pennsylvania
VICTIMS COMPENSATION
ASSISTANCE PROGRAM

Office of Victims' Services

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

Street Address:
3101 North Front Street
Harrisburg, PA 17110

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

Website: www.pacrimevictims.com

You may either complete and mail this form to the address listed above or file online at https://www.dave.state.pa.us/daveprod.

Victims Compensation Assistance Program Short Form

Please read the following 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 crime.
- You cooperate with 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 discovery of 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
- Relocation Expenses
- Funeral Expenses
- Crime-Scene Cleanup
- Transportation Expenses
- Childcare
- Home Healthcare Expenses
- Stolen Cash (If your main source of income is Social Security Retirement, Disability Income, Supplemental Income, Survivor Benefits, Retirement/Pension(s), Disability or Court-Ordered Child/Spousal Support.)

An overall maximum award shall not exceed $35,000; however, certain benefits, such as counseling and crime-scene cleanup, may be paid over and above the maximum. Monetary limits apply to most benefits.

The Program does not cover:

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

A claim may be determined ineligible or an award may be reduced if the conduct of the victim contributed to the injury.

Victims Compensation Assistance Program Short Form

Your cooperation with the Program and the submission of complete and accurate information will assist us in processing your claim in a timely manner.

IMPORTANT NOTE: You do not have to wait until the trial is over or all of your bills are received to file a claim. You may file a claim if there is no known offender or if an arrest has not been made.

General instructions for submitting your claim:

- Please print clearly.
- Complete only those sections that apply to your claim.
- Provide an accurate address and a safe phone number where you can be reached during the day.
- Provide as many of the requested documents as you can when filing your claim. You may submit your claim even if you do not have all the required documents. The Program may request additional information once the claim is received.
- Sign the **Acknowledgement and Reimbursement Agreement** and the **Authorization to Obtain Information** sections on the back of the claim form.
- If you would like assistance in filing your claim you may contact the Victim Service Program listed on the back of this form. If no agency is listed, you may contact the Victims Compensation Assistance Program at (800) 233-2339 for assistance.

Please Note: It is important that you inform the Program if you change your address or phone number. To process your claim, we must be able to contact you.

The Victims Compensation Assistance Program is the payer of last resort. This means your award will be reduced by the monies you receive from any other source as a result of the crime, such as insurance, restitution, and civil suit settlements, including monies received for pain and suffering.

We will make every effort to process your claim as quickly and efficiently as possible.

Date claim mailed_____ (keep this page for your information.)

Cut along this line and maintain this portion for your records.

Victims Compensation Assistance Program Short Form

(For Official Use Only) Claim # _____

Please complete this entire section of the form. To process your claim, we must be able to contact you.

Victim Information

☐ Male ☐ Female

Name _____ Date of Birth ____/____/____ SS# _____

Address _____ City _____ State _____ Zip Code _____

County _____ Safe Daytime Phone _____ Other Safe 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 _____ Safe Daytime Phone _____ Other Safe Phone _____

☐ Male ☐ Female Relationship to Victim _____

Crime Information

Date of Crime ____/____/____ Date Reported to Police ____/____/____ or Date PFA filed ____/____/____

Was this a crime of domestic violence? ☐ yes ☐ no Did the crime involve a motor vehicle? ☐ yes ☐ no

Did the crime occur at work? ☐ yes ☐ no

Location of crime (street name and number) _____

City _____ State _____ County _____

Police Department _____ Police Incident # _____

Person(s) who committed the crime _____

Briefly describe crime and injuries: _____

_____

Please complete the section(s) for the benefit(s) you are applying for and provide as much of the requested information that you can at this time. The Program may request additional information once the claim is received.

Benefit: Medical/Counseling Expenses

Did you incur medical expenses? ☐ yes ☐ no

Did you incur counseling expenses? ☐ yes ☐ no

Provide itemized medical or counseling bills.

Do you have insurance to cover your medical/ counseling expenses? ☐ yes ☐ no

If **yes,** provide insurance benefit statements showing payment or rejection of payment for these bills.

Benefit: Funeral Expenses/Loss of Support

Did you incur funeral expenses? ☐ yes ☐ no

Did you receive any monies due to the death? (Veteran's benefits, life insurance, Social Security) ☐ yes ☐ no

Were you or others financially dependent on the deceased victim? ☐ yes ☐ no

Provide copies of the itemized funeral bills/receipts and statements of any benefits received.

Benefit: Loss of Earnings

Did you miss work and lose pay? ☐ yes ☐ no

Dates you missed work ____/____/____ to ____/____/____

Employer's name, address, and phone number:

_____

_____

_____

Doctor's name, address, and phone number who can verify you missed work because of the crime:

_____

_____

_____

Benefit: Stolen Cash

Did you have money stolen from you? ☐ yes ☐ no

Amount of money stolen $ _____

One of the following benefits must be your main source of income to file for stolen cash. Check all that apply.

☐ Social Security Benefit ☐ Retirement/Pension(s)

☐ Disability ☐ Court-Ordered Child/Spousal Support

Provide a copy of your monthly benefit statement for the month and year of the crime.

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

If **yes,** provide a copy of your insurance declaration page.

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

If **yes,** provide a copy of your most recent tax returns.

Victims Compensation Assistance Program Short Form

Acknowledgement and Reimbursement Agreement

The Acknowledgement and Reimbursement Agreement must be signed before the claim verification process will begin.

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. I must prove the exact amount of my losses before the Program will consider awarding compensation from the Crime Victims Compensation Fund. I may file for reimbursement for additional expenses incurred relating to the crime. My claim may be denied if I do not cooperate fully with law enforcement agencies, the courts, and the Program 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 11.1303 of the Crime Victims Act. If I were to make a false statement in this claim form with the 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 Victims Compensation Fund is the payer 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.

X _____

Claimant's Signature Date

Authorization to Obtain Information

This Authorization to Obtain Information must be signed before the claim verification process will begin.

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 (print 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 crime that is the basis for this claim. Copies of this authorization may be used in place of the original.

X _____

Claimant's Signature Date

Representation by Others

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

Referral

Who referred you to the compensation program? ☐ Hospital ☐ Prosecutor ☐ Poster/Brochure

☐ Police ☐ Victim Service Program ☐ Other (Identify) _____

Victim Service Program Information

For assistance in filing your claim, please call the agency listed here.

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

Victim Statistical Information

The following information is used for statisticcal purposes only. This section is strictly voluntary.

Race:

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

Country of Birth _____

Do you have a disability?

☐ Yes ☐ No If yes, nature of disability: ☐ Physical ☐ Mental ☐ Developmental Disability

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