OKLAHOMA CRIME VICTIMS COMPENSATION PROGRAM

421 NW 13TH St., Suite 290, Oklahoma City, OK 73103-3710
405-264-5006 (OKC) 1-800-745-6098 (Toll-Free) Fax: 405-264-5097 Website: http://www.ok.gov/dac

Note: **The Claim Form must be received at the above address within one year of the crime. If you move and leave no forwarding address, your claim may be denied, so please notify us of your correct mailing address. Please thoroughly complete ALL sections and sign all three areas of page four. You may e-mail your current address information on our webpage at: http://www.ok.gov/dac/**

INSTRUCTIONS

Information on Victim The victim is the person who was injured or killed a s a result of a violent crime.

Information on Claimant (Complete only if the victim is: deceased, a child, or an incapacitated adult)
Authorized claimants can be: 1) the parent of a minor child; 2) a dependent of a victim who has died because of a crime; 3) a person authorized to act on behalf of the victim or a dependent; or 4) a person legally responsible for payment of expenses which have arisen because of a criminal act (example: person responsible for payment of funeral expenses).

Contact Person Information (Contact person should be different than the victim and claimant information)
We ask for this information in the event we are unable to contact the claimant by mail or telephone. Your contact person should be someone you trust to give you a message, someone who knows your whereabouts, and someone who knows you were a victim of a crime. If a tribal victims' assistance program is helping with the claim, the program contact person may be listed in this section.

Guardian Information (Complete only if the claimant is a child or incapacitated adult). This information is needed in the event an award is made to a minor child or an incapacitated adult. The guardian is the person who has legal responsibility for the claimant's business affairs.

Crime Information Complete all areas that apply to the incident which led to the filing of this claim.

Injury Information List the injuries suffered as a result of the crime and attach all itemized medical statements. List the hospital (if applicable) and/or the victim's treating physician or other medical professional. If medical treatment was not rendered, put N/A.

Employment Information (Complete only if applying for reimbursement of wages or loss of support). Employed people who miss work after being a victim of a violent crime may qualify for reimbursement of lost wages for the period of time he/she was recovering from the injuries, provided the crime disabled the person from working and the disability can be verified by a physician and by the victim's employer. There can be no compensation for loss of wages if the victim's employer paid him/her for the time off, regardless of the source of payment. Loss of support for dependents of a deceased victim can be compensated if there is documentation that collateral sources (i.e., Social Security and Life Insurance) are less than the net income provided by the victim prior to his/her death. If the victim was self-employed when the crime occurred or if taxes were not withheld by the employer, tax returns for the past three years will be required before work loss or loss of support can be considered. Work loss is computed based on the disability time specified by the physician and employer.

Expenses Being Claimed This area helps us to determine what documentation will be needed in order to make a decision on your claim.

Information Source This helps to determine where to focus outreach efforts in the future.

Offender Information Complete this information if you know the name of the offender(s). If the offender is unknown, write UNKNOWN.

Insurance Information Carefully follow instructions on the claim form for each area. If you do not have certain types of insurance, put N/A in the blank spots.

Limits of Compensation

The sum of all payments made to individual claimants and service providers on behalf of one victim may not exceed $20,000.00. In addition to the initial award of $20,000.00, an additional $20,000.00 may be available for work loss or loss of support. In no event shall the sum of all payments exceed $40,000.00.

OFFICIAL CLAIM FORM

CRIME VICTIMS COMPENSATION PROGRAM

Please return to: District Attorneys Council
421 NW 13TH St., Suite 290
Oklahoma City, OK 73103-3710
405-264-5006 (OKC) or 1-800-745-6098 (Toll-Free)
Fax: 405-264-5097
http://www.ok.gov/dac/

To Be Completed By OCVCB
Claim #_____
District #_____
V/W Coord. F/R_____

To Be Completed By VWC
Mailed to Claimant on ___/___/___
VWC Initials _____
Date Rec'd from Clmt.___/___/___

Please Print

Information on the Victim

Name _____
Last First MI
Mailing Address _____

_____
Street Address (if different)_____
City _____ **State** _____
Zip Code_____ **Phone** _____
Date of Birth _____ **Marital Status** _____
Age When Crime Occurred _____
Sex _____ **Social Security #** _____
Race (request for race is for statistical purposes only)
☐ American Indian or Alaska Native
Tribal Affiliation _____ ☐ Asian or Pacific Islander
☐ Black ☐ Hispanic ☐ White ☐ Other _____
Disabilities Prior to Victimization _____
_____
Dependents Names and Ages _____
_____

Information on the Claimant**

(Not the defendant's info - See note below)

Name _____
Last First MI
Mailing Address _____

_____
Street Address (if different) _____
City _____ **State** _____
Zip Code _____ **Phone** _____
Date of Birth _____ **Marital Status** _____
Sex _____ **Social Security #** _____
Relationship to Victim _____
Employer Name _____
Mailing Address _____
City _____ **State** _____
Zip Code _____ **Phone** _____

Information on Contact Person

(Do not list the Victim or Claimant or anyone living in the household)

Name_____
Last First MI
Street Address_____
Mailing Address_____
City_____State_____
Zip Code _____ Phone ( )_____
Relationship to Victim _____
☐ Check here if contact person is a Tribal Victim Advocate

Guardian Information

(Complete only if Claimant is a child or incapacitated adult)

Name_____
Last First MI
Social Security Number _____
Street Address _____
Mailing Address_____
City_____ State_____
Zip Code _____ Phone ( )_____
Relationship to Victim _____

**The Claimant is the person requesting compensation. If the victim is an adult who is able to care for himself/herself, put "Same as Victim" here. See instructions for a list of persons eligible to be a claimant.

Revised February, 2012

Information about the Crime

What crime was committed which led to the filing of this claim (select one):

___Armed Robbery
___Arson (does not include personal property)
___Assault
___Child Physical Abuse
___Child Sexual Abuse (under age 16)
___Domestic Violence/Spouse Abuse
___Domestic Violence Homicide
___DUI Homicide
___DUI Injury
___Homicide
___Kidnapping
___Leaving the Scene (auto/pedestrian incidents)
___Negligent Homicide
___Sexual Assault (16 years or older)
___Shooting with Intent to Kill
___Terrorism/Mass Casualty Incident

Date of Crime_____ Time:_____

If victim is a child, when was the crime disclosed by the child to an adult:
Date:_____ Time:_____

County/City of Crime_____

Location of Crime (check primary location)
___Bar or Club
___Business (other than victim's workplace)
___Rural Area
___Someone else's apartment/home
___Street
___Vehicle
___Victim's workplace
___Victim's own apartment/home
___Other (describe)_____

When was the crime reported to the police?
Date:_____ Time:_____

What agency was the crime reported to?
_____

Who reported the crime?
_____

Information about the Victim's Injuries

List the injuries caused by the crime (if more space is needed, continue on back of page):

List doctors and hospitals where the victim was treated after the crime (attach itemized statements):

Funeral Home (if applicable)_____

Victim's Employment Information

Employer_____

Address_____

City_____State_____

Zip Code_____Phone ( )_____

Supervisor's Name_____

Occupation_____

Starting Date_____ Ending Date_____

How much work did the victim lose because of injuries relating to the crime?_____ days

What was the victim's weekly take-home pay prior to the crime? $_____ per week

When is the victim scheduled to return to work?
_____

What is the name of the doctor that released the victim to return to work?_____

If self-employed, tax returns for the last three years will be required before work loss can be considered.

Expenses Being Claimed

___**Funeral**
___**Future Economic Loss** (submit estimates)
___**Income Loss** (victim/caregiver submit last pay stub)
___**Loss of Support** (if victim is deceased)
___**Medical** (submit itemized statement)
___**Dental** (submit itemized statements)
___**Rehabilitation** (physical or occupational therapy)
___**Counseling** (for victim only)
___**Grief Counseling** (for family of homicide victims)
___**Traditional American Indian Svs.** (submit receipts)
___**Replacement Services** (submit receipts)
___**Homicide Crime Scene Cleanup** (submit receipts)
___ **Impound fees** (submit receipts)

Information Source

How did you ***first*** find out about Victims Compensation?
___District Attorney
___Victims' Assistance Program
___Tribal Service Agency or Tribal Law Enforcement
___ Police / Sheriff / Highway Patrol
___ Medical Service Program
___ Medical Examiner's Office
___ Brochure / Poster ___ Internet Search
___ TV ___Radio ___Billboard ___ Newspaper
___ Other (please list)

Offender Information (if known)

List those who committed the crime(s) which led to the filing of this claim:_____

_____

Relationship of offender to victim (if any):

_____

Has there been an arrest? ___ Yes ___ No

Have charges been filed? ___ Yes ___ No

If charges were filed, what is the Criminal Case Number (if known) _____

Who was charged with the crime:

_____

_____

Insurance Information

Is there any insurance coverage to assist with expenses being claimed? ___ Yes ___ No. If yes, please list all insurance coverage.

Health ***(complete if medical is being claimed)***
Company_____
Agent Name _____
Phone # ( )_____
Policy Number _____

Life Insurance ***(complete if victim is deceased)***
Company_____
Amount Received $_____
Phone # ( )_____
Policy Number _____
Beneficiary _____
Relationship to victim_____
Phone # ( )_____
Address_____
City _____ State_____ Zip_____

Car Insurance ***(complete if the crime was vehicle related)***
Company_____
Amount Received $_____
Agent Name _____
Phone # ( )_____
Policy Number _____
Effective Date_____

Other Insurance ***(Example: Medicaid)***
Company_____
Amount Received $_____
Agent Name _____
Phone # ( )_____
Policy Number_____
Address_____
City_____ State_____ Zip _____

Attorney Information *(if one has been hired)*

Is the victim or claimant thinking of filing a ***civil*** lawsuit against anyone because of this crime (a lawsuit other than the criminal case that the D.A.'s office may be pursuing)? ___Yes___No.

Attorney Name_____
Address_____
City_____ State_____ Zip_____
Phone # ( ) _____

FILING DEADLINE

The Crime Victims Compensation form must be received in the Oklahoma Crime Victims Compensation Board office within one (1) year of the date of the incident or death of the victim, regardless of whether you have all of the bills and supporting documentation attached to the claim. The one year deadline may be waived up to two (2) years. In child sexual abuse cases, claims will be accepted past the two (2) year deadline.

CONFIDENTIALITY OF RECORDS

All records and information given to the Board to process a claim on behalf of a crime victim shall be confidential, pursuant to 21 O.S. 142.9 (G) of the Oklahoma Statutes.

WITH MY SIGNATURE BELOW

I agree that I have read and understand all instructions and eligibility requirements and agree that all unpaid bills or portions thereof for services conducted for the victim be paid by the Oklahoma Crime Victims Compensation Board directly to the supplier. Further, I swear that the information contained in this claim is true, and I understand that the filing of a false claim for compensation is a misdemeanor and shall be punishable by a fine not to exceed one thousand dollars ($1,000.00) or by imprisonment in the county jail for a term not to exceed one (1) year or both such fine and imprisonment. In the event I receive compensation for my injuries from another source, after receiving an award from the Victims Compensation Board, I understand that I am responsible for reimbursing the Victims Compensation Board to the extent the Board awarded compensation to me. Also, if I file a lawsuit against the defendant or another party, I agree to notify the Victims Compensation Board immediately.

_____

Signature of Victim or Claimant

_____

Date Signed

RELEASE OF INFORMATION

I hereby authorize:

* any hospital;
* physician;
* attorney;
* any person who treated or examined the victim;
* undertaker or other person rendering funeral services;
* any employer of the victim;
* any police, municipal or public authority;
* Social Security Administration;
* Department of Human Services;
* any federally funded agency;
* any insurance company; and
* any organization having knowledge of this claim,

to release any information with respect to the incident leading to the victim's personal injury or death and the claim made herewith for benefits to the Oklahoma Crime Victims Compensation Board or the District Attorney's Office Victim-Witness Staff.

_____

Signature of Victim or Claimant

_____

Date Signed

BY STATE LAW, YOU MUST BE ADVISED OF THE FOLLOWING

The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

_____

Signature of Victim or Claimant

_____

Date Signed