



ATTORNEY GENERAL OF TEXAS

TEXAS CRIME VICTIMS' COMPENSATION PROGRAM APPLICATION

- **Nota: Si tiene alguna pregunta sobre esta solicitud o si la desea en español, favor de llamar al Programa de Compensación para las Víctimas de Crimen al (512) 936-1200 o (800) 983-9933.**
- Please read the directions on this page before completing the application. Reading these instructions will help you complete each section correctly.
- Include all the documentation you can. If you have a copy of the police report, protective order with affidavit, hospital or doctor bills, health insurance card, or auto insurance declaration page (if the crime is auto-related), be sure to send them with the application.
- If you require additional space on any section of the application, please attach a separate sheet of paper and include all the required information.
- If you do not have this documentation, do not wait to mail the application. Send the application as soon as you have completed it. Collect all additional information so that you will have it when we contact you.
- Keep this page so that you will have our address and phone number. Mail your completed application to:

Office of the Attorney General
Crime Victims' Compensation Program (011)
P.O. Box 12198
Austin, Texas 78711-2198

- If your address or phone number changes, it is important that you let us know. The toll-free number for victims, claimants and service providers is (800) 983-9933. Austin callers should use (512) 936-1200. For security reasons, the Crime Victims' Compensation Program does not routinely communicate with victims via email. In some cases where security is not an issue, the CVC Program may use email to inform a victim or claimant of the status of the claim.
- If you need help completing this application, contact your local law enforcement agency's Crime Victim Liaison or your local District Attorney's Victim Assistance Coordinator. The Crime Victims' Compensation staff is also available to help by phone, or you may access our website at www.texasattorneygeneral.gov to find more information on the program.

GENERAL INFORMATION

What is the Crime Victims' Compensation (CVC) Program?

- The CVC Program may provide financial assistance to victims of violent crime for related expenses that cannot be reimbursed by insurance or other sources.
- The Program is administered by the Office of the Attorney General and is committed to assisting victims and claimants who qualify. The information provided is meant to be generally informative, and the statutory requirements of the Texas Crime Victims' Compensation Act (Texas Code of Criminal Procedure, Chapter 56) and the rules set forth in Title 1 of the Texas Administrative Code, Part 3, Chapter 61, govern the Program.
- Money in the Victims of Crime Compensation Fund comes from fees paid by those convicted of a crime.

Keep this page for your records.

What are the basic eligibility requirements for Crime Victims' Compensation Program benefits?

- The victim must be a resident of Texas, a United States resident who is victimized while in Texas, a Texas resident victimized in another state or country that does not have a crime victim compensation fund, or certain other individuals.
- The crime must be reported to the appropriate state or local public safety/law enforcement agency within a reasonable period of time.
- The victim or claimant must cooperate with law enforcement officials in the investigation and prosecution of the case.

Who may be eligible for Crime Victims' Compensation Program benefits?

- Victims of violent crime who suffer physical or mental harm as a direct result of the crime.
- A victim's dependents, family or household members who qualify as claimants under the law.
- Someone authorized by the victim to act on his or her behalf.

Who is not eligible for Crime Victims' Compensation Program benefits?

- The offender, an accomplice of the offender or any person engaged in illegal activity at the time of the crime.
- Anyone injured as a result of a motor vehicle accident, except under certain circumstances provided by law.
- Benefits may be denied or reduced if the victim's or claimant's own behavior contributed to the crime.
- Anyone incarcerated when the crime occurred.
- Any victim or claimant who knowingly or intentionally submits, or causes to be submitted, false or forged information to the Crime Victims' Compensation Program.

What expenses may be covered with Crime Victims' Compensation Program benefits?

- Reasonable and necessary medical and funeral expenses.
- Travel exceeding 20 miles one way for participation and attendance at funeral services, medical appointments and criminal justice appointment.
- Loss of earnings as a result of the disability of the victim.
- Loss of earnings for investigative, judicial or medical appointments.
- Loss of support to dependents of victim's, as a result of the victim's death or if the victim was supporting them at the time of the crime.
- Psychiatric care/counseling.
- Counseling for the victim and eligible claimants.
- Eyeglasses, hearing aids, dentures or prosthetic devices, if damaged during or needed as a result of the crime.
- Crime scene clean-up.
- Replacement of property seized as evidence or rendered unusable by the investigation.
- New expenses for child or adult dependent care as a result of the crime.
- One time rent and relocation expenses for victims of family violence or victims of sexual assault who were assaulted in their home.
- Reasonable attorney fees for assistance in filing the Crime Victims' Compensation Program application.

What expenses are not covered by Crime Victims' Compensation Program benefits?

- Damage, repair or loss to property or vehicle.
- Pain, suffering or emotional distress damages.
- Any expense which is not the direct result of the crime.

Who is the payor of last resort?

- All other available third party resources (for example, Medicare, Medicaid, personal health insurance, workers' compensation and settlements) must meet their legal obligations to pay crime-related expenses.
- The Crime Victims' Compensation Program must be notified before a civil lawsuit is filed in relation to the crime, if restitution is ordered by the criminal court, or if any party receives the proceeds of a settlement.
- CVC is considered the payor of last resort.

Payment for Cost of Medical Forensic Sexual Assault Examinations

- CVC does reimburse law enforcement agencies or DPS directly for the costs incurred for such exams. A victim of sexual assault is not required to submit a CVC application for reimbursement of the cost of a medical forensic sexual assault examination. CVC does not directly reimburse victims for the cost of medical forensic sexual assault examinations.
- If a victim of sexual assault reports the alleged crime to a law enforcement agency, the law enforcement agency may request a forensic sexual assault examination and pay all costs of the examination. If the victim of sexual assault has reported the assault to law enforcement and requires medical treatment the victim should submit this application to CVC for reimbursement of such costs.
- If a victim receives a forensic sexual assault examination, but chooses not to report the alleged crime to a law enforcement agency, the Texas Department of Public Safety will pay all costs of the examination. CVC may only pay for other crime-related expenses if a victim reports the crime to law enforcement.

Keep this page for your records.



CVC Official Use Only – VC# _____

Application Received Date _____

PLEASE COMPLETE ALL SECTIONS OR A DELAY MAY RESULT IN THE PROCESSING OF YOUR APPLICATION.
 Information about this claim is confidential and will not be released to another person unless that person is included as a claimant or as otherwise required by law.

What is the language preference of the victim and/or claimant? English Spanish Other _____

SECTION 1-VICTIM INFORMATION: The victim is the person who was injured or died as a result of the crime. If the victim is a minor or deceased, the claimant information in Section 3 MUST be completed. If there is more than one victim, each victim must submit a separate application.

First Name		Middle Name		Last Name	
Mailing Address		City		State	Zip
Home Phone		Work Phone		Cell Phone	
Email Address					
Social Security Number:		No	Yes	If yes: _____	
Tax I. D. Number:		No	Yes	If yes: _____	
Gender	Male	Female	Date of Birth		If victim is deceased, date of death

SECTION 2-CRIME INFORMATION: You must complete this section or your application cannot be processed.

Please indicate the type of crimes:

- | | | | |
|----------------------|---------------------|----------------------|----------------------|
| Adult Sexual Assault | Aggravated Assault | Assault (Non-family) | Child Physical Abuse |
| Child Sexual Assault | DWI/Vehicular Crime | Elder Abuse | Family Violence |
| Homicide | Human Trafficking | Kidnapping | Robbery |
| Stalking | Other | | |

Date of Crime	Law Enforcement Agency (e.g. police, sheriff)			Police Report Number (if known)	
Location of Crime: Street Address		City	State	Zip	County
Alleged Suspect's Name (if known)			Relationship of suspect to victim (if any)		
Has the suspect been arrested?		Have charges been filed?		Cause Number (if known)	
No	Yes	Unknown	No	Yes	Unknown
Brief Description of Crime					
Brief Description of Injuries (if any)					
If this is a family violence crime, have you obtained a permanent protective order?				No	Yes
If this is a family violence crime, are there any prior incidents reported to law enforcement				No	Yes

SECTION 3-CLAIMANT INFORMATION: The claimant is a person, other than the victim, who has out of pocket expenses as a direct result of the crime, is an immediate family member(s) of the victim who requires Psychiatric Care/Counseling as a result of the crime or is someone who has legal authority to act on behalf of the victim. CVC cannot discuss a claim with anyone who is not listed as a claimant. If there are additional claimants, please list them on a separate sheet of paper and include all the required information.

Claimant 1

First Name		Middle Name	Last Name	
Mailing Address		City	State	Zip
Home Phone		Work Phone	Cell Phone	
Email Address				
Social Security Number: No Yes If yes: _____				
Tax I. D. Number: No Yes If yes: _____				
Gender	Male	Female	Date of Birth	Relationship to Victim

Claimant 2

First Name		Middle Name	Last Name	
Mailing Address		City	State	Zip
Home Phone		Work Phone	Cell Phone	
Email Address				
Social Security Number: No Yes If yes: _____				
Tax I. D. Number: No Yes If yes: _____				
Gender	Male	Female	Date of Birth	Relationship to Victim

Claimant 3

First Name		Middle Name	Last Name	
Mailing Address		City	State	Zip
Home Phone		Work Phone	Cell Phone	
Email Address				
Social Security Number: No Yes If yes: _____				
Tax I. D. Number: No Yes If yes: _____				
Gender	Male	Female	Date of Birth	Relationship to Victim

SECTION 4-MEDICAL: Reasonable and necessary health care for the victim as a direct result of the crime. Medical insurance and benefit plan MUST meet their legal obligation to pay crime-related expenses.

VICTIM TREATMENT INFORMATION

Did the victim require medical treatment at the time of the crime? No Yes

1. Name of first treating hospital/clinic/doctor:

Address	City	State	Zip
Phone Number	Fax Number		

Did victim require additional medical treatment upon release from the hospital or clinic or did the victim seek any other medical treatment? No Yes

2. Name of health care provider who treated crime-related injuries:

Address	City	State	Zip
Phone Number	Fax Number		

3. Name of health care provider who treated crime-related injuries:

Address	City	State	Zip
Phone Number	Fax Number		

VICTIM DISABILITY INFORMATION

Was the victim a person with disability? No Yes If yes, date of disability

Was the disability: Physical Mental Both If yes, describe

Does the victim have a new disability due to the crime? No Yes If yes, describe

VICTIM INSURANCE INFORMATION

Did the victim have insurance or a benefit plan to cover medical expenses at the time of the crime? No Yes

Does the victim have insurance or a benefit plan to cover medical expenses on the date of application? No Yes

Name of Medical Insurance Company/Benefit Plan	Has an application been filed with Medicaid or Medicare since the crime? No Yes
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If there are crime-related dental injuries, does the victim have dental insurance? No Yes	If yes, name of victim's Dental Insurance Company
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Did the crime involve an auto? No Yes	If yes, name of Auto Insurance
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Was the victim the driver of auto? No Yes Unknown	If yes, does he/she have auto insurance? No Yes Unknown	Name of victim's auto insurance
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Did the owner of the auto involved in the crime have auto insurance? No Yes Unknown	If yes, name of owner's auto insurance
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Was the suspect the driver of auto? No Yes Unknown	If yes, does he/she have auto insurance? No Yes Unknown	Name of suspect's auto insurance
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Is there additional assistance available to victim from:

Workers' Compensation Disability Insurance Social Security Assistance Veterans' Benefits

Other _____

Has an insurance claim or any request for additional assistance related to this crime been filed? No Yes

SECTION 5-PSYCHIATRIC CARE/COUNSELING: Available to victim and/or certain claimants. *Please indicate who has received or will be receiving psychiatric care/counseling because of the crime.*

Name	Medical/Mental Health Insurance No Yes	If yes, name of Insurance Company
Name	Medical/Mental Health Insurance No Yes	If yes, name of Insurance Company
Name	Medical/Mental Health Insurance No Yes	If yes, name of Insurance Company

SECTION 6-LOSS OF EARNINGS: Includes reimbursement of earnings lost as a result of medical treatment or participation in, or attendance at, the investigation, prosecutorial and judicial processes. Your employer will be contacted by CVC.

Victim Employment Information

Is the victim seeking loss of earnings?	No	Yes	Was the victim employed on the date of crime?	No	Yes
Employer's Name	Phone		Fax	Victim's Occupation/Job Title	
Address	City		State	Zip	
Was the victim self-employed on the date of the crime?	No	Yes	Did the crime occur while the victim was on the job?	No	Yes
			Last Date Worked	Date Returned to Work	

Claimant Employment Information

Name of claimant seeking loss of earnings. If there are additional claimants, please list them on a separate sheet of paper and include all required information.

Employer's Name	Phone	Fax	Claimant's Occupation/Job Title
Address	City	State	Zip
Is the claimant self-employed?	No	Yes	

SECTION 7-LOSS OF SUPPORT: Available to dependents of the victim who have lost support as a result of the crime. All dependents must be listed as claimants in this application.

Name(s)

SECTION 8-RELOCATION: Available to a victim of family violence or a victim of sexual assault who is assaulted in the victim's residence. *Please indicate adult household members of the victim at the time of the crime.*

List the names of all adult household members:

SECTION 9-FUNERAL: Includes funeral and burial expenses incurred as a result of the crime. *Please attach a copy of the funeral and burial contract(s), (if available).*

Funeral Home name	Phone	Fax	Contact
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SECTION 10-CRIME-RELATED TRAVEL: Includes travel exceeding 20 miles one way for participation and attendance at funeral services, medical appointments including psychiatric care/counseling and criminal justice proceedings. This is applicable to victim or claimant(s). *Please list the victim or claimant(s) requesting travel.*

Name(S)

SECTION 11-CRIME SCENE CLEAN-UP: Includes professional cleaning services for crime scene clean-up. Does not include repair or replacement of damaged property. <i>Submit itemized bill from professional cleaning company, (if available).</i>			
Do you plan to seek compensation from an insurance company?		If yes, what is the name of the Homeowners/Renters Insurance Company?	
No	Yes	Unknown	
SECTION 12-MINOR CHILD OR DEPENDENT CARE: Available for child or dependent care that is a new expense as a result of the crime. Care must be provided by a licensed care provider.			
Is child care or dependent care a new expense?		No	Yes
SECTION 13-REPLACEMENT OF PROPERTY SEIZED: Available for clothing, bedding, or property seized by law enforcement as evidence or rendered unusable by the criminal investigation. <i>This does NOT cover damaged or stolen property.</i>			
Item:	Value \$	Item:	Value \$
Item:	Value \$	Item:	Value \$
SECTION 14-DEPARTMENT OF JUSTICE INFORMATION: The following voluntary information is used for statistical purposes only to comply with the federal regulations.			
To which ethnic group does the victim belong?			
American Indian or Alaskan Native	Black	Hispanic	White
Other _____			Asian or Pacific Islander
What is the victim's national origin (country of birth)?			
Where did you find out about the Crime Victims' Compensation Program?			
Public Service Announcement	CVC Staff	Advocacy Group	Victim Assistance Program
Brochure	Hospital	Law Enforcement	Internet
			Other _____
SECTION 15-ATTORNEY INFORMATION: This section refers to representation by an attorney who assisted the victim or claimant in filing for Crime Victims' Compensation or in pursuing a civil legal action for monetary damages. This DOES NOT include attorney representation for child custody, divorce, immigration proceedings or for criminal prosecution (District/County Attorney's Office.)			
Has an attorney been hired or retained to: Help the victim/claimant complete this Crime Victims' Compensation application?			
No	Yes	If yes, please attach a letter of representation.	
Has an attorney been hired or retained to: Represent the victim's or claimant's interests in pursuing civil legal action against the suspect/offender or in an insurance claim related to this crime?			
No	Yes	If yes, please attach a letter of representation.	
Attorney's Last Name		Attorney's First Name	Phone Number
Mailing Address		City	State
			Fax Number
			Zip
SECTION 16-LAWSUIT OR OTHER SETTLEMENT INFORMATION			
Is the victim or claimant a party to a lawsuit or insurance or other type of settlement related to this crime?			
No	Yes	Unknown	
Has the victim or claimant received insurance or any other type of third party settlement funds related to this crime?			
No	Yes	Unknown	
SECTION 17-APPLICATION ASSISTANCE			
Did someone help you complete this application?		No	Yes
Last Name	First Name	Title	Agency/Organization
Mailing Address		City	State
			Zip
E-Mail Address		Phone Number	Fax Number

IMPORTANT AFFIDAVIT

This authorization is part of your application and must be completed and signed in order to process this application. BY YOUR SIGNATURE BELOW YOU AGREE TO THE FOLLOWING TERMS.

Authorization for Release of Information. I hereby authorize any financial institution, social service agency, government agency, hospital, physician, mental health facility, counselor, psychologist, psychiatrist, employer, insurer or any other person with information relating to my financial, health or employment status to release information concerning this application for benefits to the employees of the Crime Victims' Compensation Program (CVC) of the Office of the Attorney General, as needed to process this application. This information includes, but is not limited to, criminal, medical, financial and employment information. A copy of this signed release will be considered the same as the original.

Subrogation Agreement. In accordance with Texas Code of Criminal Procedure, Articles 56.51 and 56.52, I agree to notify CVC in writing before I file a lawsuit against another party as a result of this crime. I further agree that I shall not settle or resolve any such action without prior written authorization from CVC. If I recover or anticipate recovery, of any money at any time, by judgment, settlement, restitution, collateral source or any other income as a result of the incident that gave rise to this application, I agree to notify CVC. I acknowledge that I may be responsible for repayment to CVC for any and all amounts that CVC has awarded to me.

Refund Agreement. In accordance with Texas Code of Criminal Procedure, Article 56.47 (c), I understand and agree that the Office of Attorney General may require a refund of an award if the award was obtained by fraud, or mistake or if newly discovered evidence shows the victim or claimant to be ineligible for the award under Texas Code of Criminal Procedure, Articles 56.41 or 56.45.

Authorization. I understand that the Office of the Attorney General or any agent or representative of the office, has the right to review, investigate and verify the information provided. **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 under the Texas Penal Code and the civil and administrative penalties under Ch. 56 of the Texas Code of Criminal Procedure.**

VICTIM	
Printed Name	Date
Signature	Date of Birth

CLAIMANT	
Printed Name	Date
Signature	Date of Birth