



**OFFICIAL CLAIM FORM**  
**CRIME VICTIMS COMPENSATION PROGRAM**

Please return to: District Attorneys Council  
 421 NW 13<sup>TH</sup> St., Suite 290  
 Oklahoma City, OK 73103-3710  
 405-264-5006 (OKC) or 1-800-745-6098 (Toll-Free)  
 Fax: 405-264-5097  
<http://www.ok.gov/dac/>

**To Be Completed By OCVCB**  
 Claim # \_\_\_\_\_  
 District # \_\_\_\_\_  
 V/W Coord. F/R \_\_\_\_\_

**To Be Completed By VWC**  
 Mailed to Claimant on \_\_\_/\_\_\_/\_\_\_  
 VWC Initials \_\_\_\_\_  
 Date Rec'd from Clmt. \_\_\_/\_\_\_/\_\_\_

Please Print

**Information on the Victim**

Name \_\_\_\_\_  
Last First MI

Mailing Address \_\_\_\_\_  
 \_\_\_\_\_

Street Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Age When Crime Occurred \_\_\_\_\_

Sex \_\_\_\_\_ Social Security # \_\_\_\_\_

Race (request for race is for statistical purposes only)  
 American Indian or Alaska Native  Asian or Pacific Islander  
 Black  Hispanic  White  Other \_\_\_\_\_

Disabilities Prior to Victimization \_\_\_\_\_  
 \_\_\_\_\_

Dependents Names and Ages \_\_\_\_\_  
 \_\_\_\_\_

**Information on the Claimant\*\***  
 (Not the defendant's info - See note below)

Name \_\_\_\_\_  
Last First MI

Mailing Address \_\_\_\_\_  
 \_\_\_\_\_

Street Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Sex \_\_\_\_\_ Social Security # \_\_\_\_\_

Relationship to Victim \_\_\_\_\_

Employer Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

**Information on Contact Person**  
 (Do not list the Victim or Claimant or anyone living in the household)

Name \_\_\_\_\_  
Last First MI

Street Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Relationship to Victim \_\_\_\_\_

**Guardian Information**  
 (Complete only if Claimant is a child or incapacitated adult)

Name \_\_\_\_\_  
Last First MI

Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Relationship to Victim \_\_\_\_\_

\*\*The Claimant is the person requesting compensation. If the victim is an adult who is able to care for himself/herself, put "Same as Victim" here. See instructions for a list of persons eligible to be a claimant.

### Information about the Crime

What crime was committed which led to the filing of this claim (select one):

- Armed Robbery
- Arson (does not include personal property)
- Assault
- Child Physical Abuse
- Child Sexual Abuse (under age 16)
- Domestic Violence/Spouse Abuse
- Domestic Violence Homicide
- DUI Homicide
- DUI Injury
- Homicide
- Kidnapping
- Leaving the Scene (auto/pedestrian incidents)
- Negligent Homicide
- Sexual Assault (16 years or older)
- Shooting with Intent to Kill
- Terrorism/Mass Casualty Incident

Date of Crime \_\_\_\_\_ Time: \_\_\_\_\_

If victim is a child, when was the crime disclosed by the child to an adult:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

County/City of Crime \_\_\_\_\_

Location of Crime (check primary location)

- Bar or Club
- Business (other than victim's workplace)
- Rural Area
- Someone else's apartment/home
- Street
- Vehicle
- Victim's workplace
- Victim's own apartment/home
- Other (describe) \_\_\_\_\_

When was the crime reported to the police?

Date: \_\_\_\_\_ Time: \_\_\_\_\_

What agency was the crime reported to?

\_\_\_\_\_

Who reported the crime?

\_\_\_\_\_

### Information about the Victim's Injuries

List the injuries caused by the crime (if more space is needed, continue on back of page):

List doctors and hospitals where the victim was treated after the crime (attach itemized statements):

### Victim's Employment Information

Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Supervisor's Name \_\_\_\_\_

Occupation \_\_\_\_\_

Starting Date \_\_\_\_\_ Ending Date \_\_\_\_\_

How much work did the victim lose because of injuries relating to the crime? \_\_\_\_\_ days

What was the victim's weekly take-home pay prior to the crime? \$ \_\_\_\_\_ per week

When is the victim scheduled to return to work?

\_\_\_\_\_

What is the name of the doctor that released the victim to return to work? \_\_\_\_\_

***If self-employed, tax returns for the last three years will be required before work loss can be considered.***

### Expenses Being Claimed

- Funeral**
- Future Economic Loss** (submit estimates)
- Income Loss** (victim/caregiver submit last pay stub)
- Loss of Support** (if victim is deceased)
- Medical** (submit itemized statement)
- Dental** (submit itemized statements)
- Rehabilitation** (physical or occupational therapy)
- Counseling** (for victim only)
- Grief Counseling** (for family of homicide victims)
- Traditional American Indian Svs.** (submit receipts)
- Replacement Services** (submit receipts)
- Homicide Crime Scene Cleanup** (submit receipts)
- Impound fees** (submit receipts)

### Information Source

- How did you *first* find out about the Victims Compensation Program (check all that apply):
- District Attorney                       Radio
  - Medical Service Program               TV
  - Victims' Assistance Program           Billboard
  - Police/Sheriff
  - Brochure/Poster
  - Internet
  - On-Line Newspaper

### Offender Information (if known)

List those who committed the crime(s) which led to the filing of this claim: \_\_\_\_\_

Relationship of offender to victim (if any): \_\_\_\_\_

Has there been an arrest?  Yes  No

Have charges been filed?  Yes  No

If charges were filed, what is the Criminal Case Number (if known) \_\_\_\_\_

Who was charged with the crime:  
\_\_\_\_\_  
\_\_\_\_\_

### Insurance Information

Is there any insurance coverage to assist with expenses being claimed?  Yes  No. If yes, please list all insurance coverage.

#### **Health** (complete if medical is being claimed)

Company \_\_\_\_\_  
Agent Name \_\_\_\_\_  
Phone # (     ) \_\_\_\_\_  
Policy Number \_\_\_\_\_

#### **Life Insurance** (complete if victim is deceased)

Company \_\_\_\_\_  
Amount Received \$ \_\_\_\_\_  
Phone # (     ) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Beneficiary \_\_\_\_\_  
Relationship to victim \_\_\_\_\_  
Phone # (     ) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### **Car Insurance** (complete if the crime was vehicle related)

Company \_\_\_\_\_  
Amount Received \$ \_\_\_\_\_  
Agent Name \_\_\_\_\_  
Phone # (     ) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Effective Date \_\_\_\_\_

#### **Other Insurance** (Example: Medicaid)

Company \_\_\_\_\_  
Amount Received \$ \_\_\_\_\_  
Agent Name \_\_\_\_\_  
Phone # (     ) \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### **Attorney Information** (if one has been hired)

Is the victim or claimant thinking of filing a *civil* lawsuit against anyone because of this crime (a lawsuit other than the criminal case that the D.A.'s office may be pursuing)?  Yes  No.

Attorney Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # (     ) \_\_\_\_\_

**FILING DEADLINE**

The Crime Victims Compensation form must be received in the Oklahoma Crime Victims Compensation Board office within one (1) year of the date of the incident or death of the victim, regardless of whether you have all of the bills and supporting documentation attached to the claim. The one year deadline may be waived up to two (2) years. In child sexual abuse cases, claims will be accepted past the two (2) year deadline.

**CONFIDENTIALITY OF RECORDS**

All records and information given to the Board to process a claim on behalf of a crime victim shall be confidential, pursuant to 21 O.S. 142.9 (G) of the Oklahoma Statutes.

**WITH MY SIGNATURE BELOW**

I agree that I have read and understand all instructions and eligibility requirements and agree that all unpaid bills or portions thereof for services conducted for the victim be paid by the Oklahoma Crime Victims Compensation Board directly to the supplier. Further, I swear that the information contained in this claim is true, and I understand that the filing of a false claim for compensation is a misdemeanor and shall be punishable by a fine not to exceed one thousand dollars (\$1,000.00) or by imprisonment in the county jail for a term not to exceed one (1) year or both such fine and imprisonment. In the event I receive compensation for my injuries from another source, after receiving an award from the Victims Compensation Board, I understand that I am responsible for reimbursing the Victims Compensation Board to the extent the Board awarded compensation to me. Also, if I file a lawsuit against the defendant or another party, I agree to notify the Victims Compensation Board immediately.

\_\_\_\_\_  
Signature of Victim or Claimant

\_\_\_\_\_  
Date Signed

**RELEASE OF INFORMATION**

I hereby authorize:

- \* any hospital;
- \* physician;
- \* attorney;
- \* any person who treated or examined the victim;
- \* undertaker or other person rendering funeral services;
- \* any employer of the victim;
- \* any police, municipal or public authority;
- \* Social Security Administration;
- \* Department of Human Services;
- \* any federally funded agency;
- \* any insurance company; and
- \* any organization having knowledge of this claim,

to release any information with respect to the incident leading to the victim’s personal injury or death and the claim made herewith for benefits to the Oklahoma Crime Victims Compensation Board or the District Attorney’s Office Victim-Witness Staff.

\_\_\_\_\_  
Signature of Victim or Claimant

\_\_\_\_\_  
Date Signed

**BY STATE LAW, YOU MUST BE ADVISED OF THE FOLLOWING**

The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

\_\_\_\_\_  
Signature of Victim or Claimant

\_\_\_\_\_  
Date Signed

# OKLAHOMA CRIME VICTIMS COMPENSATION PROGRAM

421 NW 13<sup>TH</sup> St., Suite 290, Oklahoma City, OK 73103-3710  
405-264-5006 (OKC) 1-800-745-6098 (Toll-Free) Fax: 405-264-5097 Website: <http://www.ok.gov/dac>

**Note: The Claim Form must be received at the above address within one year of the crime.**

**If you move and leave no forwarding address, your claim may be denied, so please notify us of your correct mailing address. Please thoroughly complete ALL sections and sign all three areas of page four.**

**You may e-mail your current address information on our webpage at: <http://www.ok.gov/dac/>**

## INSTRUCTIONS

**Information on Victim** The victim is the person who was injured or killed as a result of a violent crime.

**Information on Claimant** (Complete only if the victim is: deceased, a child, or an incapacitated adult)

Authorized claimants can be: 1) the parent of a minor child; 2) a dependent of a victim who has died because of a crime; 3) a person authorized to act on behalf of the victim or a dependent; or 4) a person legally responsible for payment of expenses which have arisen because of a criminal act (example: person responsible for payment of funeral expenses).

**Contact Person Information** (Contact person should be different than the victim and claimant information)

We ask for this information in the event we are unable to contact the claimant by mail or telephone. Your contact person should be someone you trust to give you a message, someone who knows your whereabouts, and someone who knows you were a victim of a crime.

**Guardian Information** (Complete only if the claimant is a child or incapacitated adult). This information is needed in the event an award is made to a minor child or an incapacitated adult. The guardian is the person who has legal responsibility for the claimant's business affairs.

**Crime Information** Complete all areas that apply to the incident which led to the filing of this claim.

**Injury Information** List the injuries suffered as a result of the crime and attach all itemized medical statements. List the hospital (if applicable) and/or the victim's treating physician or other medical professional. If medical treatment was not rendered, put N/A.

**Employment Information** (Complete only if applying for reimbursement of wages or loss of support). Employed people who miss work after being a victim of a violent crime may qualify for reimbursement of lost wages for the period of time he/she was recovering from the injuries, provided the crime disabled the person from working and the disability can be verified by a physician and by the victim's employer. There can be no compensation for loss of wages if the victim's employer paid him/her for the time off, regardless of the source of payment. Loss of support for dependents of a deceased victim can be compensated if there is documentation that collateral sources (i.e., Social Security and Life Insurance) are less than the net income provided by the victim prior to his/her death. If the victim was self-employed when the crime occurred or if taxes were not withheld by the employer, tax returns for the past three years will be required before work loss or loss of support can be considered. Work loss is computed based on the disability time specified by the physician and employer.

**Expenses Being Claimed** This area helps us to determine what documentation will be needed in order to make a decision on your claim.

**Information Source** This helps to determine where to focus outreach efforts in the future.

**Offender Information** Complete this information if you know the name of the offender(s). If the offender is unknown, write UNKNOWN.

**Insurance Information** Carefully follow instructions on the claim form for each area. If you do not have certain types of insurance, put N/A in the blank spots.

## Limits of Compensation

The sum of all payments made to individual claimants and service providers on behalf of one victim may not exceed \$20,000.00. In addition to the initial award of \$20,000.00, an additional \$20,000.00 may be available for work loss or loss of support. In no event shall the sum of all payments exceed \$40,000.00.

## Eligibility Requirements

- Crime must be reported to law enforcement officials within 72 hours of the incident (may be waived for good cause).
- Claim filed within one year of incident or death of victim (may be extended for good cause and in child sexual abuse cases).
- Victim was not the offender or accomplice and compensation would not benefit the offender or accomplice.
- There is economic loss after collateral resources have been deducted.
- Victim and claimant cooperated fully with the appropriate law enforcement agencies.
- The victim did not contribute in any way to the injury or death upon which the claim is based.

## Types of Expenses Covered for Eligible Crime Victims Compensation Claims

**Funeral** – Up to \$7,500 may be reimbursed for reasonable expenses related to a funeral, cremation, or burial of a deceased victim.

**Traditional American Indian Services** – In addition to expenses listed throughout the instructions, the following expenses may also be considered for reimbursement in traditional healing or burial ceremonies for American Indian victims of crime and family members of American Indian homicide victims: 1) traditional native counseling and healing from an elder or spiritual healer, minister, pastor, or faith-based counselor; 2) healing lodge and smudging ceremonies; 3) ceremonial burials, including clothing for the deceased, meals/food baskets and other expenses related to the traditional giveaway or gifting practices of the Tribe; 4) child care during burial ceremony; 5) reimbursement of gifts to individuals for the performance of service (i.e. quilts, cooking, etc.). In order for reimbursement of these expenses, receipts must be provided with the item's purpose clearly noted on the receipt. The maximum allowable for burial related expenses, including gifting, is \$7,500. The maximum allowable for healing services is \$3,000 for the injured victim. The maximum for healing services for each family member after a homicide is also \$3,000. The maximum award for all services compensated through the Crime Victims Compensation Program may not exceed \$20,000. If requesting reimbursement for healing or burial ceremonies, please also complete the "Request for Traditional American Indian Services" form located at: [http://www.ok.gov/dac/Victims\\_Services/Just\\_for\\_Victims/index.html](http://www.ok.gov/dac/Victims_Services/Just_for_Victims/index.html)

**Future Economic Loss** - Needed services which cannot be obtained without prior approval by the Victims Compensation Board or payment in advance from the victim. To submit a request for future economic loss, include an itemized list of the expenses you expect to incur, along with an explanation regarding the expense. For future dental work or surgery necessary to repair damage from the criminal incident, ask the attending physician to write an accurate estimate which clearly states the work to be performed and the cost. The attending physician should relate, in writing, the need for medical treatment due to injuries sustained during the crime.

**Income Loss** - Loss of income from work the victim would have performed if he/she had not been injured. Work loss must be verified by the employer and the attending physician. Caregiver work loss can be awarded up to \$3,000, if the work loss is verified by caregiver's employer. Caregiver work loss may only be awarded up to \$3000 to persons who have unreimbursed wage loss due to caring for an injured victim of crime.

**Loss of Support** - In the event of the death of a victim, the Board may consider providing reimbursement for loss of support to a dependent based on the victim's net income at the time of death, less any collateral sources such as: Life insurance and uninsured motorist coverage (over \$50,000), social security, workers compensation, or 3<sup>rd</sup> party reimbursements.

**Medical/Dental/Rehabilitation** - Includes products, services, and accommodations for medical care (Examples: doctor exams, medical equipment, dental work, hospital expenses and prescriptions; physical therapy, rehabilitative occupational training and other remedial treatment and care). Medical related fees owed to service providers may be paid up to 80%, with a 20% required write off by the medical service provider.

**Counseling for Victims** - Counseling expenses may be paid up to 80%, with a 20% required write-off by the mental health service provider. The maximum compensable amount for the victim's counseling is \$3,000. This limit may be waived by the Board in extenuating circumstances.

**Grief Counseling** – Crisis counseling that is initiated within three years of the crime is compensable, up to \$3,000 for each family member of a homicide victim, provided the counselor is a qualified mental health care provider. *Medical and pharmaceutical treatment for a family member of a homicide victim is not compensable.*

**Replacement Services** - Expenses reasonably incurred in obtaining ordinary and necessary services in place of those the victim would have performed for the benefit of self or family, if the victim had not been injured. Property losses are not covered under the Act.

**Crime Scene Cleanup and Impound Fees** - Homicide crime scene cleanup is compensable up to \$2,000. Up to \$750 may be paid for vehicle impound fees, provided the victim/claimant is responsible for paying those fees that are associated with a violent crime occurring in a vehicle, and provided the vehicle was held for evidentiary purposes.