OFFICE OF THE COURT OF CLAIMS
CRIME VICTIMS COMPENSATION FUND

APPLICATION
FOR WEST VIRGINIA CRIME VICTIMS COMPENSATION

Include all the documentation you can - if you have a copy of the police report, hospital or doctor bills, please send with the application.

If you do not have this documentation, do not wait to mail the application if you are near the two-year deadline. Send the application as soon as you have it completed and follow-up with the documentation later.

Keep this page so that you will have our address and telephone number.

Be sure to let us know of any address or telephone number changes.

If you need help completing the application, contact us or check with your local prosecuting attorney’s Victim Assistance Coordinator, if available.

Sign this Application (Page 4) in front of a notary public.

Failure to notarize will delay the processing of your claim.

Mail your completed application to:

CRIME VICTIMS COMPENSATION FUND
1900 KANAWHA BLVD E ROOM W-334
CHARLESTON WV 25305-0610

304.347.4850
877.562.6878 (toll free)
Fax 304.347.4915
e-mail: cvictims@wvlegislature.gov
www.legis.state.wv.us/joint/victims/.cfm
THE WEST VIRGINIA CRIME VICTIMS COMPENSATION FUND

- PROVIDES financial assistance to victims of crime for related expenses that cannot be reimbursed from insurance or other sources.
- COMPENSATION for medical, funeral/burial expenses, work loss, mileage to a medical treatment facility and to court for the prosecution of the offender, mental health counseling, and relocation expenses.
- ADMINISTERED by the West Virginia Court of Claims.

HOW IS THE SYSTEM FUNDED?

- EVERY person who is convicted of or pleads guilty to a misdemeanor or felony offense, other than a non-moving traffic violation, is assessed additional court costs, which are transmitted to the State Treasurer for deposit into the Crime Victims Compensation Fund.
- NO tax dollars are used.

WHO CAN FILE A CLAIM?

- ANY innocent victim who suffers personal injury as the result of a crime.
- ANY individual who is the dependent of a deceased victim of crime. (A dependent is one who has received over one half of his/her support from the victim.)

WHAT IS REQUIRED?

- The crime MUST be reported to law enforcement officials within 72 hours.
- The claimant must fully cooperate with law enforcement officials.
- The claim for compensation MUST BE FILED within 2 years of the date of the crime.

IS THERE A LIMIT TO THE AMOUNT RECOVERABLE?

- In injury claims, the maximum is $35,000.00.
- In death claims, the maximum is $50,000.00 (including $10,000.00 for funeral and burial expenses.)

HOW IS A CLAIM PROCESSED?

- The Claim Investigator reviews the claim and files a Finding of Fact and Recommendation.
- A Judge of the Court of Claims evaluates the claim without a hearing and renders a decision.
- A hearing on the matter will be held if either the claimant or the Claim Investigator disagrees with the decision rendered.

IS THE LOSS OF OR DAMAGE TO PROPERTY RECOVERABLE?

- No. Damaged or stolen property, including money, is NOT recoverable. However, prosthetic devices such as eyeglasses and dentures are compensable.

IS THERE A FILING FEE?

- No.

DO YOU NEED AN ATTORNEY?

- No. But if a claimant seeks the services of an attorney to file the claim, reasonable fees will be paid by the Fund at no cost to the claimant.

If you are not sure of your eligibility, call us for additional information. We care!
# Application for West Virginia Crime Victims Compensation Fund

**West Virginia Crime Victims Compensation Fund**

1900 Kanawha Blvd., E., Room W-334

Charleston, WV 25305-0610

Voice: 304-347-4850 & 877-562-6878

Fax: 304-347-4915

Email: cvictims@wvlegislature.gov

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**APPLICATION**

Please complete all sections and print clearly.

## Victim Information

Victim's First Name  
Victim's Last Name  
Victim's Mailing Address  
City  
State  
Zip Code  
( ) (Area Code) Home Phone Number  
( ) (Area Code) Daytime Phone Number

E-mail Address (please print clearly)

**Claimant Information**

Claimant's First Name  
Claimant's Last Name  
Claimant's Mailing Address  
City  
State  
Zip Code  
( ) (Area Code) Home Phone Number  
( ) (Area Code) Daytime Phone Number

E-mail Address (please print clearly)

Relationship to Victim

- Male
- Female
- Unknown
- Single
- Married
- Separated
- Divorced

Are you claiming mileage expense? (Victim only)

- To Court
- To Medical Treatment Facility

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**Victim Employment Information**

Was the victim employed on the date of the injury?  
No  
Yes

Did the victim lose earnings that were not reimbursed?  
No  
Yes

Did the victim lose work due to injury?  
No  
Yes
**CRIME INFORMATION**

**DATE OF CRIME:** __________/_________/____________

**COUNTY OF CRIME:** ___________________________________

<table>
<thead>
<tr>
<th>LOCATION WHERE INJURY OCCURRED</th>
<th>CITY</th>
<th>STATE/ZIP CODE</th>
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<tr>
<th>POLICE AGENCY CRIME WAS REPORTED TO</th>
<th>ADDRESS</th>
<th>CITY</th>
<th>STATE/ZIP CODE</th>
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<tr>
<th>INVESTIGATING OFFICER’S NAME (if known)</th>
<th>WHO REPORTED THE INCIDENT TO POLICE? (IF KNOWN)</th>
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<th>Date Reported</th>
<th>Time Reported</th>
<th>If not reported within 72 hours, explain why</th>
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<td><strong><strong><strong><strong><strong>/_____/</strong></strong></strong></strong></strong>___</td>
<td>__________________________</td>
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<tr>
<th>Suspect’s Name</th>
<th>Adult</th>
<th>Juvenile</th>
<th>2nd Suspect’s Name</th>
<th>Adult</th>
<th>Juvenile</th>
<th>3rd Suspect’s Name</th>
<th>Adult</th>
<th>Juvenile</th>
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Did the victim know the suspect(s)?

- Yes
- No

If yes, in what way?

- __________________________

Was victim living in same household with suspect(s)?

- Yes
- No

Please check the box that **most closely** describes the type of crime that occurred:

- Adult Sexual Assault
- Elder Abuse
- Arson
- Hate Crime: Racial/Religious/Gender/Sexual Orientation/Other
- Assault
- Homicide
- Child Physical Abuse/Neglect
- Human Trafficking: Sex/Labor
- Child Pornography: Production/Possession/Distribution
- Robbery
- Child Sexual Abuse
- Stalking
- DUI/DWI Incident
- Terrorism/Mass Violence
- Other: __________________________________________

**Court Proceedings**

Has the suspect(s) been charged?

- Yes
- No

**COURT:**

- Magistrate Court
- Circuit Court
- Juvenile Court
- Other (Specify) ______________________________________

Charge(s) __________________________________________

**Narrative**—In your own words, briefly describe what happened. Please do not write “See police report.” Use additional sheets if necessary.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________
VICTIM’S INJURY INFORMATION

BRIEFLY DESCRIBE VICTIM’S INJURIES

WHERE WAS THE VICTIM TAKEN FOR EMERGENCY TREATMENT?
ADDRESS CITY STATE/ZIP CODE

Was the victim hospitalized? YES ☐ NO ☐ From _______________ to _______________

DATE DATE

HOSPITAL NAME (IF DIFFERENT FROM EMERGENCY TREATMENT FACILITY)ADDRESS CITY STATE/ZIP CODE

ADDITIONAL PROVIDERS SEEN:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

IMPORTANT: SUBMIT A COPY OF EACH OF THE VICTIM’S MEDICAL BILLS. INSURANCE STATEMENTS ARE NOT ACCEPTABLE.

VICTIM’S DEATH INFORMATION

DATE OF DEATH _______/________/____________ DID VICTIM HAVE ANY DEPENDENTS? ________________________

FUNERAL HOME ADDRESS CITY STATE/ZIP CODE

NAME OF EXECUTOR OR ADMINISTRATOR OF VICTIM’S ESTATE, if any ADDRESS CITY STATE/ZIP CODE

COPIES OF THE FOLLOWING DOCUMENTS SHOULD BE SUBMITTED WITH THE APPLICATION OR AS SOON AS POSSIBLE THEREAFTER:

DEATH CERTIFICATE ~ SOCIAL SECURITY BENEFIT INFORMATION ~ FUNERAL & BURIAL EXPENSES
COURT ORDER FOR ADMINISTRATOR OF ESTATE ~ PROOF OF GUARDIANSHIP ~ BIRTH CERTIFICATES OF VICTIM’S MINOR CHILDREN

INSURANCE AND REIMBURSEMENT SOURCES

CHECK ALL COVERAGE TYPES HELD BY THE VICTIM AT TIME OF INCIDENT
☐ MEDICAID ☐ MEDICARE
☐ HEALTH INSURANCE ☐ SOCIAL SECURITY
☐ AUTO INSURANCE ☐ LIFE INSURANCE
☐ WORKERS COMPENSATION

INSURANCE COMPANY NAME ADDRESS CITY STATE/ZIP CODE

DEPENDENTS OF VICTIM INFORMATION

A DEPENDENT IS ONE WHO HAS RECEIVED OVER ONE HALF OF HIS/HER SUPPORT FROM THE VICTIM.

DEPENDENT’S NAME DEPENDENT’S FULL ADDRESS RELATIONSHIP TO VICTIM DATE OF BIRTH

/ / / / / /

/ / / / / /

/ / / / / /

ATTORNEY INFORMATION (if applicable)

You are not required to have an attorney to file your application. However, if you do, the attorney fees are paid by the Crime Victims Fund.

☐ Attorney is ATTORNEY OF RECORD
(All communication will be with ATTORNEY)
☐ Attorney is ASSISTING ONLY
(All communication will be with CLAIMANT/VICTIM)

ATTORNEY’S NAME ADDRESS CITY STATE/ZIP CODE

ATTORNEY’S SIGNATURE TELEPHONE NUMBER ATTORNEY’S EMAIL ADDRESS (please print clearly)
CLAIMANT'S RELEASE

Important:
This affidavit is part of your application and must be completed and signed in the presence of a notary.

I, the claimant, hereby state UNDER THE PENALTIES OF PERJURY AND FALSIFICATION that this application of four pages has been prepared or read by me and that the information given herein, including attached bills, records, or certificates, is true and complete.

Further, I hereby authorize any person (including any physician, health care or health services provider, organization, law enforcement or governmental agency, including the Social Security Administration), to release to the West Virginia Court of Claims upon its request, a copy of any report, document, record, criminal record or other information (including copies of my West Virginia state income tax returns and related records for the years requested), in any way relating to my claim for an award of compensation on behalf of

___________________________________, a victim of criminally injurious conduct.

PRINT VICTIM’S NAME

I also authorize release of medical records or other information regarding my treatment, hospitalization, and/or outpatient care including behavioral health, drug/alcohol, Acquired Immunodeficiency Syndrome (AIDS), tests for infection with Human Immunodeficiency Virus (HIV), blood alcohol serum tests, sexual assault/sexual abuse examinations, and those test results.

This authorization, or a copy which will be considered as valid as the original, shall be valid for twelve months from the affixed date.

THIS FORM MUST BE SIGNED BEFORE A NOTARY

__________________________________________      _________________________________________________      ______________
CLAIMANT’S SIGNATURE      CLAIMANT’S PRINTED NAME      DATE

STATE OF ____________________________________________

COUNTY OF __________________________________________

The foregoing instrument was acknowledged before me on

_______________________ by _________________________________.

(date)    (print name of claimant)

My commission expires: ________________________________

______________
Notary Public