You must fill out each section completely to have your claim processed. You must include all necessary attachments.

Print Instructions | Clear ALL Data | Print Application

DO NOT WRITE IN THIS SPACE

CLAIM #_____

DATE RECEIVED _____

ALABAMA CRIME VICTIMS COMPENSATION COMMISSION

P.O. BOX 231267 ♦ MONTGOMERY, ALABAMA 36123-1267
(334) 290-4420
1-800-541-9388 (VICTIMS ONLY)
FAX (334) 290-4455

HOW DID YOU FIRST LEARN ABOUT THE ALABAMA CRIME VICTIMS COMPENSATION COMMISSION?

◯ Police Department ◯ Sheriff's Office ◯ District Attorney ◯ Lawyer ◯ Media (TV, Radio, Newspaper,etc.) ◯ Other _____

SECTION 1. VICTIM INFORMATION

Social Security Number | Date of Birth | First Name | Middle Name | Last Name

Street Address | City | State | ZIP Code

Home Phone | Work Phone | Wireless/Cell Phone | Other Phone

Marital Status
◯ Single ◯ Married
◯ Separated ◯ Divorced

Spouse's Name

Dependant(s) Please list their name(s), age(s), and how related to victim

THE FOLLOWING INFORMATION IS COLLECTED FOR STATISTICAL PURPOSES ONLY. IT IS VOLUNTARY AND APPLIES ONLY TO THE VICTIM.

For the purposes of this application, a handicapped person is one who;
1) has a physical or mental impairment which limits the capacity to work;
2) has a record of such impairment;
3) is perceived as having such an impairment.
WAS THE VICTIM HANDICAPPED PRIOR TO THE CRIME? ◯ YES ◯ NO

GENDER
◯ Male
◯ Female

RACE/ETHNICITY
◯ White ◯ Black
◯ American Indian/Alaskan Native ◯ Hispanic
◯ Asian/Pacific Islander ◯ Other

SECTION 2. CLAIMANT INFORMATION

Only complete if someone other than victim is filing claim.

Social Security Number | Date of Birth | First Name | Middle Name | Last Name

Street Address | City | State | ZIP Code

Home Phone | Work Phone | Wireless/Cell Phone | Other Phone | Relationship to Victim

SECTION 3. ELIGIBILITY CRITERIA

Was the incident reported to law enforcement within 72 hours?
◯ YES ◯ NO If NO, please explain why not.

Did the victim have any criminal charges pending against him/her at the time of the crime?
◯ YES ◯ NO If YES, please explain.

Did you file this claim within one (1) year of the crime?
◯ YES ◯ NO If NO, please explain why not.

Was the victim under the influence of alcohol or illegal drugs at the time of the crime?
◯ YES ◯ NO If YES, please explain.

You **must** notify the ACVCC of any address change. **CLAIMS MAY BE CLOSED WHEN THERE IS NO RESPONSE TO CORRESPONDENCE.**

Revision Date - August 2008

SECTION 4. CRIME, INJURIES, AND RELATED INFORMATION

Type of crime

◯ Assault ◯ Sexual Offense ◯ Murder ◯ Vehicular ◯ Other

Date of injury to victim

Date of death of victim

Location where crime occurred — City — County — State

In your own words, please provide a brief description of the crime. Attach additional sheets if needed.

Offender(s) - Please list name, birth date, and Social Security Number if known

Witness(es) - Please list name, address, and phone number

Law enforcement agency to which crime was reported — Agency phone number — Date reported — Time reported — Name of investigating officer(s)

Was the victim living in the same house as the offender **at the time of the crime?**

◯ YES ◯ NO

Is the victim living in the same house as the offender **now**?

◯ YES ◯ NO

Has a warrant been signed?

◯ YES ◯ NO If NO, please explain why not.

Did the victim know the offender?

◯ YES ◯ NO If YES, please explain.

Has an arrest been made?

◯ YES ◯ NO If NO, please explain why not. (If known)

Is the offender related to the victim?

◯ YES ◯ NO If YES, please explain.

SECTION 5. MEDICAL/PSYCHIATRIC EXPENSES

Copies of all itemized bills and insurance statements must be sent to the ACVCC.

Describe injuries the victim received

List all medical, psychiatric, dentist, ambulance, doctor, hospital, counselor, and other medical expenses related to injuries received

Biller's Name	Biller's Phone	Biller's Address	Charge	Insurance Paid	Claimant Paid	Victim Paid	Balance Due

SECTION 6. EMPLOYMENT INFORMATION

See instruction sheet for eligibility criteria. This section must be completed if lost wages are requested. A DOCTOR'S EXCUSE MUST BE PROVIDED TO THE ACVCC.
By completing this section you are giving the ACVCC permission to contact these employers to verify employment information and wages.

Employment information for ◯ Claimant ◯ Victim

Job Title

Employer Name

Employer Contact

Street Address

City — State — ZIP

Phone — FAX

Date Left Work — Date Returned to Work

Employment information for ◯ Claimant ◯ Victim

Job Title

Employer Name

Employer Contact

Street Address

City — State — ZIP

Phone — FAX

Date Left Work — Date Returned to Work

If self-employed, submit most recent income tax returns and other proof such as statements from those for whom work was performed showing amount(s) paid and date(s) worked for a period of at least 60 days prior to injury.

SECTION 7. INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION

Name of Insurance Company | Phone

Name of Agent | Policy Number

Type of Insurance ◯ Life ◯ Burial ◯ Medical ◯ Auto ◯ Other

Name of Insurance Company | Phone

Name of Agent | Policy Number

Type of Insurance ◯ Life ◯ Burial ◯ Medical ◯ Auto ◯ Other

Name of Insurance Company | Phone

Name of Agent | Policy Number

Type of Insurance ◯ Life ◯ Burial ◯ Medical ◯ Auto ◯ Other

Name of Insurance Company | Phone

Name of Agent | Policy Number

Type of Insurance ◯ Life ◯ Burial ◯ Medical ◯ Auto ◯ Other

If you received income from any of the following sources, please indicate the amount received each month.

Social Security | Social Security Disability | Welfare | Aid to Dependant Children | Workman's Compensation | Other

SECTION 8. FUNERAL/BURIAL EXPENSES

Attach copies of ALL funeral/burial bills.

If funeral/burial expenses were paid by any of the following sources, please indicate the amount each paid.

Claimant | Social Security | Burial Insurance | Life Insurance | Veterans Insurance | Other

Name of funeral home, cemetery, or monument company

Street Address

City | State | ZIP Code | Phone

Name of funeral home, cemetery, or monument company

Street Address

City | State | ZIP Code | Phone

SECTION 9. OTHER EXPENSES

See instruction sheet for details on what may be requested. All expenses are subject to approval by the ACVCC.

FUTURE ECONOMIC LOSS - If the victim or victim's dependents will have additional future losses as a result of the crime, please list what you think those losses might include and an estimate of the cost of those losses.

Expense | Amount | Expense | Amount

REPLACEMENT SERVICES - If the victim or victim's dependents have had financial losses which they would not have had if the crime had not occurred, please list the service and the cost of replacement.

Expense | Amount | Expense | Amount

MOVING EXPENSES - In order to qualify for an award pursuant to this category, staying in your home must place you in direct danger or cause you to reasonably believe that you are in direct danger.

Expense | Amount | Expense | Amount

Expense | Amount | Expense | Amount

PROPERTY LOSS - If the victim had property taken by law enforcement or damaged during the victimization, please list the property and an estimate of its value.

Expense | Amount | Expense | Amount

Expense | Amount | Expense | Amount

SECTION 10. EMERGENCY AWARD

If you want to request emergency funds, please indicate the amount needed and explain why you feel you qualify for emergency funds.

SECTION 11. LAWSUIT RECOVERY

This section must be completed.

If the victim/claimant has filed a civil suit in connection with this case, please provide contact information for the attorney handling the civil suit.

Attorney Name

Street Address

City | State | ZIP Code | Phone

☐ **Check here if no civil suit has been filed.**

Alabama law requires that you give the Alabama Crime Victims' Compensation Commission written notice within 15 days of initiating any legal proceeding to recover restitution or damages.

ALABAMA CODE § 15-23-14(c).

Patient Authorization for Use and Disclosure of Protected Health Information

Name: _____ Social Security Number: _____ Date of Birth: _____

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 rendered a final decision for my compensation claim.

_____ _____
Patient Signature Date

_____ _____
Personal Representative (if applicable) Date

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

AUTHORIZATION MUST BE SIGNED BELOW

Service Provider Information Release: I hereby give permission to the ACVCC to release information or records about my application for assistance to service providers and their authorized representatives who represent information about the status of my pending claim. I understand that 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.

A copy of your valid, government-issued photo ID must be provided.
Failure to provide it will result in the non-approval of your claim.

Sign here if you DO NOT authorize the release of status information to service provider.

_____ _____
Victim or Claimant Signature Date

Financial Release: I hereby authorize any financial institution, any social service agency, any medical or mental health service provider or any state or federal governmental agency to release information concerning my financial status to the ACVCC. I hereby authorize my employer or former employer to release my employment information to the ACVCC.

Subrogation Agreement: I hereby agree to give the ACVCC written notice within 15 days of initiating any legal proceeding to recover restitution or damages that is related to my victimization. I agree to repay the ACVCC the amount of compensation that 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.

Authorized Parties: I hereby agree that the parties listed below are authorized to discuss this claim .

Name	Phone	Relationship	Name	Phone	Relationship

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. The undersigned swears or affirms that the information contained herein is true to his or her best knowledge. This signature authorizes the ACVCC to obtain all necessary information. I understand that the filing of a false claim is a Class C Felony offense in the State ofAlabama.

BY SIGNING THIS DOCUMENT, I CERTIFY THAT I HAVE READ THE ENTIRE APPLICATION AND AGREE TO COMPLY WITH ITS TERMS.

→ _____ _____
Victim or Claimant Signature APPLICATION MUST BE SIGNED Date

Victim must sign application unless the victim is deceased, incapacitated, or is a minor. Person signing application 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.

THE ACVCC MUST RECEIVE THIS SIGNED AND DATED ORIGINAL IN ORDER TO PROCESS YOUR CLAIM.

Print Application

ALABAMA CRIME VICTIMS COMPENSATION COMMISSION

If you have limited English proficiency, you have the right to language assistance and this language assistance will be provided to you free of charge.

P.O. BOX 231267
MONTGOMERY, ALABAMA 36123-1267
(334) 290-4420
1-800-541-9388 (VICTIMS ONLY)
FAX (334) 290-4455
www.acvcc.alabama.gov

Si usted ha limitado la pericia inglesa, usted tiene el derecho a la ayuda del idioma y esta ayuda del idioma será proporcionado a usted libre de la carga.

THE COMMISSION DOES *NOT* PROVIDE COMPENSATION FOR PROPERTY CRIMES, ACCIDENTS, IDENTITY THEFT, PAIN & SUFFERING OR ATTORNEY'S FEES.

No more than $15,000.00 may be awarded for any compensation claim.

ALABAMA CODE § 15-23-15(b).

COMPENSATION MAY BE AWARDED FOR:

A) **Medical expenses—**including doctor and hospital care, dental expenses, prescriptions, medical supplies, inpatient psychiatric care, etc. This does not include expenses covered by insurance. Victims may be eligible to receive 100% reimbursement for medical expenses he/she has paid for out-of-pocket.

B) **Rehabilitation expenses—**including vocational or physical therapy, if not covered by another source.

C) **Counseling expenses—**includes counselor, psychologist and/or psychiatrist fees for counseling services that are related to the victimization. Mental health providers must be properly licensed by the appropriate regulatory body in order for the Commission to consider their services for payment. Counseling is limited to 50 sessions per claim unless the Commission determines exigent circumstances exist. Single counseling sessions may be reimbursed at: **$80.00** per hour for licensed counselors and social workers; **$100.00** per hour for psychologists; **$125.00** per hour for psychiatrists; and **$60.00** per hour for group therapy.

D) **Work loss—**including the victim's/claimant's take-home weekly pay for a reasonable length of absence from work. There is a max of **$400.00** per week for work loss for a maximum of 26 weeks. You must provide a doctor's excuse to be eligible for lost wages.

E) **Funeral expenses—**including funeral home expenses, cremation, burial expenses including monument. There is a maximum of **$5,000.00**.

F) **Property expenses—**Compensation may be awarded for eligible property that is taken by law enforcement for evidence and/or property that was damaged during victimization. Security enhancements installed after victimization may be eligible. The maximum award is **$1000.00,** which includes a **$500.00** maximum for damaged clothing. Please contact the Commission for a list of specific items that may be eligible.

G) **Moving expenses—**including security deposits, utility deposits and the costs to move. It does not include rent payments. This is only considered in extreme circumstances in which the victim is in imminent physical danger and when the offense occurred at home. There is a maximum of **$1,000.00**.

H) **Future economic loss—**future or additional expenses or loss to victim or victim's dependents. Must be justified with explanation of how losses were calculated. There is a maximum of **$5000.00.**

I) **Replacement services loss—**expenses claimant would not have suffered had the victim lived. There is a maximum of **$1500.00.**

J) **Guardianship fees -** reimbursement for legal fees incurred by claimant to obtain guardianship of disabled or minor victim, if guardianship is awarded. There is a maximum of **$500.00** .

YOU MAY BE ELIGIBLE FOR COMPENSATION IF:

A) The crime was reported to law enforcement within **72 hours** (unless good cause can be shown for not doing so). Good cause must be submitted in writing.

B) The claim is filed within **one (1) year** of the date of the incident (unless good cause can be shown for not doing so). Good cause must be submitted in writing.

C) The victim suffered serious personal injury or death as a result of a criminal act**.**

D) The victim cooperated with law enforcement officials, the prosecutor's office, the courts and the Commission**.**

E) The victim was not engaged in illegal activity (example: drug activity) or was not in an illegal place of business (example: shot house) at the time of the incident**.**

F) The victim did not provoke, incite or willingly take part in the incident**.**

G) The victim was not convicted of a felony or criminally injurious conduct after applying for compensation**.**

H) The victim was not on probation, parole, work release or any type of custodial or non-custodial release for a violent felony conviction, at the time of his/her victimization**.**

I) The victim did not contribute to the victimization in any way**.**

J) The victim's presence in the United States of America was lawful. (Claimants/victims who are certified by federal authorities as victims of human trafficking shall be eligible for compensation benefits.)

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APPLICATION INSTRUCTIONS

Please carefully read these instructions before completing the application.

1. When completing this form, please type or print legibly, in ink.
2. Send copies of all bills, receipts, and insurance or benefit statements with the application. Also, you should send copies of additional bills as treatment continues. Only send medical bills and expenses related to the victimization. Until necessary documentation is received, that portion of your claim cannot be processed.
3. Your claim cannot be processed without a police report. The ACVCC will request a copy of your police report. If you have a copy of the police report, please send it in with your application. Doing so may shorten the processing time for your claim.
4. Promptly mail the application and all documents to the address on the form. There is a one-year deadline from the date of the crime for filing your claim.
5. If you need help with this form, please contact the Victim Service Officer (VSO) at your local District Attorney's office or a Specialist at the ACVCC at the number listed above.
6. If the ACVCC asks you for additional information, you should send it immediately. If the requested information is not received within forty-five (45) days, that portion of your claim may be declared ineligible.
7. Be sure the form is signed and dated. The ACVCC must receive a signed and dated original of this form in order to process your claim. Unsigned forms may be returned to you for signature, delaying the processing of your claim.
8. The contact information in SECTION 1 or SECTION 2 must be completed in order to process your claim. If the ACVCC is unable to contact you or there is no response to correspondence, your claim may be closed.
9. The demographic information requested in SECTION 1 (shaded box) is OPTIONAL. This information is collected for statistical purposes. You do not have to provide this information, although doing so may help the ACVCC better serve victims.
10. SECTION 2 should only be completed if someone other than the victim is filing a claim. A claimant may only apply in cases where the victim is deceased, incapacitated, or is a minor. The claimant must be the person legally authorized to act on the behalf of the victim. Documentation of this authority must be provided.
11. The questions in SECTION 3 must be answered for the ACVCC to process your claim.
12. The applicable information in SECTION 4 should be completed to the best of your ability. The questions in SECTION 4 must be answered for the ACVCC to process your claim.
13. The applicable information in SECTION 5 should be completed for any medical expenses incurred as a result of your victimization.
14. The applicable information in SECTION 6 should be completed if you want consideration of lost wages or economic loss incurred as a result of your victimization. You must provide a doctor's excuse to be eligible for lost wages.
15. The applicable information in SECTION 7 and SECTION 9 should be completed to the best of your ability.
16. The information in SECTION 8 should only be completed if the victim is deceased.
17. Complete SECTION 10 if you need emergency financial assistance.

    Emergency awards are for cases of dire economic need that result from violent crime victimization. These awards are usually granted for loss of income or moving expenses. If you are requesting an emergency award for loss of income, please attach a statement from your employer stating the time lost from work and your net (take-home) weekly pay. If you are requesting an emergency award for moving expenses, you must attach estimates or receipts for the requested items.

    Emergency awards are not usually considered for medical bills unless a service provider has refused treatment pending payment. Please have the service provider write a letter noting this, and provide a copy of the estimate.

    If you do not include these items, it will take longer to process your emergency award. There is a maximum of **$1,000.00.**
18. For SECTION 11, either provide the contact information for your attorney OR check the box stating that you have NOT filed any civil lawsuits in connection with this victimization.