financial resources checked as No become available in the future.

<i>Financial Resources</i>	<i>Yes</i>	<i>No</i>	<i>Provider Name</i>	<i>Address</i>	<i>Telephone</i>	<i>Account 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"/>	_____	_____	_____	_____

SECTION 9 - STATEMENT OF FACTS AND AUTHORIZATION

I certify that the information in this application for 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 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 OVS or its representative any and all information regarding the incident leading to the witness' 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 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, it 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 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.

Applicant signature (A parent or guardian must sign if the claimant is a minor or incompetent adult)

Date

*The parent/legal guardian of a minor child (under 18 years old) **must sign** this application. Applications that are not signed will be returned.*

Please return completed application to:

Office of Victim Services
225 Spring Street, 4th Floor
Wethersfield, CT 06109

Contact OVS at:

1-888-286-7347 (Toll-free)
860-263-2761
www.jud.ct.gov/crimevictim