Pennsylvania Commission on Crime and Delinquency

Office of Victims' Services **Victims Compensation Assistance Program**

Mailing Address:
P.O. Box 1167
Harrisburg, PA 17108-1167

Street Address:
3101 North Front St.
Harrisburg, PA 17110

Phone and Fax Numbers:
(800) 233-2339
(717) 783-5153
(717) 787-4306 (fax)

Victims Compensation Assistance Program Short Form

THE VICTIMS COMPENSATION ASSISTANCE PROGRAM HELPS VICTIMS AND THEIR FAMILIES EASE THE FINANCIAL BURDENS THEY MAY FACE AS A RESULT OF A CRIME.

PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THIS FORM.

You may be eligible for compensation if:

- **The crime occurred in Pennsylvania.**
- **The crime was reported to the proper authorities within 3 days OR a Protection From Abuse order was filed within 3 days of the incident.**
- **You cooperate with the law enforcement authorities investigating the crime, the courts, and the Victims Compensation Assistance Program in processing the claim.**
- **The claim is filed within 2 years after the crime (there are exceptions when the victim is a child).**
- **You have paid or owe at least $100 of any combination of the expenses listed below. If you are age 60 or over, there is no minimum loss requirement.**

You may be awarded compensation for:

- **Medical Expenses**
- **Counseling Expenses**
- **Loss of Earnings**
- **Loss of Support**
- **Stolen cash if your main source of income is Retirement/Pension/Disability or Court-Ordered Support**
- **Relocation Expenses**
- **Funeral Expenses**
- **Crime-Scene Cleanup**
- **Transportation Expenses**
- **Childcare/Home Healthcare Expenses**

The Program does not cover:

- **Pain and suffering.**
- **Stolen or damaged property (except replacement of stolen or damaged medical devices).**

A maximum award usually will not exceed $35,000, however, certain benefits, such as counseling and crime-scene cleanup are over and above the $35,000 maximum. In addition, limits apply to many individual benefits within the overall $35,000 maximum.

You may be determined ineligible or your award may be reduced if the victim was engaged in illegal activity that caused the crime.

In certain circumstances, others (including family members) may be eligible for compensation.

IMPORTANT NOTE: You do not have to wait until the trial is over or all of your bills are received in order to file a claim.

General instructions for submitting your claim:

- **Please print clearly or type the claim form.**
- **Fill in all spaces that apply to your claim.**
- **Sign the Acknowledgement and Reimbursement Agreement and the Authorization to Obtain information sections on the back of the claim form (2 separate signatures).**
- **Separate the claim form from this cover sheet. Keep this portion of the form for your records.**
- If you would like assistance in filing your claim, please contact the agency listed in the **Victim Service Program Information Section** of this form.

  If there is no agency listed for you to contact, please complete and mail this form to the address below. A Victims Compensation Assistance Program staff person will contact you by telephone soon after the claim is received.

Victims Compensation Assistance Program
P.O. Box 1167
Harrisburg, PA 17108-1167

If you have questions regarding the Compensation Program, or about the completion of this form, please call 1-800-233-2339.

_____
Date Claim submitted

Victims Compensation Assistance Program Large Print Short Form

For Official Use Only

Claim #_____

Check as many as apply

☐ Personal Injury ☐ Death ☐ Stolen Benefit Cash

Victim Information

Name_____Date of Birth____/___/___ SS#_____

Address_____City_____

State_____ Zip Code_____County_____

Daytime Phone_____

Claimant Information

If victim is the claimant, write "SAME." If someone other than victim is filing, complete the entire section.

Name_____Date of Birth____/___/___ SS#_____

Address_____City_____

State_____ Zip Code_____County_____

Daytime Phone_____Relationship to Victim_____

Crime Information

Date of Crime___/___/___ Date Reported to Police___/___/___or Date PFA filed___/___/___

Did the crime involve a motor vehicle? ____yes ____no

Location of crime (street name and number)_____

City_____State _____ County _____

Police Incident #_____ Police Department_____

Person who committed crime_____

1. Were you injured as a result of the crime? ☐ yes ☐ no
2. Did you incur medical or counseling expenses due to your injuries? ☐ yes ☐ no
3. Do you have insurance to cover your medical or counseling expenses? ☐ yes ☐ no
4. Were you employed at the time of the crime? ☐ yes ☐ no
5. Did you miss work and lose pay because of the crime injuries? ☐ yes ☐ no

Crime Information Continued

6. Did you receive any of the following because of the injury? ☐ yes ☐ no

If yes, check all that apply.

☐ Vacation/Annual/Sick/Personal Pay ☐ Soc. Sec. Benefit ☐ Disability Pay ☐ Other

7. Did you have money stolen from you? ☐ yes ☐ no amount of cash stolen $_____

Is one of the following your main source of income? ☐ yes ☐ no

If yes, check all that apply.

☐ Soc. Sec. Benefit(s) ☐ Retirement/Pension(s)

☐ Court Ordered Child/Spousal Support ☐ Disability

Do you have homeowner's or renter's insurance? ☐ yes ☐ no

Are you required to file IRS tax returns? ☐ yes ☐ no

8. Are you filing for funeral expenses for the victim? ☐ yes ☐ no

Did you receive any money/benefits due to the death of the victim? ☐ yes ☐ no

(for example: life insurance, veterans benefits, social security)

Were you or others financially dependent upon the homicide victim? ☐ yes ☐ no

9. Did you need to relocate because of the crime? ☐ yes ☐ no

10. Are you filing for crime-scene cleanup expenses? ☐ yes ☐ no

11. Was this a crime of domestic violence? ☐ yes ☐ no

12. Did the crime happen at work? ☐ yes ☐ no

Briefly describe crime and injuries:

_____

_____

_____

_____

_____

_____

_____

A claim may be determined ineligible or an award may be reduced if the victim was engaged in illegal activity that caused the crime.

Victim Statistical Information

The following information is used for statistical purposes only. The submission of information for this section is strictly voluntary.

☐ White ☐ Hispanic ☐ Asian/Pacific Islander

☐ Black ☐ American Indian/Alaskan Native ☐ Other

Handicapped? ☐ Yes ☐ No If yes, nature of handicap_____

Representation By Other(s)

Are you represented in this matter by an attorney?

In filing this compensation claim? ☐Yes ☐ No In a civil lawsuit? ☐Yes ☐ No

In an insurance action? ☐Yes ☐ No

Victim Service Program Information

The agency listed here provides a full range of assistance in filing your claim.

If no agency is listed, please call (800) 233-2339 for assistance.

Who referred you to the Compensation Program?

☐ Hospital ☐ Prosecutor ☐ Poster/Brochure ☐ Police

☐ Victim Service Program ☐ Other (Identify)_____

Acknowledgement and Reimbursement Agreements

This acknowledgement must be signed before the claim can be processed.

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 30 days from the date of the decision and I may file a supplemental claim. I must prove the exact amount of my losses before the Program will consider awarding compensation from the Crime Victim's Compensation Fund. My claim may be denied if I do not cooperate with the Program and its agents 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 under Section 1303 of the Crime Victims Act. If I were to make a false statement in this claim form with an intent to mislead the Program, it would be a criminal offense punishable as a misdemeanor under 18 Pa. C.S. §4904.

I understand that the Crime Victim's Compensation Fund is the payor of last resort. I specifically agree to inform the Program of and repay to the Commonwealth 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, including any award for pain and suffering. 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.

_____

Claimant's Signature Date

Authorization to Obtain Information

This acknowledgement must be signed before the claim can be processed.

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 Office of Victims' Services, Victims Compensation Assistance Program, any and all information in their possession with respect to the incident that is the basis for this claim.

_____ _____

Claimant's Signature Date

_____ _____

Victim's Signature (if age 14 or over) Date