ALASKA
DEPARTMENT OF PUBLIC SAFETY
Violent Crimes Compensation Board

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Application for Crime Victim Compensation

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Section 1: Victim Information

First Name:	Middle Initial:	Last Name:
Mailing Address:		
City:	State:	Zip Code:
Email Address:		
Phone Number:	Cell or Message Number:	
Date of Birth:	Social Security Number:	
Sex: ◯ Male ◯ Female	Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed	

COMPLETE SECTION 2 IF YOU ARE NOT THE VICTIM BUT APPLYING ON BEHALF OF THE VICTIM WHO IS:
☐ Deceased ☐ Incapacitated (submit power of attorney) ☐ Minor Child (must be child's parent or legal guardian)

Section 2: Claimant Information

First Name:	Middle Initial:	Last Name:
Relationship to Victim: ◯ Spouse ◯ Parent ◯ Sibling ◯ Child ◯ Grandparent ◯ Other:		
Mailing Address:		
City:	State:	Zip Code:
Email Address:		
Phone Number:	Cell or Message Number:	
Date of Birth:	Social Security Number:	

Section 3: Victim Statistical Information

For statistical purposes only. This is voluntary.

Ethnicity/Race:

☐ Alaska Native/American Indian ☐ Asian
☐ Black/African American ☐ Hawaiian/Other Pacific Islander
☐ Hispanic or Latinc ☐ Multiple Races ☐ White/Non-Latino
Other: _____

Disability:

◯ Yes ◯ No
If yes, ☐ mental ☐ physical ☐ developmental
Was there disability prior to the crime? ◯ Yes ◯ No

Section 4: Crime Information

Date of crime:	Date crime was reported to law enforcement:
Law enforcement agency:	Law enforcement report number:
Crime location (city or community):	Did the crime occur on the job? ◯ Yes ◯ No
Court case number (if offender has been charged with a crime):	
Name of offender (if known):	
Relationship of offender to victim (if any):	Is the offender a juvenile? ◯ Yes ◯ No ◯ Unknown

Type of Crime

☐ Arson in the First Degree ☐ Assault ☐ Child Physical Abuse ☐ Child Sexual Abuse ☐ Domestic Assault
☐ Driving Under the Influence (DUI/DWI) ☐ Homicide ☐ Human Trafficking ☐ Kidnapping ☐ Robbery ☐ Sex Trafficking
☐ Sexual Assault ☐ Threats to do Bodily Harm ☐ Vehicular Assault
☐ Other: _____

Section 5: Expenses

Select the type(s) of crime-related assistance being requested.

☐ Cell phone (damaged/evidence) ☐ Childcare ☐ Counseling/therapy ☐ Crime scene cleanup
☐ Dental ☐ Funeral/burial ☐ Items taken for evidence ☐ Lost support (deceased victim)
☐ Lost wages ☐ Medical ☐ Medical device/equipment ☐ Relocation ☐ Security measures
☐ Travel/transportation ☐ Trial-sentencing attendance ☐ Other: _____

Billing Records: Please submit invoices, billing statements, and/or payment receipts for counseling, dental, medical, or other services for which you are requesting payment. If billing records are unavailable, please attach a separate sheet listing the provider(s) name, phone or email, and date(s) of service or date range (e.g. 08/01/2023-09/30/2023).

Emergency Request: ◯ Yes ◯ No

Emergency assistance may be available if it appears that undue hardship will result if immediate payment is not made. Emergency assistance may not exceed $5,000 and is subject to eligibility.

☐ Counseling ☐ Funeral ☐ Lost Wages ☐ Relocation ☐ Security ☐ Other: _____

Section 6: Additional Dependent Information

Complete this section if you are requesting compensation for a minor child or incapacitated adult that is not the direct victim. You must be the parent or legal guardian of any dependent(s) listed below. *Example: Requesting counseling for the sibling of the victim.*

Name of Dependent	Date of Birth	Requested Expense(s)

Section 7: Wage Information

Are you applying for unpaid lost wages? ◯ Yes ◯ No | If yes, complete the sections below.

Did you miss or will you miss more than two weeks of work? ◯ Yes ◯ No

If self-employed, submit a copy of your tax return for the year before the date of the crime or year before you were unable to work.

Employee (person requesting lost wage benefits):

Employer:

Employer Address:

Contact Person: | Phone or Email:

May we contact the employer to obtain wage information? ◯ Yes ◯ No

Section 8: Insurance & Other Collateral Source Information

The Violent Crimes Compensation Board may compensate expenses not covered by insurance or other sources. Providers should bill primary insurance and/or other source(s) of payment first.

☐ Health Insurance | Company and Policy Number:

☐ Medicaid ☐ Medicare ☐ Denali Kidcare ☐ Indian Health Service ☐ Veterans Affairs

☐ Auto Insurance (for crime involving a motor vehicle, if applicable):

☐ Public or General Assistance ☐ Social Security Program ☐ Unemployment Compensation ☐ Workers' Compensation

☐ Home/Renter's Insurance | ☐ Other:

☐ **None**. No insurance or other source(s) of payment available.

Section 9: Representative Information

Victim Assistance Program or Other Representative

How did you learn about this program?

☐ Child Advocacy Center ☐ Counselor/Therapist ☐ Family/Friend

☐ Funeral Home ☐ Healthcare Provider ☐ Law Enforcement

☐ Paralegal/Prosecutor ☐ Poster/Brochure ☐ Website

☐ Victim Assistance Program ☐ Other: _____

Attorney Assistance

Do you have an attorney representing you? ◯ Yes ◯ No

If yes, the attorney is representing you in:

☐ A personal injury claim or lawsuit

☐ Both the crime victim claim and personal injury claim

Attorney/Law Firm: _____

If an advocate, service provider, or attorney assisted you with this application, please complete the following.

Name: _____ Organization: _____

Section 10: Other Information

Preferred Language (if not English): | Preferred Contact: ☐ Mail ☐ Phone ☐ Email

AUTHORIZATION FOR RELEASE OF INFORMATION & REPAYMENT AGREEMENT

The victim or legal guardian must sign this form to be valid.

Authorization to Release Confidential Information

I hereby authorize any health care provider, physician, behavioral health provider, social worker, rehabilitation counselor, funeral director, or other person who provided services; any employer; any law enforcement agency or other government agency, including state and federal services; any and all insurance companies or any other agency having knowledge necessary for the determination of eligibility of this claim for benefits to furnish to the State of Alaska Violent Crimes Compensation Board or its representatives any and all information including, but not limited to, documents generated by themselves and others, specifically relating to this claim. This authorization also applies to all sources of recovery for the claimed losses including but not limited to healthcare benefits, unemployment or disability benefits, Social Security benefits, and Veteran benefits. I also authorize the release of federal tax information including income tax returns for the purposes of verifying income. Other information may be required to determine whether conditions are related to the crime. I understand this may include results of HIV and other sexually transmitted disease testing, alcohol, drug, and psychiatric treatment. I hereby waive all legal privileges to any of this information required for the determination of eligibility of this claim.

I agree that a photocopy or fax of this signed form is as valid as the original and my signature gives permission for the release of all specified information. I agree that this information release is **valid two (2) years** from the date of my signature and that I can cancel this release by writing to the VCCB at any time, save that if any information has already been received and used, it is not subject to cancellation. I understand that all information necessary for use in law enforcement, prosecution, or the collection of restitution may be released to parole, probation, and law enforcement or prosecution authorities.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure and may not be protected by HIPAA or other confidentiality rules any longer. If research-related PHI is used or disclosed for continued research purposes, an expiration date or event does not apply. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization. I understand the information will be used to determine compensation benefits, and that only the information needed to decide compensation benefits will be requested by the compensation program.

Repayment Agreement

I understand that if I receive any recovery for my losses through court-imposed restitution or civil lawsuit against the offender, any insurance settlement, or moneys from any government or private agency, I shall reimburse the State of Alaska Violent Crimes Compensation Board for any compensation paid out under this claim.

Declaration

I understand and agree that if false, misleading, or intentionally incomplete information is provided, my application for compensation may be denied and I may be subject to criminal punishment, pursuant to Alaska Statute 18.67.150.

Printed Name	Signature	Date

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 (“HIPAA”); 45 CFR Parts 160 and 164 and Alaska Statute 18.67.

For Office use Only: RECORDS TO BE DISCLOSED

Name:	
SSN:	Date of Birth:
Authorization To:	