



ATTORNEY GENERAL OF TEXAS

TEXAS CRIME VICTIMS' COMPENSATION PROGRAM APPLICATION

- **Nota: Si tiene alguna pregunta sobre esta solicitud o si la desea en español, favor de llamar al Programa de Compensación para las Víctimas de Crimen al (512) 936-1200 o (800) 983-9933.**
- Please read the directions on this page before completing the application. Reading these instructions will help you complete each section correctly.
- Include all the documentation you can. If you have a copy of the police report, protective order with affidavit, hospital or doctor bills, health insurance card, or auto insurance declaration page (if the crime is auto-related), be sure to send them with the application.
- If you require additional space on any section of the application, please attach a separate sheet of paper and include all the required information.
- If you do not have this documentation, do not wait to mail the application. Send the application as soon as you have completed it. Collect all additional information so that you will have it when we contact you.
- Keep this page so that you will have our address and phone number. Mail your completed application to:

Office of the Attorney General
Crime Victims' Compensation Program (011)
P.O. Box 12198
Austin, Texas 78711-2198

- If your address or phone number changes, it is important that you let us know. The toll-free number for victims, claimants and service providers is (800) 983-9933. Austin callers should use (512) 936-1200. For security reasons, the Crime Victims' Compensation Program does not routinely communicate with victims via email. In some cases where security is not an issue, the CVC Program may use email to inform a victim or claimant of the status of the claim.
- If you need help completing this application, contact your local law enforcement agency's Crime Victim Liaison or your local District Attorney's Victim Assistance Coordinator. The Crime Victims' Compensation staff is also available to help by phone, or you may access our website at www.texasattorneygeneral.gov to find more information on the program.

GENERAL INFORMATION

What is the Crime Victims' Compensation (CVC) Program?

- The CVC Program may provide financial assistance to victims of violent crime for related expenses that cannot be reimbursed by insurance or other sources.
- The Program is administered by the Office of the Attorney General and is committed to assisting victims and claimants who qualify. The information provided is meant to be generally informative, and the statutory requirements of the Texas Crime Victims' Compensation Act (Texas Code of Criminal Procedure, Chapter 56) and the rules set forth in Title 1 of the Texas Administrative Code, Part 3, Chapter 61, govern the Program.
- Money in the Victims of Crime Compensation Fund comes from fees paid by those convicted of a crime.

Keep this page for your records.

What are the basic eligibility requirements for Crime Victims' Compensation Program benefits?

- The victim must be a resident of Texas, a United States resident who is victimized while in Texas, a Texas resident victimized in another state or country that does not have a crime victim compensation fund, or certain other individuals.
- The crime must be reported to the appropriate state or local public safety/law enforcement agency within a reasonable period of time.
- The victim or claimant must cooperate with law enforcement officials in the investigation and prosecution of the case.

NOTE: If a Medical Forensic Sexual Assault Exam was conducted on or after September 1, 2015, payments for emergency medical care received at the same time as the exam may be available even when a victim does not report the crime or meet certain other eligibility requirements. For more information, please visit the Crime Victims' Compensation web page or call (800) 983-9933. See Section 2a of this application.

Who may be eligible for Crime Victims' Compensation Program benefits?

- Victims of violent crime who suffer physical or mental harm as a direct result of the crime.
- A victim's dependents, family or household members who qualify as claimants under the law.
- Someone authorized by the victim to act on his or her behalf.

Who is not eligible for Crime Victims' Compensation Program benefits?

- The offender, an accomplice of the offender or any person engaged in illegal activity at the time of the crime.
- Anyone injured as a result of a motor vehicle accident, except under certain circumstances provided by law.
- Benefits may be denied or reduced if the victim's or claimant's own behavior contributed to the crime.
- Anyone incarcerated when the crime occurred.
- Any victim or claimant who knowingly or intentionally submits, or causes to be submitted, false or forged information to the Crime Victims' Compensation Program.

What expenses may be covered with Crime Victims' Compensation Program benefits?

- Reasonable and necessary medical and funeral expenses.
- Travel exceeding 20 miles one way for participation and attendance at funeral services, medical appointments and criminal justice appointment.
- Loss of earnings as a result of the disability of the victim.
- Loss of earnings for investigative, judicial or medical appointments.
- Loss of support to dependents of victim's, as a result of the victim's death or if the victim was supporting them at the time of the crime.
- Psychiatric care/counseling.
- Counseling for the victim and eligible claimants.
- Eyeglasses, hearing aids, dentures or prosthetic devices, if damaged during or needed as a result of the crime.
- Crime scene clean-up.
- Replacement of property seized as evidence or rendered unusable by the investigation.
- New expenses for child or adult dependent care as a result of the crime.
- One time rent and relocation expenses for victims of family violence, victims of sexual assault who were assaulted in their home, victims of stalking or victims of human trafficking.
- Reasonable attorney fees for assistance in filing the Crime Victims' Compensation Program application.

What expenses are not covered by Crime Victims' Compensation Program benefits?

- Damage, repair or loss to property or vehicle.
- Pain, suffering or emotional distress damages.
- Any expense which is not the direct result of the crime.

Who is the payor of last resort?

- All other available third party resources (for example, Medicare, Medicaid, personal health insurance, workers' compensation and settlements) must meet their legal obligations to pay crime-related expenses.
- The Crime Victims' Compensation Program must be notified before a civil lawsuit is filed in relation to the crime, if restitution is ordered by the criminal court, or if any party receives the proceeds of a settlement.
- CVC is considered the payor of last resort.

Keep this page for your records.



PLEASE COMPLETE ALL SECTIONS OR A DELAY MAY RESULT IN THE PROCESSING OF YOUR APPLICATION. Information about this claim is confidential and will not be released to another person unless that person is included as a claimant or as otherwise required by law.

What is the language preference of the victim and/or claimant? English Spanish Other _____

SECTION 1-VICTIM INFORMATION: The victim is the person who was injured or died as a result of the crime. If the victim is a minor or deceased, the claimant information in Section 3 **MUST** be completed. If there is more than one victim, each victim must submit a separate application.

First Name	Middle Name	Last Name	
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Email Address			
Social Security Number:	<input type="radio"/> No <input type="radio"/> Yes	If yes: _____	
Tax I. D. Number:	<input type="radio"/> No <input type="radio"/> Yes	If yes: _____	
Gender <input type="radio"/> Male <input type="radio"/> Female	Date of Birth	If victim is deceased, date of death	

SECTION 2 - CRIME INFORMATION: You must complete this section or your application cannot be processed.

Please indicate the type of crimes:

<input type="checkbox"/> Adult Sexual Assault	<input type="checkbox"/> Aggravated Assault	<input type="checkbox"/> Assault (Non-family)	<input type="checkbox"/> Child Physical Abuse/Neglect
<input type="checkbox"/> Child Sexual Assault	<input type="checkbox"/> Child Pornography	<input type="checkbox"/> DWI/Vehicular Crime	<input type="checkbox"/> Elder Abuse
<input type="checkbox"/> Family Violence	<input type="checkbox"/> Homicide	<input type="checkbox"/> Human Trafficking	<input type="checkbox"/> Kidnapping
<input type="checkbox"/> Robbery	<input type="checkbox"/> Stalking	<input type="checkbox"/> Other	

Date of Crime	Law Enforcement Agency (e.g. police, sheriff)	Police Report Number (if known)		
Location of Crime: Street Address	City	State	Zip	County
Alleged Suspect's First Name (if known)	Alleged Suspect's Last Name (if known)	Relationship of suspect to victim (if any)		
Has the suspect been arrested? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	Have charges been filed? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	Cause Number (if known)		
Brief Description of Crime				
Brief Description of Injuries (if any)				
If this is a family violence crime, have you obtained a permanent protective order?				<input type="radio"/> No <input type="radio"/> Yes
If this is a family violence crime, are there any prior incidents reported to law enforcement				<input type="radio"/> No <input type="radio"/> Yes

SECTION 2a-CRIME INFORMATION: FORENSIC MEDICAL EXAM

If this is a sexual assault, was a forensic medical exam performed? No Yes Date of forensic medical exam: _____

Are you seeking reimbursement ONLY for expenses incurred in connection with emergency medical treatment received at the time of the sexual assault forensic medical exam? No Yes

If yes, you need only complete SECTION 4 (MEDICAL), SECTION 17 (APPLICATION ASSISTANCE), and the ACKNOWLEDGEMENT AND AUTHORIZATION to finalize this application. By checking "Yes" above, you indicate that you are not applying for additional CVC awards such as counseling expenses, ongoing medical expenses, rent/relocation and loss of earnings. You have three years from the date of the crime to request additional awards.

SECTION 3-CLAIMANT INFORMATION: The claimant is a person, other than the victim, who has out of pocket expenses as a direct result of the crime, is an immediate family member(s) of the victim who requires Psychiatric Care/Counseling as a result of the crime or is someone who has legal authority to act on behalf of the victim. CVC cannot discuss a claim with anyone who is not listed as a claimant. If there are additional claimants, please list them on a separate sheet of paper and include all the required information.

Claimant 1

First Name	Middle Name	Last Name	
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Email Address			
Social Security Number: <input type="radio"/> No <input type="radio"/> Yes If yes: _____			
Tax I. D. Number: <input type="radio"/> No <input type="radio"/> Yes If yes: _____			
Gender <input type="radio"/> Male <input type="radio"/> Female	Date of Birth	Relationship to Victim	

Claimant 2

First Name	Middle Name	Last Name	
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Email Address			
Social Security Number: <input type="radio"/> No <input type="radio"/> Yes If yes: _____			
Tax I. D. Number: <input type="radio"/> No <input type="radio"/> Yes If yes: _____			
Gender <input type="radio"/> Male <input type="radio"/> Female	Date of Birth	Relationship to Victim	

Claimant 3			
First Name	Middle Name	Last Name	
Mailing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Email Address			
Social Security Number: <input type="radio"/> No <input type="radio"/> Yes If yes: _____			
Tax I. D. Number: <input type="radio"/> No <input type="radio"/> Yes If yes: _____			
Gender <input type="radio"/> Male <input type="radio"/> Female	Date of Birth	Relationship to Victim	

SECTION 4-MEDICAL: Reasonable and necessary health care for the victim as a direct result of the crime. Medical insurance and benefit plan **MUST** meet their legal obligation to pay crime-related expenses.

VICTIM TREATMENT INFORMATION

Did the victim require medical treatment at the time of the crime? <input type="radio"/> No <input type="radio"/> Yes			
1. Name of first treating hospital/clinic/doctor:			
Address	City	State	Zip
Phone Number	Fax Number		
Did victim require additional medical treatment upon release from the hospital or clinic or did the victim seek any other medical treatment? <input type="radio"/> No <input type="radio"/> Yes			
2. Name of health care provider who treated crime-related injuries:			
Address	City	State	Zip
Phone Number	Fax Number		
3. Name of health care provider who treated crime-related injuries:			
Address	City	State	Zip
Phone Number	Fax Number		

VICTIM DISABILITY INFORMATION

Was the victim a person with disability?	<input type="radio"/> No <input type="radio"/> Yes	If yes, date of disability
--	--	----------------------------

Was the disability:	<input type="radio"/> Physical <input type="radio"/> Mental <input type="radio"/> Both	If yes, describe
---------------------	--	------------------

Does the victim have a new disability due to the crime?	<input type="radio"/> No <input type="radio"/> Yes	If yes, describe
---	--	------------------

VICTIM INSURANCE INFORMATION

Did the victim have health insurance or a benefit plan to cover medical expenses <u>at the time of the crime</u> ?	<input type="radio"/> No <input type="radio"/> Yes
--	--

Does the victim have health insurance or a benefit plan to cover medical expenses <u>on the date of application</u> ?	<input type="radio"/> No <input type="radio"/> Yes
---	--

Name of Medical Insurance Company/Benefit Plan	Does the victim have Medicare?	<input type="radio"/> No <input type="radio"/> Yes
--	--------------------------------	--

If Yes, what type of Medicare? <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D	Has an application been filed with Medicaid or Medicare since the crime?	<input type="radio"/> No <input type="radio"/> Yes
---	--	--

If there are crime-related dental injuries, does the victim have dental insurance?	<input type="radio"/> No <input type="radio"/> Yes	If yes, name of victim's Dental Insurance Company
--	--	---

Was the victim the driver of auto?	If yes, does he/she have auto insurance?	Name of victim's auto insurance
<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	

Did the owner of the auto involved in the crime have auto insurance?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	If yes, name of owner's auto insurance
--	--	--

Was the suspect the driver of auto?	If yes, does he/she have auto insurance?	Name of suspect's auto insurance
<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown	

Is there additional assistance available to victim from:

Workers' Compensation Disability Insurance Social Security Assistance Veterans' Benefits

Other _____

Has an insurance claim or any request for additional assistance related to this crime been filed?	<input type="radio"/> No <input type="radio"/> Yes
---	--

SECTION 5-PSYCHIATRIC CARE/COUNSELING: Available to victim and/or certain claimants. Please indicate who has received or will be receiving psychiatric care/counseling because of the crime.

Name	Medical/Mental Health Insurance No <input type="radio"/> Yes <input type="radio"/>	If yes, name of Insurance Company
Name	Medical/Mental Health Insurance No <input type="radio"/> Yes <input type="radio"/>	If yes, name of Insurance Company
Name	Medical/Mental Health Insurance No <input type="radio"/> Yes <input type="radio"/>	If yes, name of Insurance Company

SECTION 6-LOSS OF EARNINGS: Includes reimbursement of earnings lost as a result of medical treatment or participation in, or attendance at, the investigation, prosecutorial and judicial processes. Your employer will be contacted by CVC.

Victim Employment Information

Is the victim seeking loss of earnings? <input type="radio"/> No <input type="radio"/> Yes		Was the victim employed on the date of crime? <input type="radio"/> No <input type="radio"/> Yes	
Employer's Name		Phone	Fax
Address		City	State
Was the victim self-employed on the date of the crime? <input type="radio"/> No <input type="radio"/> Yes		Did the crime occur while the victim was on the job? <input type="radio"/> No <input type="radio"/> Yes	Date Returned to Work
		Last Date Worked	

Claimant Employment Information

Name of claimant seeking loss of earnings. If there are additional claimants, please list them on a separate sheet of paper and include all required information.

Claimant Name:		Is the claimant self-employed? <input type="radio"/> No <input type="radio"/> Yes	
Employer's Name		Phone	Fax
Address		City	State
			Zip

SECTION 7-LOSS OF SUPPORT: Available to dependents of the victim who have lost support as a result of the crime. All dependents must be listed as claimants in this application.

Name(s)

SECTION 8-RELOCATION: Available to a victim of family violence, a victim of sexual assault who is assaulted in the victim's residence, a victim of stalking or a victim of human trafficking. *Please indicate adult household members of the victim at the time of the crime.*

List the names of all adult household members:

SECTION 9-FUNERAL: Includes funeral and burial expenses incurred as a result of the crime. *Please attach a copy of the funeral and burial contract(s), (if available).*

Funeral Home name	Phone	Fax	Contact
-------------------	-------	-----	---------

SECTION 10-CRIME-RELATED TRAVEL: Includes travel exceeding 20 miles one way for participation and attendance at funeral services, medical appointments including psychiatric care/counseling and criminal justice proceedings. This is applicable to victim or claimant(s). *Please list the victim or claimant(s) requesting travel.*

Name(S)

SECTION 11-CRIME SCENE CLEAN-UP: Includes professional cleaning services for crime scene clean-up. Does not include repair or replacement of damaged property. <i>Submit itemized bill from professional cleaning company, (if available).</i>			
Do you have homeowners/renters insurance? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		If yes, what is the name of the Homeowners/Renters Insurance Company?	
SECTION 12-MINOR CHILD OR DEPENDENT CARE: Available for child or dependent care that is a new expense as a result of the crime. Care must be provided by a licensed care provider.			
Is child care or dependent care a new expense? <input type="radio"/> No <input type="radio"/> Yes			
SECTION 13-REPLACEMENT OF PROPERTY SEIZED: Available for clothing, bedding, or property seized by law enforcement as evidence or rendered unusable by the criminal investigation. <i>This does NOT cover damaged or stolen property.</i>			
Item:	Value \$	Item:	Value \$
Item:	Value \$	Item:	Value \$
SECTION 14-DEPARTMENT OF JUSTICE INFORMATION: The following voluntary information is used for statistical purposes only to comply with the federal regulations.			
To which ethnic group does the victim belong? <input type="radio"/> American Indian/Alaskan Native <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> Hispanic/Latino <input type="radio"/> Multiple Races <input type="radio"/> Native Hawaiian and Other Pacific Islander <input type="radio"/> White Non-Latino/Caucasian <input type="radio"/> Other Race			
What is the victim's national origin (country of birth)?			
Where did you find out about the Crime Victims' Compensation Program? <input type="radio"/> Public Service Announcement <input type="radio"/> CVC Staff <input type="radio"/> Advocacy Group <input type="radio"/> Victim Assistance Program <input type="radio"/> Poster <input type="radio"/> Brochure <input type="radio"/> Hospital <input type="radio"/> Law Enforcement <input type="radio"/> Internet <input type="radio"/> Other			
SECTION 15-ATTORNEY INFORMATION: This section refers to representation by an attorney who assisted the victim or claimant in filing for Crime Victims' Compensation or in pursuing a civil legal action for monetary damages. This DOES NOT include attorney representation for child custody, divorce, immigration proceedings or for criminal prosecution (District/County Attorney's Office.)			
Has an attorney been hired or retained to: Help the victim/claimant complete this Crime Victims' Compensation application? <input type="radio"/> No <input type="radio"/> Yes If yes, please attach a letter of representation.			
Has an attorney been hired or retained to: Represent the victim's or claimant's interests in pursuing civil legal action against the suspect/offender or in an insurance claim related to this crime? <input type="radio"/> No <input type="radio"/> Yes If yes, please attach a letter of representation.			
Attorney's Last Name		Attorney's First Name	Phone Number
Mailing Address		City	State
			Fax Number
			Zip
SECTION 16-LAWSUIT OR OTHER SETTLEMENT INFORMATION			
Is the victim or claimant a party to a lawsuit or insurance or other type of settlement related to this crime? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown			
Has the victim or claimant received insurance or any other type of third party settlement funds related to this crime? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown			
SECTION 17-APPLICATION ASSISTANCE			
Did someone help you complete this application? <input type="radio"/> No <input type="radio"/> Yes			
Last Name	First Name	Title	Agency/Organization
Mailing Address		City	State
			Zip
E-Mail Address		Phone Number	Fax Number

Acknowledgement and Authorization

This authorization is part of your application and must be completed and signed in order to process this application.
BY YOUR SIGNATURE BELOW YOU AGREE TO THE FOLLOWING TERMS.

Authorization for Release of Information. I hereby authorize any financial institution, social service agency, government agency, hospital, physician, mental health facility, counselor, psychologist, psychiatrist, employer, insurer or any other person with information relating to my financial, health or employment status to release information concerning this application for benefits to the employees of the Crime Victims' Compensation Program (CVC) of the Office of the Attorney General, as needed to process this application. This information includes, but is not limited to, criminal, medical, financial and employment information. A copy of this signed release will be considered the same as the original.

Subrogation Agreement. In accordance with Texas Code of Criminal Procedure, Articles 56.51 and 56.52, I agree to notify CVC in writing before I file a lawsuit against another party as a result of this crime. I further agree that I shall not settle or resolve any such action without prior written authorization from CVC. If I recover or anticipate recovery, of any money at any time, by judgment, settlement, restitution, collateral source or any other income as a result of the incident that gave rise to this application, I agree to notify CVC. I acknowledge that I may be responsible for repayment to CVC for any and all amounts that CVC has awarded to me.

Refund Agreement. In accordance with Texas Code of Criminal Procedure, Article 56.47 (c), I understand and agree that the Office of Attorney General may require a refund of an award if the award was obtained by fraud, or mistake or if newly discovered evidence shows the victim or claimant to be ineligible for the award under Texas Code of Criminal Procedure, Articles 56.41 or 56.45.

Authorization. I understand that the Office of the Attorney General or any agent or representative of the office, has the right to review, investigate and verify the information provided. **I understand and agree that if false, misleading or intentionally incomplete information is provided, my application for compensation may be denied and I may be subject to criminal punishment under the Texas Penal Code and the civil and administrative penalties under Ch. 56 of the Texas Code of Criminal Procedure.**

VICTIM	
Printed Name	Date
Signature	Date of Birth

CLAIMANT	
Printed Name	Date
Signature	Date of Birth