

Office of Kansas Attorney General
STEPHEN N. SIX



CRIME VICTIMS COMPENSATION BOARD
120 SW 10th Ave., 2nd Floor
Topeka, KS 66612-1597

Telephone: (785) 296-2359 FAX: (785) 296-0652

Claim# _____
(for CVCB office use only)

APPLICATION FOR CRIME VICTIMS COMPENSATION

Must be filed within two years of incident. Cases of child sexual assault are based on the date the crime was reported to law enforcement. It is the claimant's responsibility to establish proof that the claim was filed timely pursuant to K.S.A. 74-7305(b).

Questions regarding financial stress are required by Kansas Statute.

Please check the type(s) of crime victim compensation for which you are applying:

Medical Counseling Loss of wages Funeral

Section A -- VICTIM INFORMATION

1. Victim's Name:

2. Date of Birth:

3. Age:

4. Victim's Social Security Number:

The following information is optional and will be used for statistical purposes only and is requested to comply with Federal Civil Rights Act under Section 1407(e) of the Victims of Crimes Act of 1984.

A. Handicapped:

Yes

No

B. Race:

- White American Indian/Alaskan
 Black Native
 Hispanic Asian/Pacific Islander
 Other _____

C. How did you find out about this program?

- Police Victim Assistance Program
 Hospital Poster/Brochure
 Prosecutor Public Service Announcement
 Other (please specify) _____

D. Sex:

- Male
 Female

Section B -- APPLICANT (CLAIMANT) INFORMATION

1. Claimant's Name:

2. Claimant's Relationship to Victim:

3. Mailing Address:

4. City:

5. State:

6. Zip Code:

7. Home Telephone:

8. Work Telephone:

9. Claimant's Social Security Number:

Section C -- ATTORNEY REPRESENTATION

Are you represented by a private attorney in a civil lawsuit of insurance action as a result of this incident? Yes No.
If yes, please complete the following:

1. Attorney's Name:

2. Firm Name:

3. Mailing Address:

4. City, State, Zip Code:

Telephone Number:

Section D -- CRIME INFORMATION 1. Type of Crime: (please check one)

<input type="checkbox"/> Domestic Violence <input type="checkbox"/> Domestic Violence (homicide) <input type="checkbox"/> Sexual Assault/Rape (adult) <input type="checkbox"/> Child Sexual Abuse <input type="checkbox"/> Child Physical Abuse	<input type="checkbox"/> Assault <input type="checkbox"/> Kidnapping <input type="checkbox"/> Stalking <input type="checkbox"/> DUI <input type="checkbox"/> DUI/homicide	<input type="checkbox"/> Murder/Homicide <input type="checkbox"/> Robbery <input type="checkbox"/> Arson <input type="checkbox"/> Other (please specify) _____
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2. Date of Crime:	3. Date Crime Reported:	4. Name of Law Enforcement Agency Reported to:
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5. Police Report #	6. Investigating Officer's Name:
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7. Brief Description of Crime: _____

8. Location of Crime - Street Address:	City:	County:	State:
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9. Name(s) of Offender(s):

10. Did victim know offender(s)? Yes No *If yes, in what way?*

11. Has an arrest been made? Yes No Unknown

12. Court Case #:	<input type="checkbox"/> District Court <input type="checkbox"/> Municipal Court
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Section E -- FUNERAL/BURIAL EXPENSES (Maximum allowable is \$5000.00)

Are you seeking funeral benefits for a deceased victim? Yes No *If yes, complete Section E and attach copies of bills.*

**** Applications for grief therapy for family members are available. Please contact our office for details.**

1. Name of Funeral Home:

2. Street Address:

3. City, State, Zip Code:	4. Phone Number:
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5. Total amount of funeral expenses \$ _____ Total amount of burial expenses \$ _____

6. Have funeral and burial expenses been paid? Yes No *If yes, by whom?* _____

7. Will applicant receive funeral payment or death benefits from any of the following? Yes No *If yes, amount:*

Social Security \$ _____ Insurance \$ _____ Donations \$ _____

Workers Compensation \$ _____ Other (describe) \$ _____

Section F -- LOSS OF SUPPORT (*Maximum allowable \$400.00 per week.*)

Have you or any dependent children sustained loss of financial support resulting from the death of the victim? Yes No
 If yes, complete Section F.

Dependent's Name	Date of Birth	Social Security Number	Relationship to Victim

Section G -- MEDICAL INFORMATION (*All information confidential pursuant to K.S.A. 74-7308.*)

Briefly describe victim's injuries: _____

Please list **all** medical expenses incurred as a result of this incident, including hospital and doctor charges, ambulance fees, x-rays and prescriptions. *Please attach itemized statements or bills, receipts and insurance statements if they are available.*

MEDICAL PROVIDER INFORMATION

Name of Medical Provider	Address	City and State	Zip Code	Telephone #

Section H -- COUNSELING INFORMATION

** *Please attach itemized statements or bills, receipts and insurance statements if they are available.*

MENTAL HEALTH INFORMATION

Counselor/Organization	Address	City and State	ZipCode	Person Receiving Counseling & Relationship to Victim

Section L -- CERTIFICATION OF FINANCIAL HARDSHIP (Required by K.S.A. 74-7305(d))

I (claimant) affirm the customary level of health, safety and education for self and dependents cannot be maintained without undue hardship as a result of the incident upon which this claim is based.

Section M -- ASSIGNMENT OF BENEFITS

(1) Medical care expenses -I hereby assign any compensation awarded for unpaid medical care to the applicable medical care provider. This assignment is conditional that such provider agrees to accept a direct payment from the Kansas State Treasurer to pay 80% of allowable charges as satisfaction of payment in full. I authorize the Kansas State Treasurer to pay 80% of such allowable unpaid medical charges to the appropriate medical care provider.

(2) Non-medical care expenses - I hereby assign any compensation awarded for unpaid non-medical care charges to the applicable provider. I authorize the Kansas State Treasurer to pay any such allowable unpaid non-medical charges directly to the provider.

Section N -- CERTIFICATION OF CLAIM

I hereby certify, subject to the penalty of fine or imprisonment, that all losses claimed herein are a direct result of the crime and that the information contained in this application for an award is true and correct to the best of my knowledge and belief.

Section O -- PROMISE TO REPAY

Pursuant to K.S.A. 74-7312, I promise to repay the Kansas Crime Victims Compensation Fund, through the Crime Victims Compensation Board if I receive payments from the offender (restitution or civil action), insurance or any other government or private agency resulting from this incident.

Section P -- AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I authorize and request any person having information with respect to the incident leading to the victim's personal injury or death necessary to the administration of this claim, including all past law enforcement records, to release that information to the Crime Victims Compensation Board, or its representative. This release includes but is not limited to, private and governmental physicians and hospitals; local, state and federal law enforcement and prosecutors offices; local, state and federal court personnel, any employer; any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I hereby agree and certify that no person shall incur any legal liability by releasing any information pursuant to this authorization. A photocopy of this authorization is effective and valid as the original. All information obtained by the Board will remain confidential pursuant to K.S.A. 74-7308 and amendments thereto.

(Claimant's Signature)

for _____
(If victim is 12 years or older, they must sign on this line.)

Date _____

**** If you have not received a letter within two weeks of mailing this application, please call (785) 296-2359 to verify that the application has been received.**

OFFICE OF THE ATTORNEY GENERAL
CRIME VICTIMS COMPENSATION BOARD
APPLICATION FOR CRIME VICTIMS COMPENSATION
AND ELIGIBILITY REQUIREMENTS

If you have been an innocent victim of a violent crime and have suffered financial losses that are not covered by insurance or any other source, the Kansas Crime Victims Compensation Fund may be of assistance to you. The State of Kansas is committed to helping victims who meet the eligibility requirements of the Kansas Crime Victims Compensation Act. While no amount of financial aid can erase the trauma of crime, it is the goal of this program to ease the aftermath of crime for the victim whenever possible.

Eligibility Requirements:

1. *Must be filed within two years of incident. Cases of child sexual assault are based on the date the crime was reported to law enforcement. It is the claimant's responsibility to establish proof that the claim was filed timely pursuant to K.S.A. 74-7305(b).*
2. *Victim suffered bodily injury (including mental disorder or death) as a result of the criminal actions of another.*
3. *The incident occurred in Kansas, or outside the United States to a Kansas resident.*
4. *The incident was reported to law enforcement officials within 72 hours, or would have been reported within that time except for a valid reason.*
5. *The claimant (and/or victim) fully cooperated with law enforcement officials during their investigation and prosecution.*
6. *Economic loss (medical expenses, wage loss, etc.) will total \$100.00 or more and has not been (or will not be) totally paid by other sources except in cases of sexual abuse.*
7. *The victim was not an accomplice to and did not commit a crime in connection with this incident (e.g. gang activity, drug dealing.) Victim must not have provoked or caused the injury or death.*

**KANSAS STATUTE AUTHORIZES THE BOARD TO REDUCE OR DENY CLAIMS THAT INVOLVE
THE VICTIM'S CONTRIBUTORY MISCONDUCT.**

Eligible and Ineligible Expenses:

- ❖ *Medical expenses not covered by other sources are eligible expenses.*
- ❖ *Reasonable costs for replacement of clothing and bedding seized as evidence are compensable.*
- ❖ *Victims or claimants who are required to testify in sexually violent predator cases may be eligible for compensation for mental health counseling.*
- ❖ *Property loss, property damage and pain and suffering are ineligible expenses.*

Award Maximums:

- ◆ *Overall maximum award of \$25,000.00.*
- ◆ *Funeral expense maximum of \$5,000.00 .*
- ◆ *Grief therapy for family members of homicide victims is available. Call for separate grief therapy application.(Maximum award is \$1,000.00.)**
- ◆ *Outpatient mental health counseling maximum of \$3,500.00.**
- ◆ *Inpatient mental health care maximum of \$10,000.00.**
- ◆ *Lost wages/loss of support maximum of \$400.00 per week.*
- ◆ *Crime scene clean-up maximum of \$1,000.00.*

**Additional compensation may be awarded based on extenuating circumstances.*

HOW TO FILE YOUR APPLICATION FOR COMPENSATION

Read all instructions for each section before completing this application. Please provide all information requested. Applications which are not completed and signed will be returned, thus delaying a decision on your claim. Please include copies of your medical bills and other expenses. Once your completed application is received and all requests for additional documents and information have been received and reviewed, you will be notified in writing of the Board's decision. You have the right to appeal that decision if you disagree. The complete application process takes approximately 3 months. If you have any questions while completing the application, please call our office at (785) 296-2359.

