# ALABAMA CRIME VICTIMS COMPENSATION COMMISSION

P.O. Box 231267
Montgomery, AL 36123-1267

Everette Johnson
EXECUTIVE DIRECTOR

COMMISSIONERS
Holly Brown-Owens, Ph.D.
Sheriff Jay Jones
Hon. Darlene Hutchinson

| ***For Office Use Only**** | **Claim Number:** _____ | **County:**_____ **Type:**_____ |
|---|---|---|

| *You have the right to free language assistance.* | *Tiene derecho a asistencia lingüística gratuita.* | *귀하는 무료 언어 지원을 받을 권리가 습니다.* |
|---|---|---|

| **Section 1 – Eligibility Criteria** | |
|---|---|
| **A.** Was the victim **physically present** during a violent crime**?** | ☐ **Yes** ☐ **No** |
| **B.** Did you file this application **within one (1) year** of the crime**?**<br>*If you marked no, you must explain why in the box below.* | ☐ **Yes** ☐ **No** |
| | |
| **C.** Does the applicant have any **criminal charges pending** against him/her at the time of the crime**?**<br>*If you marked yes, you must explain them in the box below.* | ☐ **Yes** ☐ **No** |
| | |
| **D.** Was the crime **reported to Law Enforcement** within **72 hours** of the occurrence**?**<br>*If you marked yes, type/write in the date reported.*<br>*If you marked no, you must explain your reason in the box below.* | ☐ **Yes** ☐ **No**<br>**Date Reported:**<br>/ / |
| | |

**You must submit proof of US citizenship or that you are an alien eligible for public benefits. Please see https://acvcc.alabama.gov/victims/who-is-eligible/legal-presence/ for the list of acceptable documents.**

| **Section 2 – Victim Information** | | |
|---|---|---|
| **A.** Last Name: | First Name: | Middle Initial: |
| **B.** Date of Birth: / / | **C.** Social Security Number*: | |
| **D.** Mailing Address:<br>*(number, street, apartment number)* | | |
| City: | State: | Zip Code: |
| **E.** Primary Phone Number: | **F:** Work Phone Number: | |
| **G.** Email Address: | | |
| **H.** Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | | |

**Submission of Social Security Numbers is voluntary. Social Security Numbers are requested to verify eligibility pursuant to ALA. CODE §§ 15-23-1 - 15-23.F; Failure to submit your Social Security Number may result in inability to process all expenses.*

## Section 3 – Claimant Information

This section is to be completed only if the victim is a **minor**, **deceased**, or **incapacitated**. If the victim is 19 or older, but is incapacitated, you will have to provide **proof of guardianship/conservatorship** over the victim.

| | | |
|---|---|---|
| **A.** Last Name: | First Name: | Middle Initial: |
| **B.** Date of Birth: / / | **C.** Social Security Number*: | |
| **D.** Mailing Address: *(number, street, apartment number)* | | |
| City: | State: | Zip Code: |
| **E.** Primary Phone Number: | **F:** Work Phone Number: | |
| **G.** Email Address: | | |

**J.** Your relationship to the Victim:

☐ Spouse ☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandparent

☐ Grandchild ☐ Legal Guardian ☐ Other:

**If you are not the victim's *legal* next of kin, we will hold this application until one year and one day has passed from the date of the crime, which is when you will be eligible to be the claimant for this Claim, or until the claimant's legal next of kin provides you with an ACVCC-issued *Power of Attorney* document, whichever comes first.**

## Section 4 – Emergency Award ($1,000 maximum)

*If you want to request emergency funds, please select the appropriate category and type/write in your explanation in the box below.*

☐ Funeral ☐ Moving/Relocation ☐ Crime Scene Cleanup ☐ Medication(s)

| | |
|---|---|
| Business Name: | Business Phone Number: |

Explanation:

## Section 5 – Crime Information

Complete this section and, if one is available, provide a copy of the Police Report.

**A.** Type of Crime (select only one)

☐ Assault ☐ Domestic Violence ☐ Homicide ☐ Human Trafficking

☐ Sexual Assault ☐ Other (please explain):

**B.** What is the Victim's relationship to the alleged offender, if any**?**

| | |
|---|---|
| **C.** Offender's Name: | **D.** Has an arrest been made**?** ☐ Yes ☐ No |
| **E.** Date of the Crime: / / | **F.** Date of Death: / / |

**G. Law Enforcement Agency** the crime was reported to:
Officer's Name:

**H.** Physical address at which crime occurred:

**J.** Please give a brief description of the crime:

## Section 6 – Compensation Request

**The ACVCC considers several types of compensation. Please select which type you are requesting. Provide any corresponding and directly related bills/receipts.**

- ☐ Counseling Services: Name of Provider _____ Phone Number_____
- ☐ Moving/Relocation
- ☐ Medical Expenses: Name of Provider _____Phone Number _____
- ☐ Travel/Transit *(for funeral, court, and/or medical treatment)* Loss Wages
- ☐ Crime Scene Cleanup: Name of Provider _____Phone Number _____
- ☐ Fees (Birth Certificate, Identification, Power of Attorney Fees)
- ☐ Funeral/Burial: Name of Funeral Home _____Phone Number _____
- ☐ Lost Wages: Name of Employer _____ Phone Number _____

## Section 7 – Financial Recovery

Alabama law requires that you give the Alabama Crime Victims Compensation Commission written notice within fifteen (15) days of initiating any legal proceeding to recover restitution or damages, or prior to any attempt by Claimant to reach a negotiated settlement. ALABAMA CODE § 15-23-14(c).

**ACVCC is a payer of last resort; you must tell the Commission if you receive funding from a collateral source.**

| | |
|---|---|
| **A.** Has a civil lawsuit been filed in connection with this case? | ☐ **Yes** ☐ **No** |
| **B.** Have you received any money for the damages that resulted from this crime (insurance of any type, restitution, etc.)? | ☐ **Yes** ☐ **No** |

**C.** If an attorney has been handling financial recovery for you, please provide their contact information, including mailing address, phone number, fax number, and/or email address.

**If you contact an attorney about financial recovery as a result of this crime, please show him/her this application.**

## Section 8 – Statistical Information

For statistical purposes only; completion of this section is strictly voluntary.

**A.** Please tell us how you first found out about the Crime Victims Compensation program:

- ☐ Prosecuting Attorney ☐ Medical Provider ☐ Civil Attorney
- ☐ Media, Brochure, or Poster ☐ Police/Sherrif ☐ Victim Service Agency
- ☐ Friend/Acquaintance
- ☐ Other:

**B.** Race/Ethnic Background:

- ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic or Latino
- ☐ Black/African American ☐ White Non-Latino/Caucasian
- ☐ American Indian/Alaskan Native ☐ Asian ☐ Multi-Racial

**C.** If the victim is disabled, check one:

- ☐ **Before** crime ☐ As a **Result** of this crime

**D.** Gender:

# PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Printed Name: _____

Date of Birth: _____

Social Security Number: _____

* Submission of your social security number is voluntary. However, not having your social security number may slow processing of your claim.

1. I hereby authorize the Alabama Crime Victims' Compensation Commission (ACVCC) to obtain and use my health, medical, psychiatric and billing information for the purpose of processing my compensation claim.
2. I authorize any and all service providers, including physicians, hospitals, clinics, laboratories, psychologists, psychiatrists, nurses, physician assistants and counselors, to release my health, medical, psychiatric and billing information, which includes discharge summary, laboratory reports, history and physical, operative procedure, pathology reports and billing information to the ACVCC and its agents and employees who are acting within the scope of their employment.
3. I understand that this authorization is for any and all health, medical, psychiatric and billing information related to my victimization, which occurred on: _____.
4. I understand that such medical records may contain information concerning psychological, drug, and/or alcohol conditions, and/or diagnosis, treatment and care of sexually transmitted diseases or complications related to the same, including but not limited to HIV testing and results. I understand that the health, medical, psychiatric and billing information to be released may be subject to re-disclosure by the recipient of the health, medical and billing information and no longer be protected by the Federal Privacy Rules.
5. I understand that this authorization is voluntary. I also understand that I may revoke this authorization at any time by notifying the ACVCC in writing. If I do revoke authorization, it will not have any effect on uses and disclosures made before the receipt of the revocation.
6. In the event that this authorization is being signed by a personal representative of the patient, a description of such individual's authority to do so must be attached to this document along with proper documentation of this authority.
7. This authorization shall be valid for the entire duration of the processing of my compensation claim at the ACVCC and shall terminate at such time the ACVCC has closed my compensation claim.

X _____ _____

Patient Signature or Personal Representative | Date

**Either the patient (victim) or their representative must sign and date this authorization if consideration of medical expenses is being requested.**

# Claim Authorization

**Information Release:** I authorize financial institutions, social service agencies, funeral providers, insurance companies, medical/mental health service providers, or any state/federal agency to release my information to the ACVCC. I authorize my employer or former employer to release my employment information to the ACVCC.

**Prosecuting Attorney's Office:** I understand information related to my claim may be released to the prosecuting attorney's office and/or law enforcement.

**Criminal Background Check:** I will be subject to a criminal background check to verify my eligibility for compensation benefits.

**Subrogation Agreement:** I hereby agree to give the ACVCC written notice within 15 days of initiating any legal proceeding to recover restitution for damages that is related to my victimization. I agree to repay the ACVCC the amount of compensation I have received in the event that my economic loss is recouped from any collateral source. I understand that failure to comply with this agreement may result in legal action being taken against me.

**Payment of Benefits:** I understand the ACVCC will pay the maximum amount possible for all expenses/financial losses. I understand that these payments may result in the expenditure of all crime victims' compensation benefits for this claim. I acknowledge it is my responsibility to notify the ACVCC in writing if I do not want the maximum benefits expended for this claim.

**Service Provider Information Release:** I authorize the ACVCC to release information or records about my application for assistance to service providers and their authorized representatives who request information about the status of my pending claim. I understand this release is for the limited purpose of helping service providers determine the status of the claim in order to receive payment for services rendered.

**Life Insurance Policy Search:** I authorize the ACVCC to search the National Association of Insurance Commissioners' (NAIC) database and any other available resources for a life insurance policy for the deceased victim for whom this application is filed. I understand the purpose of this search is to determine whether a collateral source of compensation is available or not.

**Authorized Parties:** I hereby agree that the parties listed below may receive information regarding this claim. I understand that status only will be provided to employees of service providers.

| **Name** | **Phone** | **Relationship** |
|---|---|---|
| | | |
| | | |
| | | |

| Are you a US Citizen? | Or, are you a legally present alien? |
|---|---|
| ☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No** |

**The ACVCC does not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, religion, age, genetic information, pregnancy and related conditions, equal pay, disability, or retaliation for filing a discrimination charge, in employment or the provision of the compensation benefits.**

**Therefore, I HEREBY AND FOREVER HOLD HARMLESS, the ACVCC and its authorized representatives and agents from any and all legal responsibility/liability which may arise from the release of any of the above information. By signing this document I affirm that the information provided in this application is true and correct to the best of my knowledge. I understand that if there is any credible evidence that I submitted a false claim for grant funds or have intentionally given any false information on this application, I will be referred for criminal investigation.**

☐ Check this box if you **do not** authorize the release of status information to service providers.

**X**_____
**Applicant's Signature**

_____
**Print Name**

_____
**Date**

**You Must Provide Proof of Legal Presence with your Application**

Please download the completed application and email it to **info@acvcc.alabama.gov** or fax it to 334-290-4455.

The victim **must** sign this authorization unless he/she is **deceased**, **incapacitated**, or is a minor. The person signing this authorization must be **19 or older**. The claimant (if other than victim) must be the person legally authorized to act on the behalf of the victim. Documentation of this authority **must** be provided.