OFFICE OF VICTIM SERVICES

Focusing on a brighter future

PERSONAL INJURY APPLICATION

JD-VS-8PI Rev. 10/17

We are here to help. If you have any questions about filling out this application or the Victim Compensation Program, please call us at 1-888-286-7347. Please know that it is important that you tell us if your contact information changes. If we cannot reach you, you may miss important deadlines set by state law or your claim may be closed.

SECTION 1 – VICTIM INFORMATION

The person who was physically injured because of the crime.

Name of victim (first, middle, last) | Birth date (mm/dd/yyyy) | Age

Address | City | State | Zip

Daytime phone number | Cell phone | Email

Primary language spoken | Gender: ☐ female ☐ male ☐ other _____

SECTION 2 – CLAIMANT INFORMATION

The person who has expenses because of the crime. If the victim and the claimant are the same person, you do not have to fill out this section.

How is the claimant related to the victim?

☐ child ☐ spouse ☐ parent ☐ grandchild ☐ grandparent ☐ spouse's parent ☐ stepparent

☐ brother ☐ sister ☐ half-brother ☐ half-sister ☐ step-child ☐ adopted child ☐ party to a civil union

☐ aunt ☐ uncle ☐ niece ☐ nephew ☐ other _____

Name of claimant (first, middle, last) | Birth date (mm/dd/yyyy) | Age

Address | City | State | Zip

Daytime phone number | Cell phone | Email

Primary language spoken | Gender: ☐ female ☐ male ☐ other _____

FOR OFFICE USE ONLY | Claim Number | Claims Examiner

SECTION 3 – PARENT/LEGAL GUARDIAN/CONSERVATOR INFORMATION

This section is for parents or legal guardians of children under 18 years old and legal guardians or conservators for an incapacitated adult.

Name of parent/legal guardian/conservator (first, middle, last) _____ Relationship: ☐ parent ☐ adoptive parent ☐ legal guardian ☐ conservator

Address _____ City _____ State _____ Zip _____

Daytime phone number _____ Cell phone _____ Email _____

Primary language spoken _____ Gender: ☐ female ☐ male ☐ other _____

SECTION 4 – ATTORNEY REPRESENTATION

You do not need an attorney to receive victim compensation. If you do have an attorney, please check if the attorney is helping you with your claim, a civil lawsuit, or both and provide the attorney's contact information.

☐ Representing me on this application ☐ Representing me in a civil lawsuit

Name of attorney (first, middle, last) _____ Name of firm _____

Address _____ City _____ State _____ Zip _____

Work telephone _____ Fax number _____ Email _____ Juris number _____

SECTION 5 – PERMISSION TO CONTACT OR SPEAK WITH ANOTHER PERSON

Please check if you are giving OVS permission to contact someone if we can't reach you, permission to speak with someone about your claim, or both, and provide that person's contact information.

☐ Permission to contact, if OVS can't reach me ☐ Permission to speak with about my claim

Name of person (first, middle, last) _____ How do you know this person? _____

Address _____ City _____ State _____ Zip _____

Daytime phone number _____ Cell phone _____ Email _____

SECTION 6 – STATISTICAL INFORMATION

It is your choice to answer these questions. This information is used in state and federal reports.

Would you describe the victim as:

☐ american indian/alaska native ☐ asian ☐ black/african american ☐ hispanic/latino/latina

☐ native hawaiian/other pacific islander ☐ white non-latino/caucasian ☐ other race _____

Was the victim disabled before the crime? ☐ yes ☐ no ☐ don't know

Was the victim disabled after the crime? ☐ yes ☐ no ☐ don't know

How did you find out about the Victim Compensation Program: _____

SECTION 7 – CRIME INFORMATION

If the crime involved sexual assault or human trafficking, please do not fill out this section but answer the questions in Section 7a.

Date of crime _____ Address and city where crime happened _____

Type of crime: ☐ physical assault ☐ robbery with injury ☐ driving under the influence (dui) ☐ evading (hit and run) ☐ other crime causing physical injury

Briefly describe the crime and physical injuries: _____

Date crime reported to police: _____ Was the crime reported within 5 days? ☐ yes ☐ no (if no, please explain):

Police department _____ Name of officer investigating the crime _____ Police report number _____

If the crime was domestic violence and not reported to police, please check which professional you told about the assault:
☐ judge (if the judge gave you a restraining or civil protection order, please attach a copy of the application or affidavit.)

☐ domestic violence counselor ☐ sexual assault counselor ☐ other _____

SECTION 7a – SEXUAL ASSAULT OR HUMAN TRAFFICKING CRIMES

Type of crime: ☐ sexual assault ☐ forced labor ☐ other _____

If a sexual assault, did you have a sexual assault medical examination and evidence collected? ☐ yes ☐ no

If yes, name of health care facility _____ Date of examination _____

Please check which professional you told about the assault:
☐ judge (if the judge gave you a restraining or civil protection order, please attach a copy of the application or affidavit.)
☐ sexual assault or domestic violence counselor ☐ medical professional ☐ mental health professional ☐ police
☐ Department of Children and Families employee ☐ school professional ☐ other _____

Name of the person you told about the assault _____ Title _____ Date you told that person _____

Address (street, city, state, zip) _____ Telephone _____

SECTION 8 – OFFENDER INFORMATION

Was someone arrested for the crime? ☐ yes ☐ no ☐ don't know _____
Name of person arrested, if known

Did the offender go to court? ☐ yes ☐ no ☐ don't know _____
If yes, city where courthouse is located

Docket number, if known: _____

Did the court order the offender to pay for your crime-related expenses (restitution)? ☐ yes ☐ no ☐ don't know

SECTION 9 – CRIME-RELATED EXPENSES AND FINANCIAL RESOURCES

Please check the box next to the compensation benefit you are applying for, the boxes next to the financial resources you have available to you, and fill out the information requested. You must contact us if any of the financial resources not checked become available to you. If you do not have any crime-related expenses at this time, it is important that you still submit the application in case you need financial help in the future.

☐ **NO EXPENSES AT THIS TIME** (please skip to Section 10 and sign the application)

☐ **MEDICAL, MENTAL HEALTH, DENTAL, AND PRESCRIPTION EXPENSES**

Please list the names of all providers who treated you and provide copies of crime-related bills, prescription printouts for co-pay amounts, and insurance benefit statements, if available.

Provider Name	Address (street, city, state, zip)	Telephone

Financial Resources	Insurance Company	Member Number	Telephone
☐ Dental Insurance			
☐ Department of Social Services (Medicaid/Husky)			
☐ Health Insurance (primary)			
☐ Health Insurance (secondary)			
☐ Medicare			
☐ Supplemental Insurance (accident/illness)			
☐ Vehicle Insurance (for crimes involving vehicles)			
☐ Veterans Health Administration			
☐ Workers' Compensation (for crimes at work)			
☐ Donations (example GoFundMe)			

☐ **CRIME SCENE CLEAN-UP EXPENSES** (Maximum benefit $1,000)

Please fill out this section if you paid all or part of the crime scene clean-up expenses and provide copies of bills and receipts, if available. Expenses may include biohazard cleaning, replacing or repairing damaged locks, windows, doors, and alarm systems.

Provider Name	Address (street, city, state, zip)	Telephone

Financial Resources	Insurance Company	Policy Number	Telephone
☐ Homeowners' Insurance			
☐ Renters' Insurance			
☐ Vehicle Insurance (for crimes involving vehicles)			

☐ EXPENSES TO ATTEND ADULT COURT PROCEEDINGS

Please fill out this section if you have or will have expenses to attend adult court proceedings. The relatives of the victim that are eligible for this benefit include the victim's child (natural, adopted, step), spouse, parent, spouse's parents, grandchild, grandparent, stepparent, brother and sister (natural and half), aunt, uncle, niece, and nephew.

Please check the type of expenses and losses you have or will have to attend court proceedings:

☐ travel expenses (includes mileage reimbursement)

☐ lost wages (please fill out the information about your employer in the Wage Loss section. OVS will contact your employer for the dates absent and salary and benefit information. If you have a concern about this, please call us.)

Please list the dates you attended or will attend court proceedings: _____

☐ WAGE LOSS (employed or self-employed)

If you were employed or self-employed at the time of the crime and are applying for wage loss, it is important for you to know that we can only consider taxable income. Please check if you are self-employed or if you are giving OVS permission to contact your employer for the dates you were absent and salary and benefit information.

☐ I am self-employed (a claims examiner will contact you)

☐ You have my permission to contact my employer (please fill out your employer information)

☐ You do not have my permission to contact my employer (a claims examiner will contact you)

Name of employer _____ Contact name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Hours worked per week _____ Wages per hour _____ Tips, bonuses per week _____

Dates absent because of crime-related injuries or care to victim _____

If you missed more than 1 week of work, you must provide a note from the treating health care provider listing the days you were absent from work because of the crime-related injuries. Please include a copy of the note with this application or fill out the information below:

Name of health care provider _____ Address (street, city, state, zip) _____ Telephone _____

Financial Resources	Insurance Company	Member Number	Telephone
☐ Department of Social Services (financial)			
☐ Disability Insurance			
☐ Life Insurance – Disability Rider			
☐ Police/Firefighters Insurance			
☐ Social Security Disability			
☐ Supplemental Insurance (accidental/illness)			
☐ Unemployment Compensation			
☐ Vehicle Insurance (for crimes involving vehicles)			
☐ Workers' Compensation (for crimes at work)			
☐ Donations (example GoFundMe)			

SECTION 10 – STATEMENT OF FACTS AND AUTHORIZATION

I certify that the information in this application for victim compensation is true to the best of my knowledge, information, and belief. I give permission to any hospital, physician(s) or other person(s) who attended, examined, or gave services to me or to any minor child or incapacitated adult for whom I am the parent, legal guardian, or conservator and have the authority to act on his or her behalf; to my employer(s) and the employer(s) of the person I am acting on behalf of; any police or other municipal authority or agency, or public authorities including state and federal revenue services, any insurance company or organization having knowledge of the incident to give to the Office of Victim Services (OVS) or its representative any and all information regarding the incident leading to the victim's physical injuries and this application for victim compensation. A copy of this authorization will be considered as effective and valid as the original.

I give permission to OVS to disclose any information in its records, including confidential information, to the offices of the Court Support Services Division, the State's Attorney, the Attorney General, the Office of the United States Attorneys, and to private attorneys retained by OVS or by me, and to communicate freely with them when necessary (Sections 54-208(e), 54-212, and 54-215 of the Connecticut General Statutes).

I understand that I must notify OVS if I file a lawsuit against whoever is responsible for the injury for which OVS paid the compensation within 30 days of the filing of the action in court. If I recover money from the lawsuit, either by a judgment or by settlement, I understand that OVS is entitled by state law to 2/3 of the amount OVS paid (Section 54-212 of the Connecticut General Statutes). If I have filed a lawsuit, I agree to provide a copy of the writ, summons, and complaint to OVS immediately.

I understand that OVS will have the right to bring a lawsuit in my name against whoever is responsible for the injury for which the money was paid. I also understand that if OVS recovers money from the lawsuit, OVS is entitled by state law to keep 2/3 of the amount paid, plus costs and interest. OVS will pay me any balance over that amount (Section 54-212 of the Connecticut General Statutes).

I understand that if I or the person I am filing on behalf of receives money from any other sources, including payments from state or municipal agencies, insurance benefits, or workers' compensation because of the incident, OVS is entitled by state law to 2/3 of the amount OVS paid (Section 54-212 of the Connecticut General Statutes).

I understand that if the court orders restitution to me or to the person I am filing on behalf of for expenses paid by OVS, OVS is entitled to receive full reimbursement, unless the court orders differently (Section 54-215 of the Connecticut General Statutes).

I also understand that my providers may be reimbursed directly for debts that I owe.

Applicant signature	Print your name	Date

The adult applicant, the parent/legal guardian/conservator of a minor child (under 18 years old), or the legal guardian/conservator for an incapacitated adult must sign this application. Applications that are not signed will be returned.

Please mail, fax, or email the completed application to: Office of Victim Services, 225 Spring Street, 4th Floor, Wethersfield, CT 06109; Fax: 860-263-2780; Email: OVSCompensation@jud.ct.gov

Contact OVS at: 1-888-286-7347 or www.jud.ct.gov/crimevictim/

ADA NOTICE

The Judicial Branch of the State of Connecticut complies with the Americans with Disabilities Act (ADA). If you need a reasonable accommodation, in accordance with the ADA, call OVS at 1-800-822-8428.