ALABAMA CRIME VICTIMS' COMPENSATION COMMISSION

P.O. BOX 231267
MONTGOMERY, ALABAMA 36123-1267
(334) 290-4420
1-800-541-9388 (VICTIMS ONLY)
FAX (334) 290-4455
www.acvcc.alabama.gov

If you have limited English proficiency, you have the right to language assistance and this language assistance will be provided to you free of charge.

Si usted ha limitado la pericia inglesa, usted tiene el derecho a la ayuda del idioma y esta ayuda del idioma será proporcionado a usted libre de la carga.

APPLICATION INSTRUCTIONS

Please carefully read these instructions before completing the application.

1. **When completing this form, please type or print legibly, in ink.**
2. If you need help with this form, please contact the Victim Service Officer (VSO) at your local District Attorney's office or the ACVCC at the number(s) listed above.
3. Only send copies of bills and expenses related to the victimization. Include copies of bills, receipts, and insurance or benefit statements related to the victimization with the application if you have them. You may send copies of additional medical bills as treatment continues. Until necessary documentation is received, that portion of your claim cannot be processed.
4. Promptly submit the application to the ACVCC. You may submit it as a PDF by email at info@acvcc.alabama.gov, by fax at 334-290-4455, or by mail to ACVCC, PO Box 231267, Montgomery, AL 36123-1267. (Please note that a PDF is the only electronic format the ACVCC can accept for email submission.) There is a one-year deadline from the date of the crime for filing your claim.
5. If the ACVCC asks you for additional information, you should send it immediately. If the requested information is not received within forty-five (45) days, your claim may be not approved.
6. The contact information in SECTION 1 or SECTION 2 must be completed in order to process your claim. If the ACVCC is unable to contact you or there is no response to correspondence, your claim may be not approved. **It is your responsibility to update your contact information if it changes.**
7. The demographic information requested in SECTION 1 (shaded box) is OPTIONAL. This information is collected for statistical purposes. You do not have to provide this information.
8. SECTION 2 should only be completed if someone other than the victim is filing a claim. A claimant may apply in cases where the victim is deceased, incapacitated, or a minor. The claimant must be the person legally authorized to act on the behalf of the victim. Documentation of this authority must be provided. In Alabama, unless you are married, divorced, or an emancipated minor, you must be a minimum age of 19 to file your own claim.
9. The questions in SECTION 3 must be answered for the ACVCC to process your claim.
10. The applicable information in SECTION 4 should be completed to the best of your ability. The questions in SECTION 4 must be answered for the ACVCC to process your claim.
11. The applicable information in SECTION 5 should be completed for any medical expenses incurred as a result of your victimization.
12. The applicable information in SECTION 6 should be completed if you want consideration of lost wages or economic loss incurred as a result of your victimization. You must provide a doctor's excuse to be eligible for lost wages.
13. The applicable information in SECTION 7 and SECTION 9 should be completed to the best of your ability.
14. The information in SECTION 8 should only be completed if the victim is deceased.
15. Complete SECTION 10 if you need emergency financial assistance. Emergency awards are for cases of dire economic need that result from violent crime victimization. These awards are usually granted for loss of income, moving expenses, prescriptions, or crime scene clean-up. If you are requesting an emergency award for loss of income, please attach a statement from your employer stating the time lost from work and your net (take-home) weekly pay. If you are requesting an emergency award for moving expenses, you must attach estimates or receipts for the requested items. Emergency awards are not usually considered for medical bills unless a service provider has refused treatment pending payment. Please have the service provider write a letter noting this, and provide a copy of the estimate. If you do not include these items, it will take longer to process your emergency award. There is a maximum of **$2,000.**
16. For SECTION 11, either provide the contact information for your attorney OR check the box stating that you have NOT filed any civil lawsuits in connection with this victimization.

The ACVCC must receive the **signed and dated** forms in order to process your claim.

A claim filed on behalf of a minor victim or by the next-of-kin of a homicide victim cannot be processed without a completed and notarized ***Affidavit of the Parent or Legal Guardian of a Crime Victim*** (if a minor victim) or ***Affidavit for the Surviving Spouse or Next-of-Kin*** (if a homicide victim).

Copies of documents are acceptable.

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THE COMMISSION DOES *NOT* PROVIDE COMPENSATION FOR

PROPERTY CRIMES, ACCIDENTS, IDENTITY THEFT, PAIN & SUFFERING OR ATTORNEY'S FEES.

The Commission can only provide compensation for actual expenses.

No more than $20,000 may be awarded for any compensation claim.

COMPENSATION MAY BE AWARDED FOR:

A) **Medical expenses**—including doctor and hospital care, dental expenses, prescriptions, medical supplies, inpatient psychiatric care, etc. This does not include expenses covered by insurance. Victims may be eligible to receive 100% reimbursement for medical expenses he/she has paid for out-of-pocket.

B) **Rehabilitation expenses**—including vocational or physical therapy, if not covered by another source.

C) **Counseling expenses**—includes counselor, psychologist and/or psychiatrist fees for counseling services that are related to the victimization. Mental health providers must be properly licensed by the appropriate regulatory body in order for the Commission to consider their services for payment. Counseling is limited to 50 sessions per claim unless the Commission determines exigent circumstances exist. Single counseling sessions may be reimbursed at: **$80** per hour for licensed counselors and social workers; **$100** per hour for psychologists; **$125** per hour for psychiatrists; and **$60** per hour for group therapy.

D) **Work loss** — work the claimant/victim missed due to the crime. **Replacement services loss** - expense that the claimant/victim would not have incurred if the victim had not been injured or died. The maximum award for work loss and replacement services loss is **$600** per week. Work loss and replacement services loss are limited to 52 weeks.

E) **Funeral expenses**—including funeral home expenses, cremation, burial expenses including monument. There is a maximum of **$7,000.**

F) **Property expenses**—Compensation may be awarded for eligible property that was damaged during victimization. Security enhancements installed after victimization may be eligible. The maximum award is **$3,000**, which includes a **$500** maximum for damaged clothing. Please contact the Commission for a list of specific items that may be eligible.

G) **Moving expenses**—including security deposits, utility deposits and the costs to move. It does not include rent payments. Moving expenses may be awarded in cases in which the crime occurred in the victim's home, the victim has a reasonable fear for his/her life if he/she does not move from the home, or moving the victim's personal belongings is necessary. There is a maximum of **$2,000; $3,000** for exigent circumstances.

H) **Future economic loss**—monetary loss to victim or a deceased victim's dependent spouse and dependent child(ren). The maximum possible award is **$20,000.**

I) **Guardianship fees**—reimbursement for legal fees incurred by claimant to obtain guardianship of disabled or minor victim, if guardianship is awarded. There is a maximum of **$1000**.

J) **Crime scene clean-up**— reasonable costs to clean the scene of the crime. The service provider must be certified, licensed, and in compliance with all applicable federal and state regulations. There is a maximum of $2,500.

YOU MAY BE ELIGIBLE FOR COMPENSATION IF:

A) The crime was reported to law enforcement within seventy-two hours (unless good cause can be shown for not doing so). Good cause must be submitted in writing.

B) The claim is filed within one year of the date of the incident (unless good cause can be shown for not doing so). Good cause must be submitted in writing.

C) The victim suffered serious personal injury (including a face-to-face threat of physical harm), or death as a result of a criminal act.

D) The victim/claimant cooperated with law enforcement officials, the prosecutor's office, the courts, and the Commission.

E) The claimant/victim was not the offender, or an accomplice of the offender, or encouraged or participated in the crime in any way.

F) The compensation award would not unjustly benefit the offender.

G) The victim/claimant was not convicted of a felony and/or did not perpetrate criminally injurious conduct after applying for compensation.

H) The victim/claimant did not contribute to the victimization.

I) The victim/claimant is a U.S. citizen, legally present in the U.S., or an alien eligible for public benefits. Domestic violence victims and certified victims of human trafficking are considered to be aliens eligible for public benefits regardless of immigration status.

J) Your expenses were not paid by a collateral source (another source of payment).

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ACCEPTABLE DOCUMENTATION FOR PROOF OF LEGAL PRESENCE

You must be a U.S. citizen, legally present in the U.S., or an alien eligible for public benefits to qualify for compensation benefits. Proof of this must be provided for BOTH the claimant AND the victim.

LIST A

If you are an U.S. citizen, please provide the Commission with a copy of one of the following documents:

- A birth certificate issued in or by a city, county, state, or other governmental entity within the United States or its outlying possessions
- A U.S. Certificate of Birth Abroad (FS-545, DS-135) or a Report of Birth Abroad of a U.S. Citizen (FS-240)
- A birth certificate or passport issued from:
    1. Puerto Rico, on or after January 13, 1941
    2. U.S. Virgin Islands, on or after February 25, 1927
    3. American Samoa
    4. District of Columbia
    5. Guam, on or after April 10, 1898
    6. Northern Mariana Islands, after November 4, 1986
    7. Swains Island
- An unexpired U.S. passport
- Certificate of Naturalization (N-550, N-57, N-578)
- Certificate of Citizenship (N-560, N-561, N-645)
- U.S. Citizen Identification Card (I-179, I-197)
- Free Alabama Photo Voter Identification Card

If the Commission is not satisfied with the authenticity of a copy of one of the above-listed documents, it may request that the original or a certified copy be submitted for inspection. If you obtain(ed) your birth certificate after the date of your victimization, the Commission will reimburse you for the cost of the birth certificate if your claim is approved. The Commission does not reimburse for passports.

LIST B

If you are not a U.S. citizen, you must provide proof of legal presence. Submission of a copy of one of the following documents and subsequent positive verification in the Systematic Alien Verification for Entitlements (SAVE) system is proof of legal presence:

- I-327 (Reentry Permit)
- I-551 (Permanent Resident Card)
- I-571 (Refugee Travel Document)
- I-766 (Employment Authorization Card)
- Certificate of Citizenship
- Naturalization Certificate
- Machine Readable Immigrant Visa (with Temporary I-551 Language)
- Temporary I-551 Stamp (on Passport or I-94)
- I-94 (Arrival/Departure Record)
- I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
- Unexpired Foreign Passport
- I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status)
- DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)
- Documents not included in this list will be examined on a case-by-case basis

If you submit a LIST B document, your legal presence will be verified by the Systematic Alien Verification for Entitlements (SAVE) system.

You will be presumed to not be an alien who is unlawfully present in the U.S. if you provide a copy of one of the following documents to the Commission for inspection:

- A valid, unexpired Alabama driver's license.
- A valid, unexpired Alabama non-driver identification card.
- A valid tribal enrollment card or other form of tribal identification bearing a photograph or other biometric identifier.
- Any valid United States federal or state government issued identification document bearing a photograph or other biometric identifier, if issued by an entity that requires proof of lawful presence in the United States before issuance.

If the Commission is not satisfied with the authenticity of a copy of one of the above-listed documents, it may request that the original or a certified copy be submitted for inspection. The Commission can only provide compensation benefits to U.S. citizens, individuals legally present in the U.S., and aliens eligible for public benefits.

Victims of domestic violence and certified victims of human trafficking are considered to be aliens eligible for public benefits regardless of immigration status.

ALABAMA CRIME VICTIMS' COMPENSATION COMMISSION

You must fill out each section completely to have your claim processed. You must include all necessary attachments.

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DO NOT WRITE IN THIS SPACE

CLAIM # _____

DATE RECEIVED _____

HOW DID YOU FIRST LEARN ABOUT THE ALABAMA CRIME VICTIMS' COMPENSATION COMMISSION?

○ Law Enforcement ○ District Attorney ○ Lawyer ○ Media (TV, Radio, Internet, etc.) ○ Medical Provider ○ Other _____

SECTION 1. VICTIM INFORMATION

Social Security Number* | Date of Birth | First Name | Middle Name/Maiden Name | Last Name

Street Address | City | State | ZIP Code

Home Phone | Work Phone | Cell Phone | Other Phone | Email

Marital Status

○ Single ○ Separated ○ Divorced ○ Widowed ○ Married

Spouse's Name

Dependent(s) Please list name(s), age(s), and how related to victim.

THE FOLLOWING INFORMATION IS COLLECTED FOR STATISTICAL PURPOSES ONLY. IT IS VOLUNTARY AND APPLIES ONLY TO THE VICTIM.

For the purposes of this application, a handicapped person is one who;
1) has a physical or mental impairment which limits the capacity to work;
2) has a record of such impairment;
3) is perceived as having such an impairment.

WAS THE VICTIM HANDICAPPED PRIOR TO THE CRIME? ○ YES ○ NO

GENDER

○ Male
○ Female

RACE/ETHNICITY

○ American Indian/Alaskan Native ○ Asian ○ Multiple Races
○ Native Hawaiian/Pacific Islander ○ Black/African American
○ White Non-Latino/Caucasian ○ Hispanic/Latino

SECTION 2. CLAIMANT INFORMATION

Only complete if someone other than victim is filing claim.

Social Security Number* | Date of Birth | First Name | Middle Name/Maiden Name | Last Name

Street Address | City | State | ZIP Code

Email Address

Home Phone | Work Phone | Cell Phone | Other Phone | Relationship to Victim

SECTION 3. ELIGIBILITY CRITERIA

Was the incident reported to law enforcement within 72 hours?
○ YES ○ NO If NO, please explain why not.

Did the victim have any criminal charges pending against him/her at the time of the crime?
○ YES ○ NO If YES, please explain.

Did you file this claim within one (1) year of the crime?
○ YES ○ NO If NO, please explain why not.

Was the victim under the influence of alcohol or illegal drugs at the time of the crime?
○ YES ○ NO If YES, please explain.

You must notify the ACVCC of any address change. CLAIMS MAY BE CLOSED WHEN THERE IS NO RESPONSE TO CORRESPONDENCE.

*Submission of social security numbers is voluntary. Social security numbers are requested to verify eligibility pursuant to ALA. CODE §§ 15-23-1 - 15-23-23.F
Failure to submit your social security number may result in slower processing of your claim.

SECTION 4. CRIME, INJURIES, AND RELATED INFORMATION

Type of Crime
○ Assault ○ Sexual Offense ○ Murder ○ Vehicular ○ Domestic Violence ○ Other

Date of injury of victim _____ Date of death of victim _____

Location where crime occurred- City _____ County _____ State _____

In your own words, please provide a brief description of the crime. Attach additional sheets if needed.

Offender(s) Please list name, birth date, and Social Security Number if known.

Witness(es) Please list name, address, and phone number if known.

Law enforcement agency to which crime was reported | Agency phone number | Date reported | Time reported | Name of investigating officer(s)

Was the victim living in the same house as the offender **at the time of the crime**? ○ YES ○ NO

Is the victim living in the same house as the offender **now**? ○ YES ○ NO

Was the incident domestic violence? ○ YES ○ NO

Has a warrant been signed?
○ YES ○ NO If NO, please explain why not.

Did the victim know the offender??
○ YES ○ NO If YES, please explain.

Has an arrest been made?
○ YES ○ NO If NO, please explain why not.

Is the offender related to the victim?
○ YES ○ NO If YES, please explain.

SECTION 5. MEDICAL/PSYCHIATRIC EXPENSES

Copies of all itemized bills and insurance statements must be sent to the ACVCC.

Describe injuries the victim received.

List all medical, psychiatric, dentist, ambulance, doctor, hospital, counselor, and other medical expenses related to injuries received. Attach additional sheets if needed.

Biller's Name	Biller's Phone	Biller's Address	Charge	Insurance Paid	Claimant Paid	Victim Paid	Balance Due

SECTION 6. EMPLOYMENT INFORMATION

See instruction sheet for eligibility criteria. This section must be completed if lost wages are requested. A DOCTOR'S EXCUSE MUST BE PROVIDED TO THE ACVCC.
By completing this section you are giving the ACVCC permission to contact these employers to verify employment information and wages.

Employment information for ○ Claimant ○ Victim
Is\was this person self-employed? ○ YES ○ NO
Job Title _____
Employer Name _____
Employer Contact _____
Street Address _____
City _____ State _____ ZIP _____
Phone _____ FAX _____
Date Left Work _____
Date Returned to Work _____

Employment information for ○ Claimant ○ Victim
Is\was this person self-employed? ○ YES ○ NO
Job Title _____
Employer Name _____
Employer Contact _____
Street Address _____
City _____ State _____ ZIP _____
Phone _____ FAX _____
Date Left Work _____
Date Returned to Work _____

SECTION 7. INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION

Name of Insurance Company | Phone

Name of Agent | Policy Number

Type of Insurance ○ Life ○ Burial ○ Medical ○ Auto ○ Other

Name of Insurance Company | Phone

Name of Agent | Policy Number

Type of Insurance ○ Life ○ Burial ○ Medical ○ Auto ○ Other

Name of Insurance Company | Phone

Name of Agent | Policy Number

Type of Insurance ○ Life ○ Burial ○ Medical ○ Auto ○ Other

Name of Insurance Company | Phone

Name of Agent | Policy Number

Type of Insurance ○ Life ○ Burial ○ Medical ○ Auto ○ Other

If you received income from any of the following sources, please indicate the amount received each month.

Social Security	Social Security Disability	SNAP	TANF	Worker's Compensation	Other

SECTION 8. FUNERAL/BURIAL EXPENSES

Attach copies of ALL funeral/burial bills.

If funeral/burial expenses were paid by any of the following sources, please indicate the amount each paid.

Claimant	Social Security	Burial Insurance	Life Insurance	Veterans Burial Benefit	Other

Name of funeral home, cemetery, or monument company

Street Address

City | State | ZIP

Phone | FAX

Name of funeral home, cemetery, or monument company

Street Address

City | State | ZIP

Phone | FAX

SECTION 9. OTHER EXPENSES

See instruction sheet for details on what may be requested. All expenses are subject to approval by the ACVCC.

FUTURE ECONOMIC LOSS - Anticipated monetary loss caused by the injury or death of the victim.

Expense	Amount	Expense	Amount

REPLACEMENT SERVICES - Expenses reasonably incurred in obtaining ordinary and necessary services the victim would have performed prior to the injury or death.

Expense	Amount	Expense	Amount

MOVING EXPENSES - May be considered if the crime occurred in the victim's home, the victim has a reasonable fear for their life if they do not move from the home, or moving the victim's personal belongings is necessary.

Expense	Amount	Expense	Amount

PROPERTY LOSS - Please list the property damaged during the victimization and an estimate of its value.

Expense	Amount	Expense	Amount

SECTION 10. EMERGENCY AWARD

If you want to request emergency funds, please indicate the amount needed and explain why an emergency award is needed ($2,000 maximum).

Moving/Relocation	Lost Wages	Funeral/Burial	Crime Scene Cleanup	Prescriptions	Medical Procedure	Medical Equipment

SECTION 11. FINANCIAL RECOVERY

Alabama law requires that you give the Alabama Crime Victims' Compensation Commission written notice within 15 days of initiating any legal proceeding to recover restitution or damages, or prior to any attempt by claimant to reach a negotiated settlement. ALABAMA CODE § 15-23-14(c).

Has a civil lawsuit been filed in connection with this case? ○ YES ○ NO

Have you received any money for the damages that resulted from this crime? ○ YES ○ NO

If an attorney is handling financial recovery for you, please provide his/her name and contact information.

Attorney Name

Street Address

City | State | ZIP

Phone | FAX

CLAIM AUTHORIZATION

Information Release: I hereby authorize any financial institution, any social service agency, any funeral provider, any insurance company, any medical or mental health service provider or any state or federal governmental agency to release my information to the ACVCC. I hereby authorize my employer or former employer to release my employment information to the ACVCC.

Prosecuting Attorney's Office: I understand that information related to my claim may be released to the prosecuting attorney's office and/or law enforcement.

Criminal Background Check: I understand that as a victim/claimant, I will be subject to a criminal background check in order to verify my eligibility for compensation benefits.

Subrogation Agreement: I hereby agree to give the ACVCC written notice within 15 days of initiating any legal proceeding to recover restitution or damages that is related to my victimization. I agree to repay the ACVCC the amount of compensation that I have received in the event that my economic loss is recouped from any collateral source. I understand that failure to comply with this agreement may result in legal action being taken against me.

Payment of Benefits: I understand that the ACVCC will pay the maximum amount possible for all expenses/financial losses. I understand that these payments may result in the expenditure of all crime victims' compensation benefits for this claim. I acknowledge that it is my responsibility to notify the ACVCC in writing if I do not want the maximum benefits expended for this claim.

Service Provider Information Release: I hereby give permission to the ACVCC to release information or records about my application for assistance to service providers and their authorized representatives who request information about the status of my pending claim. I understand that this release is for the limited purpose of helping service providers determine the status of the claim in order to receive payment for services rendered. **Sign here if you DO NOT authorize the release of status information to service provider(s).**

_____ _____
Victim or Claimant Signature Date

Authorized Parties: I hereby agree that the parties listed below are authorized to discuss this claim.

Name	Phone	Relationship	Name	Phone	Relationship

Are you a victim of human trafficking or domestic violence?	**Are you a U.S. citizen?**	**Are you a legally present alien?**
○ YES ○ NO	○ YES ○ NO	○ YES ○ NO

The ACVCC does not discriminate on the basis of race, color, national origin, sex, religion, age, genetic information, pregnancy, or disability in employment or the provision of compensation benefits.

Therefore, I HEREBY AND FOREVER HOLD HARMLESS, the ACVCC and its authorized representatives and agents from any and all legal responsibility/liability which may arise from the release of any of the above information. By signing this document I affirm that the information provided in this application is true and correct to the best of my knowledge. I understand that if there is any credible evidence that I submitted a false claim for grant funds I will be promptly referred to the United States Department of Justice, Office of Inspector General for investigation.

X

_____ _____
Victim or Claimant Signature Victim or Claimant Printed Name

_____
Date

The victim must sign this authorization unless he/she is deceased, incapacitated, or is a minor.
The person signing this authorization must be **19 or older**.
The claimant (if other than victim) must be the person legally authorized to act on the behalf of the victim.
Documentation of this authority MUST be provided.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Printed Name: _____

Date of Birth: _____

Social Security Number: _____

* Submission of your social security number is voluntary. However, not having your social security number may slow processing of your claim.

1. I hereby authorize the Alabama Crime Victims' Compensation Commission (ACVCC) to obtain and use my health, medical, psychiatric and billing information for the purpose of processing my compensation claim.
2. I authorize any and all service providers, including physicians, hospitals, clinics, laboratories, psychologists, psychiatrists, nurses, physician assistants and counselors, to release my health, medical, psychiatric and billing information, which includes discharge summary, laboratory reports, history and physical, operative procedure, pathology reports and billing information to the ACVCC and its agents and employees who are acting within the scope of their employment.
3. I understand that this authorization is for any and all health, medical, psychiatric and billing information related to my victimization, which occurred on: _____.
4. I understand that such medical records may contain information concerning psychological, drug, and/or alcohol conditions, and/or diagnosis, treatment and care of sexually transmitted diseases or complications related to the same, including but not limited to HIV testing and results. I understand that the health, medical, psychiatric and billing information to be released may be subject to re-disclosure by the recipient of the health, medical and billing information and no longer be protected by the Federal Privacy Rules.
5. I understand that this authorization is voluntary. I also understand that I may revoke this authorization at any time by notifying the ACVCC in writing. If I do revoke authorization, it will not have any effect on uses and disclosures made before the receipt of the revocation.
6. In the event that this authorization is being signed by a personal representative of the patient, a description of such individual's authority to do so must be attached to this document along with proper documentation of this authority.
7. This authorization shall be valid for the entire duration of the processing of my compensation claim at the ACVCC and shall terminate at such time the ACVCC has closed my compensation claim.

X _____ _____

Patient Signature or Personal Representative | Date

Either the patient (victim) or their representative must sign and date this authorization if consideration of medical expenses is being requested.

Cassie T. Jones, Ed.D.
EXECUTIVE DIRECTOR

ALABAMA CRIME VICTIMS' COMPENSATION COMMISSION

P.O. Box 231267
Montgomery, AL 36123-1267

STATE OF _____)
)
_____COUNTY)

AFFIDAVIT OF THE PARENT OR LEGAL GUARDIAN OF A MINOR CRIME VICTIM (FOR CLAIMS WITH A MINOR (CHILD) VICTIM ONLY)

I, _____, after having first been duly sworn, do depose and state under oath as follows:
CLAIMANT'S PRINTED NAME

1. I am over the age of nineteen.

2. I am the _____, of the victim, _____.
STATE WHETHER YOU ARE PARENT OR LEGAL GUARDIAN PRINT MINOR VICTIM'S NAME

3. I am the person legally authorized to act on behalf of the minor victim.

4. I understand that this information will be used to determine the minor victim's parent or legal guardian for the purpose of providing crime victims' compensation benefits.

5. I understand that knowingly submitting false information to the Alabama Crime Victims' Compensation Commission with the intent to obtain compensation benefits is a violation of section 15-23-21 of the Code of Alabama (1995) and is a Class C felony.

Further the deponent sayeth not.

X _____
CLAIMANT SIGNATURE (Parent or Legal Guardian)

THIS DOCUMENT MUST BE NOTARIZED

STATE OF _____)
)
_____COUNTY)

I, _____, a Notary Public in and for said County and State, hereby certify that, he/she, whose name is signed to the foregoing document, and who is known to me, acknowledged before me on this date that, being informed of the contents of said document, he or she executed the same voluntarily on the day the same bears date.
GIVEN UNDER MY HAND AND OFFICIAL SEAL OF OFFICE at _____County, State of _____, on this the _____ day of _____, 20_____.

_____
Notary Public
My Commission expires: _____

Cassie T. Jones, Ed.D.
EXECUTIVE DIRECTOR

ALABAMA CRIME VICTIMS' COMPENSATION COMMISSION

P.O. Box 231267
Montgomery, AL 36123-1267

STATE OF_____)
)
_____COUNTY)

AFFIDAVIT FOR THE SURVIVING SPOUSE OR NEXT-OF-KIN (FOR DEATH/HOMICIDE CLAIMS ONLY)

I, _____, after having first been duly sworn, do depose and state under oath as follows:
CLAIMANT'S PRINTED NAME

1. I am over the age of nineteen.

2. I am the _____,of the deceased
SURVIVING SPOUSE, CHILD, FATHER, MOTHER, BROTHER, SISTER, GRANDPARENT, AUNT, (SPECIFY OTHER RELATIONSHIP)
victim, _____.
VICTIM'S PRINTED NAME

3. I understand that this information will be used for the purpose of determining the deceased victim's next-of-kin and providing crime victims' compensation benefits.

4. I understand that knowingly submitting false information to the Alabama Crime Victims' Compensation Commission with the intent to obtain compensation benefits is a violation of section 15-23-21 of the Code of Alabama (1995) and is a Class C felony.

NAMES OF SURVIVORS

Please print the name of living relatives in the appropriate sections. Please indicate N/A if a section is not applicable. Please complete even if you only have partial information.

Victim's living spouse

Name	Date of Birth	Address	Phone

Victim's minor children (under age 19)

Name	Date of Birth	Address	Custodial Parent	Phone

Victim's adult children (19 and over)

Name	Date of Birth	Address	Phone

EXECUTED ON THE FOLLOWING PAGE

X _____
CLAIMANT'S INITIALS

Victim's father/mother:

Name	Date of Birth	Address	Phone

Victim's brother(s)/sister(s):

Name	Date of Birth	Address	Phone

Victim's grandparents:

Name	Date of Birth	Address	Phone

Victim's aunt(s)/uncle(s):

Name	Date of Birth	Address	Phone

Other relatives of victim (please list only if no relatives are listed above):

Name	Date of Birth	Address	Phone	Relationship to victim

Further the deponent sayeth not.

X _____ _____

Victim or Claimant Signature | Victim or Claimant Printed Name

THIS DOCUMENT MUST BE NOTARIZED

STATE OF _____)
)
_____COUNTY)

I, _____, a Notary Public in and for said County and State, hereby certify that, he/she, whose name is signed to the foregoing document, and who is known to me, acknowledged before me on this date that, being informed of the contents of said document, he or she executed the same voluntarily on the day the same bears date.
GIVEN UNDER MY HAND AND OFFICIAL SEAL OF OFFICE at _____County, State of _____, on this the _____ day of _____, 20_____.

_____
Notary Public
My Commission expires: _____