Claim # _____
(DCVC Use Only)

Kansas Attorney General
Kris W. Kobach

Division of Crime Victims Compensation
120 SW 10th Avenue, 2nd Floor
Topeka, KS 66612-1597
PHONE: (785) 296-2359 ● FAX: (785) 296-0652
www.ag.ks.gov

APPLICATION FOR CRIME VICTIM COMPENSATION

Must be filed within five years of the incident, except pursuant to K.S.A. 74-7305.
Cases of child sexual assault are based on the date the crime was reported to law enforcement.
It is the claimant's responsibility to establish proof that the claim was filed timely pursuant to K.S.A. 74-7305.
All information provided is confidential, pursuant to K.S.A. 74-7308.

Please check the type(s) of crime victim compensation for which you are applying:

☐ **Medical** ☐ **Counseling** ☐ **Loss of wages** ☐ **Funeral** ☐ **Crime scene cleanup** ☐ **Clothing/Bedding** ☐ **Moving**

Section A – Victim Information *(Person who was injured or killed during the crime.)*

Name of victim (first, middle, last) | Date of birth | SSN or Government ID Number

Address (include Apt #, Lot #, PO Box, etc.) | City | State | ZIP

Safe daytime phone number | Other safe phone number | Email address

Preferred language: ☐ English ☐ Spanish ☐ Other _____

The following information is optional and will be used for statistical purposes only and is requested to comply with Federal Civil Right Act under Section 1403(e) of the Victims of Crimes Act of 1984.

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White Non-Latino or Caucasian
- ☐ Biracial or Multiracial
- ☐ Other _____

How did you find out about this program?
- ☐ Police or Police Advocate
- ☐ Victim Assistance Program
- ☐ Hospital
- ☐ Prosecutor or Prosecutor's Advocate
- ☐ Counselor or Therapist
- ☐ Media/News
- ☐ Poster/Brochure
- ☐ Other _____

Gender:
- ☐ Male
- ☐ Female

Special Needs:
- ☐ Disability
- ☐ Deaf
- ☐ Blind
- ☐ Homeless
- ☐ Other _____

Section B – Applicant Information *(Complete this section if the victim is a minor, incapacitated or deceased.)*

☐ Person applying is the victim. ***(Proceed to section C)***

☐ Person applying is <u>not</u> the victim Applicant's relationship to the victim: _____

Name of applicant (first, middle, last) | Date of birth | SSN or Government ID Number

Address (include Apt #, Lot #, PO Box, etc.) | City | State | ZIP

Safe daytime phone number | Other safe phone number | Email address

Section C – Contact Person ***(Complete this section you would like to give permission for this office to contact someone other than you about your claim if we can't reach you.)***

Name of contact person | How do you know them?

Address (include Apt #, Lot #, PO Box, etc.) | City | State | ZIP

Safe daytime phone number | Other safe phone number | Email address

Section D – Information about the crime ***(This section must be completed.) *Property crimes such as identity theft, fraud, & damage to property are not eligible for compensation.***

Subsection 1: Type of crime ***(Please check one)*****:**

- ☐ Arson
- ☐ Assault
- ☐ Child Physical Abuse
- ☐ Child Pornography
- ☐ Domestic Abuse
- ☐ DUI
- ☐ Electronic Solicitation
- ☐ Homicide/Murder
  - ☐ Child Abuse Homicide
  - ☐ Domestic Abuse Homicide
  - ☐ DUI Homicide
  - ☐ Vehicular Homicide
- ☐ Human Trafficking
- ☐ Kidnapping
- ☐ Robbery
- ☐ Sexual Assault (Adult)
- ☐ Sexual Assault (Child)
- ☐ Stalking
- ☐ Vehicular crime (Other than homicide)
- ☐ Child witnessed a crime

Brief description of the crime:

Date of Crime

Location of the crime:

Address (include Apt #, Lot #, etc.) | City | County | ZIP

Did you report to law enforcement? ☐ Yes **(skip to Subsection 2)** ☐ No
Did you go to the hospital or seek medical care because of the crime? ☐ Yes ☐ No
Name of hospital or health care facility where you went: _____

Subsection 2:

Name of law enforcement agency reported to | **Date crime reported**

Police report number | **Name of investigating officer/detective**

Name(s) of suspect(s): _____
Did the Victim know the suspect(s)? ☐ Yes ☐ No **If yes, in what way?** _____

Has an arrest been made(s)? ☐ Yes ☐ No ☐ Unknown

Court case number: _____ ☐ District Court ☐ Municipal Court ☐ Federal Court

Section E – Attorney Representation ***(Complete this section if you are represented by a private attorney in a civil lawsuit or insurance action as a result of the incident.)***

Attorney's name | Name of law firm

Address (include Apt #, Lot #, PO Box, etc.) | City | State | ZIP

Phone number | Fax number | Email address

Section F – Funeral/burial expenses ***(Complete section if you are seeking funeral benefits for a deceased victim and attach copies of bills. Maximum benefit is $7,500.) *Homicide claims must also meet eligibility requirements on Page 7***

Note: Applications for grief therapy for immediate family members of deceased victims are also available.

Name of the funeral home

Street address | City | **S**tate | ZIP

Phone number | Total amount paid | Total amount still due

Have funeral and burial expenses been paid? ☐ Yes ☐ No **If yes, by whom?** _____

Will applicant receive funeral payment, death benefits or other help with the costs of the funeral? ☐ Yes ☐ No

If yes, please explain:

Section G – Loss of support ***(For death claims only. Maximum benefit is $800 per week.)***

Was the victim employed or paying child support when they were killed? ☐ Yes ☐ No

If yes, please attach copies of a marriage certificate, birth certificate(s) and/or child support order(s).

Section H – Medical Information ***(List all medical expenses incurred as a result of this incident, including hospital and doctor charges, ambulance fees, x-rays, prescriptions and dental. Please attach itemized statements or bills, receipts and insurance statements if they are available.)***

Name of medical provider	**Address**	**City**	**State**	**ZIP code**	**Phone number**

Briefly describe the victim's injuries:

Section I – Counseling Information *(Please attach itemized statements or bills, receipts and insurance statements if they are available.)*

Name of counselor/organization	Address	City	State	ZIP	Person receiving counseling and relationship to victim

Section J – Financial Information *(Required by K.S.A. 74-7305.)*

Number of dependents: _____ **Net income per year:** $_____

Resources (savings, checking): _____ **Total monthly living expenses:** $_____

Special needs of applicant and dependents: _____

Section K – Insurance/Collateral Sources *(This section must be completed.)*

Please check all available sources that could be applied to your claim

- ☐ Health/Life Insurance
- ☐ Automobile Insurance
- ☐ Burial Insurance
- ☐ Social Security
- ☐ Medicaid
- ☐ Medicare
- ☐ Veterans Administration Benefits
- ☐ Armed Services (CHAMPUS)
- ☐ Workers Compensation
- ☐ Other Sources
- ☐ I do not have insurance or other financial resources.

Name/type of source	Name & address of source	Policy/claim number

Section L – Wage Loss *(Applicants for wage loss must attach a copy of their most recent Federal Income Tax Return and/or pay stubs. Compensation may be awarded at a maximum rate of $800 per week for unreimbursed wage loss.)*

Was the victim employed at the time of the crime?
☐ Yes ☐ No

Did the victim miss work and pay because of the crime?
☐ Yes ☐ No

If you answered yes to both of these questions, please complete section L.

Name of employer Phone number

Employer's mailing address City State ZIP

Did the victim use any vacation, sick leave or PTO? ☐ Yes ☐ No

Did the victim receive short- or long-term disability pay? ☐ Yes ☐ No

Name of doctor or therapist who can verify length of disability to work Phone number

Doctor's street address City State ZIP

Section M – Certification of Financial Hardship *(Required by K.S.A. 74-7305(d).)*

I (Applicant) affirm the customary level of health, safety and education for self and dependents cannot be maintained without undue hardship as a result of the incident upon which this claim is based.

Section N – Assignment of Benefits

1) **Medical care expenses** – -I hereby assign any compensation awarded for unpaid medical care to the applicable medical care provider. This assignment is conditional that such provider agrees to accept a direct payment from the Kansas State Treasurer to pay 80% of allowable charges as satisfaction of payment in full. I authorize the Kansas State Treasurer to pay 80% of such allowable unpaid medical charges to the appropriate medical care provider.
2) **Non-medical care expenses** – I hereby assign any compensation awarded for unpaid non-medical care charges to the applicable provider. I authorize the Kansas State Treasurer to pay any such allowable unpaid non-medical charges directly to the provider.

Section O – Certification of Claim

I hereby certify, subject to the penalty of fine or imprisonment, that all losses claimed herein are a direct result of the crime and that the information contained in this application for an award is true and correct to the best of my knowledge and belief.

Section P – Promise to Repay

Pursuant to K.S.A. 74-7312, I promise to repay the Kansas Crime Victims Compensation Fund, through the Crime Victims Compensation Board if I receive payments from the offender (restitution or civil action), insurance, settlements or any other government or private agency resulting from this incident.

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I authorize and request any person having information with respect to the incident leading to the victim's personal injury or death necessary to the administration of this claim, ***including all past law enforcement records, medical diagnosis, medical records, medical examination information, and medical claim information***, to release that information to the Crime Victims Compensation Board, or its representative. This release includes but is not limited to, private and governmental physicians and hospitals; local, state and federal law enforcement and prosecutors' offices; local, state and federal court personnel, any employer; any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I hereby agree and certify that no person shall incur any legal liability by releasing any information pursuant to this authorization. A photocopy of this authorization is effective and valid as the original. All information obtained by the Board will remain confidential pursuant to K.S.A. 74-7308 and amendments thereto. This Release of Confidential Information will remain in effect until terminated by me in writing.

	for	
Applicant's Signature		***(If victim is 12 years or older, they must sign this line.)***

Applicant's Printed Name — Victim's Date of Birth

Date Signed — Last 4 Digits of Victim's Social Security Number

Kansas Attorney General
Kris W. Kobach
Division of Crime Victims Compensation
120 SW 10th Avenue, 2nd Floor
Topeka, KS 66612-1597
PHONE: (785) 296-2359 ● FAX: (785) 296-0652
www.ag.ks.gov

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize all health care providers to disclose my protected health information to the Kansas Crime Victims Compensation Board ("Board"), its employees, and agents, for purposes of processing my claim for crime victims compensation. This authorization includes my entire medical record, to the extent requested by the Board.

I understand that after this information is disclosed, it may not be protected by federal law and may be subject to redisclosure. However, all records and information given to the Board shall remain confidential in accordance with K.S.A. 74-7308(e).

The Board is not a covered entity under the Health Insurance Portability and Accountability Act (HIPAA). This authorization is voluntary, but I understand that refusal to sign this authorization may impact my eligibility for crime victims compensation if the Board is unable to obtain information necessary to process my claim.

This authorization will expire when the Board has completed processing my claim for compensation.

I understand that I am entitled to receive a copy of this authorization.

I understand that I have the right to revoke this authorization at any time by notifying the Board in writing at 120 SW 10th Ave, 2nd Floor, Topeka, KS 66612-1597. I understand that any use or disclosure made prior to a revocation will not be affected by the revocation.

_____ _____

Signature of Individual Date

If a Personal Representative executes this form, that Representative warrants that he/she has authority to sign the form on the basis of:

Office of the Kansas Attorney General • Division of Crime Victims Compensation

APPLICATION FOR CRIME VICTIMS COMPENSATION AND ELIGIBILITY REQUIREMENTS

(You may wish to keep this page for your information. Not required to be submitted with your application.)

If you have been an innocent victim of a violent crime and have suffered financial losses that are not covered by insurance or any other source, the Kansas Crime Victims Compensation Fund may be of assistance to you. The State of Kansas is committed to helping victims who meet the eligibility requirements of the Kansas Crime Victims Compensation Act. While no amount of financial aid can erase the trauma of crime, it is the goal of this program to ease the aftermath of crime for the victim whenever possible.

Eligibility Requirements:

1. Applications must be filed within five years of the incident with certain exceptions. In some circumstances, compensation may be awarded to victims if a claim is filed beyond the five-year period. Cases of child sexual assault are based on the date the crime was reported to law enforcement. It is the claimant's responsibility to establish proof that the claim was filed timely pursuant to K.S.A. 74-7305.
2. Victim suffered bodily injury (including mental disorder or death) as a victim of a violent crime. Property crimes such as identity theft, fraud, or damage to property are not eligible.
3. The incident occurred in Kansas, or outside the United States to a Kansas resident.
4. The incident was reported to law enforcement officials within 72 hours, or a forensic medical examination was done within 7 days, or the board finds good cause for a delay in reporting or obtaining an exam.
5. The claimant (and/or victim) fully cooperated with law enforcement officials during their investigation and prosecution.
6. The victim was not an accomplice to and did not commit a crime in connection with this incident (e.g. gang activity, drug dealing.) Victim must not have provoked or caused the injury or death.

Requirements 4, 5, and 6 do not apply to a victim of human trafficking who was 18 years old or younger at the time of the crime.

KANSAS STATUTE AUTHORIZES THE BOARD TO REDUCE OR DENY CLAIMS THAT INVOLVE THE VICTIM'S CONTRIBUTORY MISCONDUCT OR PARTICIPATION IN UNLAWFUL ACTIVITIES.

Eligible and Ineligible Expenses:

- Medical expenses not covered by other sources are eligible expenses.
- Reasonable costs for replacement of clothing and bedding seized as evidence are compensable.
- Crime scene cleanup expenses may include replacement of materials that were removed because such materials were biohazardous or were damaged as part of evidence collection.
- Other property loss, property damage and pain and suffering are ineligible expenses.

Award Maximums:

- Overall maximum award of $25,000
- Funeral expense maximum of $7,500
- Grief therapy for family members of homicide victims is available. Call for more information. (Maximum of $1,500)*
- Outpatient mental health counseling maximum of $5,000*
- Inpatient mental health care maximum of $10,000*
- Lost wages/loss of support maximum of $800 per week.
- Crime scene clean-up maximum of $2,500

***Additional compensation may be awarded based on extenuating circumstances.**

HOW TO FILE YOUR APPLICATION FOR COMPENSATION

Read all instructions for each section before completing this application. Please provide all information requested. Applications which are not completed and signed will be returned, thus delaying a decision on your claim. Please include copies of your medical bills and other expenses. Once your completed application is received and all requests for additional documents and information have been received and reviewed, you will be notified in writing of the Board's decision. You have the right to appeal that decision if you disagree.

The complete application/investigation process may take approximately 3 months.

If you have any questions while completing the application, please call our office at (785) 296-2359.