WISCONSIN

CRIME VICTIM COMPENSATION PROGRAM APPLICATION INFORMATION

An application may be filed by, or on behalf of, a person who was injured or died as a result of the crime. The Program may help with certain expenses such as medical or mental health bills or other losses directly related to the crime. **Personal property losses including cash and "pain and suffering" claims cannot be reimbursed by the Program.**

WHAT TO DO

- Please print clearly in ink. Separate applications must be completed for each injured victim.
- Enclose copies of crime-related medical, dental and/or counseling bills received as of this date and send all other crime-related bills as they are received. The Program requires that the bills be itemized. It is the applicant's responsibility to document the losses. If there is insurance, Medical Assistance, or another source of payment, those sources must be used first. If there is a provider in the network or a provider that the insurance will cover, that provider must be used. If those sources are not used, the Program may not be able to reimburse those costs.
- Send the completed application to the Crime Victim Compensation Program as soon as possible. Do **not** wait until court is over or until treatment is completed.
- The application must be signed by the injured victim or, if the victim is under 18 years of age, by the parent or guardian. If the victim is deceased, the application may be signed by a family member or by the administrator of the victim's estate.
- Provide all restitution information requested by the District Attorney's Office promptly. A restitution request must be made if the criminal case is being prosecuted. The Crime Victim Compensation Program application is to be sent to this office at the address below. The victim/witness program staff, a program advocate or other professional can assist you in completing this application.
- Return the competed application to the address listed on the bottom of this page. The applicant will receive a letter from the Crime Victim Compensation Program acknowledging the receipt of the application. Call the Program if a letter is not received after two weeks of submitting the application. Notify the Program of any changes in address, e-mail or phone number. If you have any questions, please call (608) 264-9497 or 1-800-446-6564 (Toll-free). **Keep this information sheet for your records.**

ELIGIBILITY REQUIREMENTS

In order to qualify for Crime Victim Compensation:

- The crime must be reported to law enforcement within 5 days of the date of the crime or within 5 days of the time when a report could reasonably have been made.
- The application must be filed within 1 year of the date of the crime.
- There are very limited circumstances in which these requirements may be waived. If the crime was not reported within 5 days or the claim was not filed within 1 year, attach a written statement explaining the reason for the delay. Victims who were under 18 at the time of the crime may file within one year after turning 18.
- The victim must cooperate in the investigation and prosecution. A victim must request restitution in order to be eligible for Crime Victim Compensation benefits.

NOTE: If a claim is approved, the Program may be able to assist certain family/household members of the deceased victim with losses due to emotional/physical reactions to the death. More information can be obtained by calling the Crime Victim Compensation Program office.

- Any money received from other sources such as restitution, lawsuits, insurance settlement, etc. **must be repaid** to the Crime Victim Compensation Program for crime related expenses paid by the Program.

Wisconsin Department of Justice
Crime Victim Compensation Program
Post Office Box 7951
Madison, WI 53707-7951
(608) 264-9497 or 1-800-446-6564 (Toll-free)

All information will be verified by the Crime Victim Compensation Program.
Section 949.17 of the Wisconsin Statutes provides penalties for persons who submit fraudulent applications.

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CRIME VICTIM COMPENSATION APPLICATION

Post Office Box 7951
Madison, WI 53707-7951
(608) 264-9497 or 1-800-446-6564 (Toll-free)

WI Statutes Chapter 949

CLAIM NO: _____

DATE RECEIVED:

(For Office Use Only)

PLEASE BE SURE TO SIGN THE APPLICATION ON THE LAST PAGE

THE APPLICATION MUST BE FILED WITHIN 1 YEAR OF THE DATE OF THE CRIME

SECTION 1: VICTIM INFORMATION

1. Victim's First Name	Victim's Last Name	2. ☐Female ☐Male	3. Date of Birth / /
4. Social Security Number	5. Mailing Address		
6. City	7. State	8. Zip Code	9. County
10. Home Telephone ( )	11. Cell Phone ( )	12. Work Telephone ( )	13. E-mail

14. Is the victim represented by an attorney due to this crime:

In filing this application? ☐ Yes ☐ No

In a civil lawsuit? ☐ Yes ☐ No

In an insurance action? ☐ Yes ☐ No

15. Name of Attorney	Telephone ( )
Street Address	E-mail
City	State / Zip Code

16. **The following information is used for statistical purposes only and is needed to comply with federal regulations**

A. Handicapped

Before Crime: ☐ Yes ☐ No

After Crime: ☐ Yes ☐ No

B. Race: ☐ White ☐ American Indian or Alaskan Native ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other

C. How did you learn about the Compensation Program? (Check all that apply)

☐ Law Enforcement ☐ Attorney ☐ Probation or Parole ☐ Friend ☐ Poster or Brochure

☐ District Attorney ☐ Sexual Assault Program ☐ Newspaper ☐ Relative ☐ Public Service Announcement

☐ Victim/Witness Program ☐ Domestic Abuse Program ☐ Funeral Director ☐ Hospital ☐ Other

SECTION 2A: PERSON FILLING OUT THE APPLICATION IF VICTIM IS A MINOR, HAS A GUARDIAN, OR IF VICTIM IS DECEASED

1. Person's Name	2. Relationship to Victim		
3. Mailing Address	4. City	5. State	6. Zip Code
7. Home Telephone ( )	8. Cell Phone ( )	9. Work Telephone ( )	10. E-mail

SECTION 2B: THIS SECTION IS FOR VICTIM ADVOCATES OR VICTIM WITNESS STAFF WHO ARE PROVIDING ASSISTANCE

1. Name	2. Organization/Title	3. Work Phone ( )
4. Address	5. E-mail	6. Preferred/Alternate Contact for Victim

SECTION 3: CRIME INFORMATION

1. Type of Crime (Check all that apply)

☐ Homicide ☐ Domestic Violence ☐ Hit and Run of Pedestrian ☐ Drunk Driving / DUI
☐ Attempted Homicide ☐ Child Physical Abuse ☐ Sexual Assault ☐ Other _____
☐ Assault/Battery ☐ Child Sexual Abuse ☐ Robbery

2. Location of Crime: Street Address	3. City	4. State	5. County

6. Date of Crime / /	7. Date Crime Reported / /	8. Law Enforcement Agency to which crime was reported	Officer's Name

9. Offender(s) Names(s):

10. Did victim know offender(s)? ☐Yes ☐No If yes, in what way?

Description of crime (optional):

SECTION 4: MEDICAL/MENTAL HEALTH EXPENSE INFORMATION

1. Name and address of medical facility where victim was **first treated:**	2. Date of Treatment: / /

3. Mental Health Treatment received, or to be received? ☐ Yes ☐ No ☐ Unknown

SECTION 5: MISCELLANEOUS EXPENSES

Homemaker Services $ _____ Documented Crime Scene Cleanup $ _____

Securing a Crime Scene $ _____ Property held as evidence and damaged by Crime Lab testing $ _____

Clothing/bedding held as evidence and the reasonable replacement value of each:

_____ $_____ _____ $_____

_____ $_____ _____ $_____

SECTION 6: INSURANCE AND BENEFIT INFORMATION

1. Was there insurance or other source of payment to cover expenses at the time of the crime? ☐ Yes ☐ No

Please attach copies of any crime-related itemized bills and explanation of benefits.

2. Check all that apply:

☐ Employers/Union Group ☐ Workers' Compensation ☐ Medical Assistance/Title 19 ☐ Homeowners Insurance

☐Veterans' Benefits ☐ County Welfare/GAMP ☐ Victim/Spouse/Parent Insurance ☐ Badger Care

☐ Lawsuit ☐Disability ☐ Medicare ☐ Other (describe) _____

SECTION 7: CRIMES INVOLVING MOTOR VEHICLES

Did the victim have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company:
Did the driver have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company:
Did the offender have auto insurance? ☐ Yes ☐ No ☐ Unknown	Name of company:

SECTION 8: EMPLOYMENT INFORMATION

Complete the section **ONLY** if the victim was employed at the time of injury.

1. Did victim miss time from work immediately following the crime?

☐ Yes ☐ No ☐ Unknown

2. Is the victim self-employed?

☐ Yes ☐ No

3. Dates absent from work due to crime related injuries: From _____ To _____

4. Name of Employer	5. Employer Telephone ( )

6. Employer Mailing Address	7. City	8. State	9. Zip Code

FOR CRIME RESULTING IN DEATH

SECTION 9: FUNERAL/BURIAL EXPENSES

1. Funeral Home Name		2. Mailing Address	
3. City	4. State	5. Zip Code	6. Telephone ( )

7. Life Insurance ☐ Yes ☐ No ☐ Unknown Amount: $ _____ Beneficiary _____

SECTION 10: DEPENDENTS FINANCIALLY SUPPORTED BY VICTIM AT TIME OF DEATH

First Name Last Name	Date of Birth Month / Day / Year	Relationship to Victim
	/ /	
	/ /	
	/ /	

AGREEMENT

- My signature below means that I certify that information on this application is true and correct.
- I agree that payments for bills may be paid directly to whom the payment is owed.
- I understand that the Crime Victim Compensation Program reimburses for costs not covered by any other source.
- I agree to notify the Crime Victim Compensation Program if a lawsuit is filed.
- I agree to repay the Crime Victim Compensation Program for all payments made if I receive money from any other source.
- I agree to refund the Crime Victim Compensation Program for all money paid by the Program if this claim is determined to be false or fraudulent.

AUTHORIZATION

I authorize and request any person having information needed by the Crime Victim Compensation Program to process my claim to release that information to the Wisconsin Department of Justice. That includes, but is not limited to, all past law enforcement records or child support agency records concerning me; private and governmental physicians and hospitals; all billing information; local, state and federal law enforcement and prosecutors office and federal court personnel; any employer, unemployment compensation insurance program, workers compensation program; and any private company or governmental agency that is providing or may provide medical or monetary benefits. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I authorize the Crime Victim Compensation Program to release copies of crime-related medical bills and wage information to the Office of the District Attorney for determination and documentation of restitution. I certify that I understand and agree to the above statements.

_____ _____

Signature of Victim or Person filing Claim Date

RETURN COMPLETED APPLICATION TO:

Wisconsin Department of Justice
Crime Victim Compensation Program
Post Office Box 7951
Madison, WI 53707-7951
FAX (608) 264-6368

FOR ASSISTANCE CALL: In Madison (608) 264-9497
Toll Free 1-800-446-6564