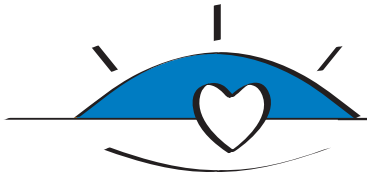

SURVIVOR BENEFITS

APPLICATION

JD-VS-8SB 10/12

OFFICE OF VICTIM SERVICES

Focusing on a brighter future

We understand that this is a very difficult time for you and your family. We are here to help. If you have any questions about filling out this application or the Compensation Program, please call us toll-free at 1-888-286-7347. Please know that it is important that you tell us if your contact information changes. If we cannot reach you, your claim may be closed or you may miss important deadlines set by state law.

SECTION 1 - VICTIM INFORMATION

Name of victim (last, first, middle) | Birth date | Age

Address | City | State | Zip

Gender: ❍ Female ❍ Male ❍ Other _____

SECTION 2 - CLAIMANT INFORMATION

The claimant is the person who has expenses because of the crime. Parents and legal guardians of a minor child (under 18 years old) and legal guardians of an incapacitated adult must also fill out Section 3. If you are applying for loss of support for minor child(ren) of the victim, please fill out Section 3 and Section 7.

Name of claimant (last, first, middle) | Birth date | Age

Address | City | State | Zip

Home telephone | Work telephone | Cell phone | Email

Primary language spoken | Gender: ❍ Female ❍ Male ❍ Other _____

Relationship to victim:

❍ child ❍ spouse ❍ parent ❍ grandchild ❍ grandparent ❍ spouse's parent ❍ stepparent

❍ brother ❍ sister ❍ half-brother ❍ half-sister ❍ stepchild ❍ adopted child ❍ party to a civil union

❍ administrator of the estate ❍ other _____

An adult claimant, the parent/legal guardian of a minor child (under 18 years old), or the legal guardian of an incapacitated adult ***must sign*** *Section 12 of this application. Applications that are not signed will be returned.*

SECTION 3 - PARENT/LEGAL GUARDIAN INFORMATION

This section is for parents and legal guardians of children under 18 years old and legal guardians of an incapacitated adult. If you have your own expenses because of the crime, please fill out another application and list yourself as the claimant. (Legal guardians or conservators must provide a copy of the court order.)

Name of parent or legal guardian (last, first, middle) | How are you related to the claimant?

Address | City | State | Zip

Home telephone | Work telephone | Cell phone | Email

Primary language spoken | Gender: ❍ Female ❍ Male ❍ Other _____

SECTION 4 - ATTORNEY REPRESENTATION

Please check if an attorney is representing you on this application, a civil lawsuit, or both and provide the attorney's contact information. ❍ Representing me on this application ❍ Representing me in a civil lawsuit

Name of attorney (last, first, middle) | Name of firm

Address | City | State | Zip

Work telephone | Fax number | Juris number

SECTION 5 - STATISTICAL INFORMATION

How did you find out about the Victim Compensation Program?

❍ community advocate
❍ family member
❍ friend/acquaintance
❍ hospital
❍ Infoline 211
❍ medical provider
❍ mental health provider
❍ Office of Adult Probation
❍ OVS victim advocate
❍ OVS web page
❍ police
❍ poster/brochure
❍ private attorney
❍ prosecutor/state's attorney
❍ public service announcement
❍ telephone book
❍ other _____

Statistics are voluntary and needed for federal reporting requirements.

❍ white
❍ hispanic
❍ asian
❍ other
❍ black/african american
❍ native hawaiian/pacific islander
❍ american indian/alaskan native
❍ unknown

SECTION 6 - CRIME INFORMATION

Please fill out this section.

Type of crime: ❍ homicide ❍ dui ❍ hit and run ❍ other _____

Briefly describe the crime: _____

_____

_____

_____

Date of crime | Address and city or town where crime happened

Date crime was reported to police | Police department crime was reported to

Police department incident number | Name of police officer investigating the crime

Was the crime reported to the police within 5 days? ❍ yes ❍ no (If no, please explain) _____

_____

_____

Was someone arrested for the crime? ❍ yes ❍ no ❍ unknown _____
Name of person(s) arrested, if known

Did the person(s) arrested go to court? ❍ yes ❍ no ❍ unknown _____ _____
If yes, court location | Docket number, if known

SECTION 7 - LOSS OF FINANCIAL SUPPORT

Are you applying for Loss of Support Compensation? ❍ yes ❍ no

Please list all of the financial dependents (spouse and children) of the victim. For a child, attach a copy of the child's birth certificate. For a spouse, attach a copy of the marriage certificate. (Attach additional pages, if needed).

Dependent's name	Address (street, city, state, zip)	Relationship to victim	Birth date (mm/dd/yyyy)	Guardian (if minor)

SECTION 8 - COUNSELING/MEDICAL EXPENSES

Please fill out this section if you are applying for medical/mental health benefits. List all of the hospitals, doctors, counselors, ambulance services, and others who provided treatment or services because of the crime and list the prescriptions (drugs) you were given because of it (attach additional pages, if needed) and include copies of any crime related bills.

Provider	*Telephone*	*Address*	*City*	*State*	*Zip*

SECTION 9 - COURT RELATED BENEFITS

Please fill out this section if you have expenses for attending court proceedings. State law defines relatives of the victim that are eligible for this benefit. Please check your relationship to the victim below. If your relationship is not listed below, you are not eligible for this benefit.

❍ child (natural, step, and adopted) ❍ spouse ❍ parent ❍ grandchild ❍ grandparent
❍ spouse's parent ❍ stepparent ❍ brother (natural and half) ❍ sister (natural and half)

Are you applying for mileage or travel expenses to attend court proceedings? ❍ yes ❍ no
Are you applying for lost wages to attend court proceedings? ❍ yes ❍ no (If yes, please fill out below.)

Employer Name	Contact name	Telephone number	
Address	City	State	Zip

SECTION 10 - FUNERAL EXPENSES

Please fill out this section if you are applying for reimbursement of funeral expenses. If an estate has been opened, the administrator of the estate must file an application for benefits. Anyone who paid all or a portion of the funeral expenses would have to apply to the estate for reimbursement. Please attach a copy of the funeral bill and death certificate. The estate administrator must also attach a copy of the court appointment.

Name of funeral home	Contact name	Telephone number	
Address	City	State	Zip

SECTION 11 - INSURANCE & OTHER FINANCIAL RESOURCES

This section must be filled out. Please check yes or no for each type of victim compensation benefit listed below that you are applying for. If you are applying for that benefit, you must check yes or no for each of the financial resources below that benefit that you have or may be able to get paid by. If the financial resource is not one that you can get paid by, please check no. You must contact us if any of the financial resources checked as No become available in the future.

1. Are you applying for Medical or Mental Health Benefits? ❍ yes ❍ no

Financial Resources	Yes	No	*Provider Name*	*Address*	*Telephone*	*Account No.*
Department of Social Services (MEDICAL)	❍	❍				
Health Insurance (PRIMARY)	❍	❍				
Health Insurance (SECONDARY)	❍	❍				
Health Savings/Spending Accounts						
Flexible Spending Account	❍	❍				
Health Reimbursement Account	❍	❍				
Health Savings Account	❍	❍				
Medicare	❍	❍				
Veterans Administration	❍	❍				

2. Are you applying for Crime Scene Cleanup Benefits? ❍ yes ❍ no

Financial Resources	Yes	No	*Provider Name*	*Address*	*Telephone*	*Account No.*
Homeowners Insurance	❍	❍				
Renters Insurance	❍	❍				

3. Are you applying for Funeral Benefits? ❍ yes ❍ no

Financial Resources	Yes	No	*Provider Name*	*Address*	*Telephone*	*Account No.*
Department of Social Services (FUNERAL)	❍	❍				
Did the victim have burial or funeral insurance?	❍	❍				
Workers Compensation (CRIMES WHILE AT WORK)	❍	❍				

4. Did the incident involve a Motor Vehicle? ❍ yes ❍ no

Financial Resources	Yes	No	*Provider Name*	*Address*	*Telephone*	*Account No.*
Auto Insurance	❍	❍				
Claims against Other Parties' Auto Insurance	❍	❍				
Did you receive an auto insurance settlement?	❍	❍				
Did you file a Dram Shop Liability claim?	❍	❍				

5. You must check yes or no for each of the sources listed below.

Other Sources of Income	Yes	No	*Court Location and Docket Number*
Was restitution ordered by the court?	❍	❍	
Did you or will you file a lawsuit?	❍	❍	

If the victim had life insurance, are you the beneficiary? ❍ yes ❍ no

Provider Name	*Address*	*Telephone*	*Policy No.*
Other			
Other			
Other			
Other			

SECTION 12 - STATEMENT OF FACTS AND AUTHORIZATION

I certify that the information in this application for compensation is true to the best of my knowledge, information, and belief and I give permission to any hospital, physician(s) or other person(s) who attended, examined, or gave services to _____ and _____, any employer(s) of the victim or claimant, any police or other municipal authority or agency, or public authorities including state and federal revenue services, any insurance company or organization having knowledge of the incident to give to OVS or its representative any and all information regarding the incident leading to the victim's personal injuries and the victim's or family member's application for compensation. A copy of this authorization will be considered as effective and valid as the original.

victim's name *claimant's name*

I, _____ give permission to OVS to disclose any information in its records, including confidential information, to the offices of the Court Support Services Division, the State's Attorney, the Attorney General and to private attorneys retained by OVS or the victim, and to communicate freely with them when necessary (Sections 54-208(e), 54-212, and 54-215 of the Connecticut General Statutes).

claimant's name

I understand that I must notify OVS if I file a lawsuit against whoever is responsible for the injury or death for which OVS paid the award within 30 days of the filing of the action in court. If I recover money from the lawsuit, either by a judgment or by settlement, I understand that OVS is entitled by law to 2/3 of the amount OVS paid. (Section 54-212 of the Connecticut General Statutes). If I have filed a lawsuit, I agree to provide a copy of the writ, summons, and complaint to OVS immediately.

I understand that OVS will have the right to bring a lawsuit in my name against whoever is responsible for the injury or death for which the money was paid. I also understand that if OVS recovers money from the lawsuit, it is entitled by law to keep 2/3 of the amount paid, plus costs and interest. OVS will pay me any balance over that amount (Section 54-212 of the Connecticut General Statutes).

I understand that if I receive money from any other sources, including payments from state or municipal agencies, insurance benefits, or workers' compensation as a result of the criminal incident, OVS is entitled by law to 2/3 of the amount OVS paid (Section 54-212 of the Connecticut General Statutes).

I understand that if the court orders restitution to the victim for expenses paid by OVS, OVS is entitled to receive full reimbursement, unless the court orders differently (Section 54-215 of the Connecticut General Statutes).

I also understand that my providers may be reimbursed directly for debts that I owe.

Applicant signature **Date**

*The parent or guardian **must sign** if the claimant is a minor or incompetent adult. The estate administrator must sign the application with the full appointment title assigned by the probate court. Applications that are not signed will be returned.*

Please return completed application to:
Office of Victim Services
225 Spring Street, 4th Floor
Wethersfield, CT 06109

Contact OVS at:
1-888-286-7347 (Toll-free)
860-263-2761
www.jud.ct.gov/crimevictim

FOR OFFICE USE ONLY Claim Number Claims Examiner