CLAIM FORM

Complete and submit to:

Delaware Victims' Compensation Assistance Program
900 North King St., Suite 4
Wilmington, DE 19801
http://www.attorneygeneral.delaware.gov/VCAP

Please contact the DE VCAP if you need assistance completing this form (Phone)302.255.1770 (Fax)302.577.1326

SECTION 1. VICTIM INFORMATION SECTION	Name of person injured or killed as the result of the violent crime. If there was more than one victim, complete a separate claim form for each victim.		
Victim's Name (last, first, m.i.)	Date of Birth (MM/DD/YY) / /	**Social Security Number**	
Gender ❒ Male ❒ Female	Race (optional) ❒ Asian/Pacific Island ❒ American Indian/Alaska Native ❒ Black ❒ Hispanic ❒ White ❒ Other _____	Is Victim Deceased? ❒ Yes ❒ No	
Street Address (including apartment #)	City	State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )	E-Mail Address
Who referred you to the compensation program? Contact Person:_____			
❒ Hospital	❒ Police Agency	❒ Prosecutor	❒ Victim Services Police
❒ Victim Services DOJ	❒ Poster/Brochure/Advertisement	❒ Public Service Announcement	❒ Other:_____

SECTION 2. CLAIMANT INFORMATION	Name of person filing on behalf of a deceased victim, minor victim, or an incapacitated adult victim.		
Claimant's Name (last, first, m.i.)	Date of Birth (MM/DD/YY) / /	**Social Security Number**	
Gender ❒ Male ❒ Female	Relationship to Victim ❒ Parent ❒ Spouse/Partner ❒ Former Spouse/Partner ❒ Child ❒ Sibling ❒ Grandparent ❒ Other _____		
Street Address (including apartment #)	City	State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )	E-Mail Address

SECTION 3. CRIME INFORMATION	Date of Crime / /	Date Reported to Police / /	Name of Suspect
Relationship of suspect to victim: _____			
Name of Police Department Investigating Crime	Police Complaint Number	Investigating Officer's Name	
Location of Crime (address)	City	State	Zip Code

Type of Crime: (please check one)

❒ Assault	❒ DWI/DUI	❒ Homicide/Murder	❒ Child Sexual Abuse
❒ Child Physical Abuse	❒ Stalking	❒ Kidnapping	❒ Arson
❒ Domestic Abuse	❒ Adult Sexual Abuse	❒ Robbery	❒ Burglary
❒ Protection From Abuse (PFA) or PFA ex parte (emergency hearing)		❒ Other Please specify if other: _____	

SECTION 4. LOSS INFORMATION	Check the type of expenses/losses you are seeking for compensation. You must attempt to recover your losses from any/all other sources(s).			
❒ Medical/Dental	❒ Wage/Income Loss	❒ Funeral/Burial	❒ Mental Health Counseling	❒ Crime Scene Cleanup
❒ Mental Health Counseling (Secondary Victim)	❒ Loss of Support for Victim's Dependents	❒ Moving	❒ Relocation	❒ Temp. Housing
❒ Other Please specify if other:		Approximate amount of Loss (Must demonstrate a minimum of $25.00 loss.) $		
Name of Secondary Victim's (last, first, m.i.)		Relationship to Victim		
Address	Phone No.	Date of Birth (MM/DD/YY) / /		
Other Secondary Victim(s)		Relationship to Victim		
Address	Phone No.	Date of Birth (MM/DD/YY) / /		

SECTION 5. MEDICAL INFORMATION	List all Medical/Dental Providers, and/or those who have provided services to the victim and attach any medical bills you have received.		
Name of Provider	Address	Phone	Amount Due $
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Name of Provider	Address	Phone	Amount Due $

SECTION 6. VICTIM'S EMPLOYER INFORMATION	Complete only if filing for income loss			
Name of Employer	Address	City	State	Zip Code
Telephone Number ( )	Fax Number ( )	Was the victim self-employed? ❒ Yes ❒ No		
Dates absent from work due to crime related injury From: To:		Amount of wages lost due to injuries $		
Victim was released back to work on:	By (Name of physician)	Phone Number of Physician ( )		

SECTION 7. SOURCES OF FINANCIAL ASSISTANCE	Check all that may apply				
Did the victim have insurance at the time of the crime? ❒ Yes ❒ No		Does secondary victim have insurance? ❒ Yes ❒ No			
❒ Health	❒ Auto	❒ Workers Compensation	❒ Medicaid	❒ Medicare	❒ SSI
❒ Social Security Disability	❒ Disability Benefits	❒ Homeowners/Renters	❒ General Assistance	❒ None	
Provider Name:				Policy #	

ACKNOWLEDGEMENT AND REIMBURSEMENT AGREEMENTS	The Acknowledgement, Reimbursement and Authorization Agreements must be signed before the claim verification process will begin.

Certification of Application

Subject to the penalty of fine or imprisonment, the information contained in this application for a Crime Victim Compensation award is true and correct to the best of my knowledge.

Consent

I agree that any award(s) may be paid directly, at the discretion of the Delaware Victims' Compensation Assistance Program, to the person(s) owed payment.

Subrogation Agreement

I agree that I HAVE NOT and WILL NOT sign any release or participate in any settlement or compromise with any person who may be liable to me for damages as a result of the criminal act for which I am making a claim. In consideration of any award made by the AGENCY, I agree to subrogate to the AGENCY any right or cause of action to the extent of the award that I may have against any third party. I authorize the AGENCY to pursue in my name at the expense of the AGENCY recovery from any third party any sums paid to me from the VICTIM'S COMPENSATION FUND. In any suit that is brought by the AGENCY, I agree to fully cooperate and assist in any manner including executing and returning papers as required.

Repayment

If later I recover any money through legal action, restitution or otherwise, I agree to immediately repay the award(s) to the AGENCY.

Civil Lawsuit

Will there be a Civil Lawsuit in relation to this crime? ❒ Yes ❒ No ❒ Unknown
If yes, list the name and address of Attorney:_____

Appeal

I understand if I am dissatisfied with the initial decision of the Victims' Compensation Assistance Program, I may submit a written request for a Reconsideration within 15 days after the date the decision is mailed. If the claimant is dissatisfied with the Agency's final decision, the claimant, may, within 15 days after the date the decision is mailed, request a hearing before the Appeals Board. If I am not satisfied with the Appeals Board's final decision, I understand that I may appeal the decision to the Superior Court of the State of Delaware within thirty (30) days for the final decision.

Acknowledgement and Reimbursement Agreements

My signature below signifies I understand each of the following statements or points of law:
The decision to approve my claim is that of the Program's. I may object to all or part of the Program's decision in writing within 15 days from the date that the decision is mailed. I must prove the exact amount of my losses before the Program will consider awarding compensation from the Crime Victim's Compensation Fund. I may file for reimbursement for additional expenses incurred relating to the crime. My claim may be denied if I do not cooperate fully with law enforcement agencies, the courts, and the Program or maintain a valid address with the Program. If I were to make a false claim, it would be a criminal offense punishable as a misdemeanor. If I were to make a false statement in this claim form with the intent to mislead the Program, it would be a criminal offense punishable as a misdemeanor. I understand that the Delaware Victims' Compensation Assistance Program is the payor of last resort. I specifically agree to inform the Program of and repay to the Delaware VCAP any funds that I may receive from any other source that has not already been considered, as a result of the crime and to the extent of the award. That is, I agree to repay any funds that I receive from the offender, any other person or source, which compensates me for the injury I suffered. I further agree that if the claim is at any time determined to be in error, false or fraudulent, I will refund to the Program all sums of money paid by the Program.

X_____ _____
Claimant's Signature **Date**

X_____ _____
Witness Verification of Signature **Date**

Your signature must be witnessed in order for your claim to be processed. A witness can be any adult over the age of 18 who can verify who you are.

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 42 USC§§1320d et seq.) any hospital, physician, health care provider or other person who attended or examined (Name of Victim) _____ _____; any funeral director or other person who rendered related services; any employer of the victim or claimant; any police or governmental agency, including state or federal taxing authorities; any insurance company; or any organization having relevant knowledge, to furnish to the Delaware Victims' Compensation Assistance Program, any and all information in their possession with respect to the incident that is the basis for this claim. Copies of this authorization may be used in place of the original.

X_____ _____
Claimant's Signature **Date**

X_____ _____
Victim's Signature (if age 18 or over) **Date**