Kentucky Claims Commission – Crime Victim Compensation Form
500 Mero Street, Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

This form must be legibly written, typed, or printed, and must be signed. Incomplete submissions may not be considered. All answers may be supplemented with additional explanatory pages.

Section 1: Claimant Information

Claimant's Name: _____ SSN or Gov't ID#: _____

Relationship to Victim _____

Address: _____

Telephone #: (Primary) _____ (Other) _____ E-Mail: _____

Section 2: Victim and Offender Information

Victim's Name: _____ SSN or Gov't ID # _____

Date of Birth: ___/___/_____ Male __ Female __ Age at time of Crime ____

Address: _____

Telephone #: (Home) _____ (Other) _____

E-Mail: _____

Name of Offender(s): _____

Was the Offender charged with a crime? __Yes __No

If yes, what charge? _____

If yes, in what Court? District: _____ Circuit: _____ Juvenile: _____

Type of Crime (Check all that apply)

- € Arson
- € Assault
- € Burglary
- € Child Physical Abuse / Neglect
- € Child Pornography
- € Domestic Assault
- € DUI / DWI
- € Fraud / Financial Crimes
- € Homicide (Murder)
- € Human Trafficking
- € Kidnapping
- € Other Vehicular Crimes
- € Robbery
- € Sexual Assault Adult
- € Sexual Assault Child
- € Stalking
- € Terrorism
- € Other

Section 3: Financial Information

Employment at time of crime: __ Full __ Part __ Self __ Unemployed Time missed from work as a result of crime: __Yes __No

Are you applying for lost wages? __Yes __No Are you applying for loss of support? __Yes __No
These claims require completion of the Employment Verification Form. Where applicable, these claims also require completion of the Physician Statement and Mental Health Counselor's Report.

Total monthly income prior to incident: $_____
Income or payment sources at time of incident: $_____Wages $_____Social Security $_____Worker's Compensation
$_____Insurance $_____Medicare $_____Medicaid $_____Veteran's Benefits
$_____ Other (please specify) _____

Total monthly income as a result of incident: $_____
Income or payment sources as a result of incident: $_____Wages $_____Social Security $_____Worker's Compensation
$_____Insurance $_____Medicare $_____Medicaid $_____Veteran's Benefits
$_____ Other (please specify) _____

Section 4: Crime Incident Information

Date of incident ___/___/____ Time of incident __:__ a.m./p.m.

Location where the incident occurred: _____

(Please be specific so as to provide exact location)

Date reported ___/___/____ Reported To:_____

Law Enforcement Agency

If not reported within 48 hours of discovery, please explain: _____

Describe the incident:

_____

_____

_____

_____

_____

_____

Describe any injuries:

_____

_____

_____

_____

Section 5: Expenses

Each expense must be listed below to be considered. Each must be a direct result of the crime, and documentation must include date, type, and charge for service. If you need additional space please attach a separate page or the itemized bill(s).

5a. Medical Expenses

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

5b. Mental Health Expenses

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

5c. Funeral/Burial Expenses

Date of Death ___/___/_____ Funeral Home _____ Address _____

Total Funeral Expenses: $_____ Paid? __ Yes __ No If yes, by whom? _____ Relationship to Victim: _____

Benefits available and amounts: $_____ Life Insurance $_____ Worker's Compensation $_____Funeral/Burial Insurance

$_____ Social Security $_____ Estate $_____ Donations (including crowd-funding websites) Other: _____

Section 6. Federal Government Information (*optional/for statistical use only)*

Ethnic Group (Victim)
( ) Caucasian
( ) African American
( ) American Indian or Alaskan Native
( ) Hispanic / Latino
( ) Multiracial
( ) Asian
( ) Native Hawaiian / Other Pacific Islander
( ) Other

Are you (please check all that apply)
( ) U.S. Citizen ( ) Handicap ( ) Kentucky Resident

Who referred you to the compensation program?
( ) Law Enforcement ( ) Hospital ( ) Victim Advocate
( ) Prosecutor ( ) Judge ( ) Other _____

Is this a Federal Crime? ( ) Yes ( ) No

Section 7. Restitution and Civil Lawsuit

Has the victim or claimant filed or plan to file a civil suit relating to the injury received as a result of the crime? __ Yes __ No

If yes, Attorney:_____ Telephone: _____ E-mail: _____

Has the Offender been ordered by a court to pay restitution to the victim or claimant? __Yes __No If yes, amount: $_____

Has the victim received any of the ordered restitution? __ Yes __ No If yes, amount: $_____

Section 8. Authorization and Subrogation

I hereby certify, subject to penalty, fine, or imprisonment that the information contained in this form and all attachments is true and correct to the best of my knowledge.

SUBROGATION: In consideration of the payment received from the Kentucky Claims Commission, in the event I recover damages or compensation from the offender or from any other public or private source as a result of the injuries or death which was the basis of my claim for compensation from the fund, I agree to repay such amount up to the full amount I received from the fund. I understand that compensation from any other public or private source includes but is not limited to: receipt of insurance, Medicare, Medicaid, Workers Compensation, disability pay, etc. I further agree and understand that no part of recovery due the Kentucky Claims Commission may be diminished by any collection fees or for any other reason whatsoever.

Should I choose to recover damages or compensation for the injury or death from any sources, I agree to promptly notify the Kentucky Claims Commission by sending copies of any pleadings, settlement proposals and any other documents relative thereto. I further agree to fully cooperate with the Kentucky Claims Commission should the Commission decide to institute an action against any person or entity for the recovery of all or any part of the compensation I received from the fund.

MEDICAL/PSYCHIATRIC/EMPLOYMENT RELEASE: I hereby authorize any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility, or any other person or firm to release any and all information requested by the Kentucky Claims Commission. I understand and acknowledge that my mental health records may contain confidential remarks made by me, information regarding drug or alcohol abuse, HIV status, or other personal data. I further agree and hold blameless any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility or any staff person of any and all liability for the release of these records.

YOUR SIGNATURE: _____ DATE: _____

Attorney's Name*: _____ Address:_____

Telephone: _____ E-mail Address: _____

Attorney's Signature: _____ Date: _____

*You are <u>not</u> required to have an attorney assist in submitting your application. However, if an attorney does assist you, the attorney must sign the application as well.

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EMPLOYMENT VERIFICATION

Complete only if applying for lost wages/ loss of support.
To be completed and signed by EMPLOYER only. *This form must be NOTARIZED.*

Employee's Name: _____ Social Security #: _____

Date of Crime: _____ Victim was employed at the time of crime ( ) Yes ( ) No

If SELF-EMPLOYED, attach copies of State and Federal taxes for the two-year period prior to the crime.

Employer's Name: _____ Telephone: _____

_____

Address City State Zip Code

Victim missed time from work because of injuries related to the crime: ( ) Yes ( ) No

If yes, from _____ to _____

The items listed below are to be **weekly amounts:**
Gross Earnings: $_____ Net Take Home Earning Per Week: $ _____

Federal Tax Withheld: $ _____ State Tax Withheld : $ _____ Social Security Withheld: $ _____

Other Deductions (itemized): $ _____ Typical days worked per week: M T W TH F Sat Sun
Attach additional pages if necessary.

Please Circle
Victim has returned to work: ( ) Yes ( ) No Victim's wage continued while off work: ( ) Yes ( ) No

If the victim's wage continued while off work, complete the following:

Deductions	Amount Per Week	Starting Date	Ending Date
Workers Comp	$		
Unemployment	$		
Insurance – Health	$		
Insurance – Other	$		
Vacation	$		
Sick	$		
Employers Group	$		
Disability	$		
Union	$		
Other	$		

_____ _____
Employer's Name and Title Employers Signature

The following must be completed by a Notary:

SUBSCRIBED AND SWORN TO BEFORE ME BY _____

THIS _____ DAY OF _____. 20____

MY COMMISSION EXPIRES: _____

Signature: _____

Seal or Stamp affixed here

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PHYSICIAN STATEMENT

Complete only if applying for lost wages/ loss of support.
To be completed and signed by PHYSICIAN only.

Victim / Patient Name: _____

Type of Injury: _____

Date of Injury: _____ Date(s) victim/patient unable to work: _____to _____

Victim/Patient suffered permanent disability: ( ) Yes ( ) No

If yes, please state the victim's percentage of permanent disability to the body as a whole in accordance with the AMA Guidelines:

_____

Description of injury/trauma resulting from crime and comments:

Name of Physician: _____ Specialty: _____

Office Address: _____
Address City State Zip Code

Telephone: _____ State License Number: _____

_____ _____
Physician's Signature Date

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MENTAL HEALTH COUNSELOR'S REPORT

Complete only if applying for mental therapy or where applicable for lost wages.
To be completed by COUNSELOR only. *Treatment plan must be attached.*

Victim/Claimant receiving treatment: _____

Date of crime: _____ Date(s) victim/claimant unable to work: _____ to _____

The trauma and treatment is a direct result of this crime ( ) Yes ( ) No

Presenting Complaint: _____

Diagnosis of Record:

_____

Description of psychological trauma resulting from crime:

Health Insurance: _____
Company Name Phone Number/ Extension

_____
Address City State Zip Code

****PLEASE ATTACH PATIENT TREATMENT PLAN****

Name of Physician/Therapist/Counselor: _____ Specialty: _____

Office Address: _____
Address City State Zip Code

Telephone: _____ State License Number: _____

_____ _____
Physician/Therapist/Counselor Signature Date