Arkansas Department of Public Safety
Arkansas Crime Victims Reparations Board
1 State Police Plaza Drive
Little Rock, Arkansas 72209
(501) 682-1020 Fax: (501) 682-5313

Application for Crime Victim Compensation

Claim No.

Application Distributed By

This application must be completed in its entirety. Incomplete applications may be returned without processing. If you need assistance completing the application, please call the Crime Victims Reparations Office. You ***do not*** need to be represented by an attorney to apply for or receive benefits from the Crime Victims Reparations Board. All correspondence will be sent to the below-listed address unless you specify that an alternate address and phone number should be used. Please notify our office if your address or phone number is changed.

■ Section A – Victim/Applicant Information

A separate application must be completed for each victim.

Victim's Name	Sex M / F	Date of Birth (M/D/Y)
Mailing Address	City/State/ZIP	Age at Time of Incident
Home Telephone ( )	Work Telephone ( )	Marital Status / Social Security Number
Has the Victim ever been convicted of a felony? If yes, in what state and county? ☐ No ☐ Yes State: _____ County: _____ Briefly explain conviction (month/year/offense):		Email Address

The above person is listed as victim because:
They suffered a personal injury or death as the result of a violent crime. ☐ Yes ☐ No
They are the dependent or child (including by adoption) of a victim. ☐ Yes ☐ No
They are the spouse, parent, child, sibling, or grandparent of a deceased victim, child victim, or victim of sexual assault. ☐ Yes ☐ No
They resided, at the time of the crime, in the same permanent household as a deceased victim. ☐ Yes ☐ No
They discovered the body of a homicide victim. ☐ Yes ☐ No

This information about the victim will be used for statistical purposes only and is needed to comply with federal regulations.

Race: ☐ White ☐ African American ☐ Hispanic or Latino ☐ American Indian/Alaska Native ☐ Asian ☐ Pacific Islander ☐ Bi-racial

Referred to Reparations Board by: ☐ Victim-Assistance Worker ☐ Prosecutor ☐ Hospital ☐ Funeral Home ☐ Law-Enforcement Agency ☐ Brochure ☐ Media ☐ Other_____

Complete this section only if you are submitting this application but are different than the person listed above.

Applicant's Name	Sex M / F	Date of Birth (M/D/Y)	Relationship to Victim
Mailing Address	City/State/ZIP		Age at Time of Incident
Home Telephone ( )	Work Telephone ( )	Marital Status	Social Security Number
Has the Applicant ever been convicted of a felony? If yes, in what state and county? ☐ No ☐ Yes State: _____ County: _____			Email Address

Briefly explain conviction (month/year/offense):

Contact person other than victim or applicant:
Name Address Telephone
( )

■ Section B – Crime Information

NOTE: You must attach a copy of the law-enforcement agency's incident report to this application.

Type of crime:

□ Domestic Abuse (Spouse) □ Assault (Non-Family) □ Adult Sexual Assault
□ Child Sexual Abuse by Family Member □ Child Sexual Abuse by Non-Family Member □ Child Physical Abuse
□ Homicide □ DWI / Hit and Run □ Other _____

Did the victim submit to a sexual assault examination? □ Yes □ No

Name and address of medical provider: _____
_____

Date crime occurred: _____ Date crime reported: _____ Time crime reported: _____

Address where crime occurred: _____ County: _____

Briefly describe crime: _____
_____
_____

Was the crime reported to the proper authorities within 72 hours? □ Yes □ No

If no, explain why: _____

Agency to which reported: _____

Address: _____ Telephone: (_____) _____

Name of agency representative, caseworker, or person handling case: _____

Who reported the incident to the proper authorities? _____

Name of assailant or perpetrator and accomplices (if known). _____
_____
_____

Did the victim know offender? □ Yes □ No If yes, in what way? _____
Was the victim living with the offender at the time of the incident? □ Yes □ No
Has the offender been charged in court? □ Yes □ No □ Not sure

If yes, court case #: _____ Which court? _____

Have you filed, or do you intend to file, a civil law suit? □ Yes □ No

If yes, attorney's name/address: _____

_____

■ Section C – Request for Medical Treatment/Mental-Health Counseling

☐ Check here if this section does not apply to this victim/applicant at this time.

NOTE: In addition to completing this section, you must attach copies of all itemized medical bills, mental health counseling bills, or other statements verifying expenses.

I am seeking compensation for:

☐ Medical Care ☐ Dental Care ☐ Mental-Health Counseling

☐ Replacement Service Loss (child care, convalescent care, etc.)

☐ Eyeglasses, hearing aids, or other medically necessary devices for the health of the victim

List any physical disabilities the victim had before the victimization: _____

_____

Describe injuries that resulted from the victimization. Use additional sheets if necessary: _____

_____

List all medical expenses incurred as a result of crime related injuries, including hospital and doctor charges, counseling expenses, ambulance fees, and prescription medication costs. Attach itemized statements or bills that you have received to date.

NOTE: Statements or bills must be attached in order for claim to be processed.

Provider's Name	Street Address	City/State/ZIP	Phone Number	Amount of Bill
				$
				$
				$
				$

Attach additional sheets if necessary. Will there be additional medical bills? ☐ Yes ☐ No ☐ Unknown

Were any of the bills paid or will they be paid by any of the following sources?

Source	Yes	No	Amount Paid	Identification Number
Yourself			$	
Medicare/Medicaid			$	
Workers' Compensation			$	
Veterans Administration			$	
Auto Insurance			$	
Restitution/Civil Recovery			$	

Name of Health Insurer: _____ Policy Number _____

Address: _____ Telephone: (_____) _____

Name of Auto Insurer: _____ Policy Number _____

Address: _____ Telephone: (_____) _____

■ Section D—Request for Lost Wages

☐ Check here if this section does not apply to this victim/applicant at this time.

NOTE: To be eligible for work loss, the victim must have been employed at the time of the incident. Attach a copy of your most recent pay stub from your employer. If you are self-employed, you must furnish copies of your tax returns from the last three (3) years so lost wages can be most accurately determined. You must also provide the complete name and address of the physician who can verify your disability period, or you may attach a copy of a recent disability statement.

Do you wish to file for work loss? ☐ Yes ☐ No

Employer: _____ Contact Person: _____

Phone Number: _____

Mailing Address _____City/State/ZIP_____

Dates absent from work due to crime related injuries: From: _____ To: _____

How many total days were missed: _____ How many total hours were missed? _____ Hourly wage? _____

Do/did you receive compensation while off work? ☐ Yes ☐No If Yes, complete the following:

	Amount per week	From (date)	To (date)
Workers' Compensation	$		
Unemployed Compensation	$		
Work Loss Insurance	$		
Vacation	$		
Sick Leave	$		
Union/Fraternal Insurance	$		
Other	$		

■ Section E—Request for Funeral/Burial Expenses

☐ Check here if this section does not apply to this victim/applicant at this time.

NOTE: You must submit a copy of the funeral bill and the death certificate with this application.

Are you seeking funeral benefits for a deceased victim? ☐ Yes ☐ No

Name of funeral home: _____ Telephone: (_____) _____

Mailing Address:_____ City/State/ZIP:_____

Total amount of funeral bill: $_____ Have the funeral expenses been paid? ☐ Yes ☐ No

Were funeral expenses paid by any of the following? If yes, please list the amounts paid from each of the following sources:

Social Security	Burial Insurance	Life Insurance	Veterans Insurance	Other (list source) _____	Donations
$	$	$	$	$	$
Family Members/ Individuals	Name/Relationship/Mailing Address of Family Member or Individual				
$					

Burial/Life Insurance Company _____ Policy # _____

Mailing Address _____ Telephone: (_____) _____

Who received the benefits? _____ Relationship to victim: _____

■ Section F—Request for Loss of Support

☐ Check here if this section does not apply to this victim/applicant at this time.

NOTE: You must attach copies of the deceased victim's last three (3) years' tax returns. You must also provide verification regarding the denial or receipt of any benefits from the Social Security Administration. You must be the legal guardian of a minor dependent to request loss of support on their behalf and must provide verification of guardianship.

Are you requesting loss of support that resulted from the death of the victim? ☐ Yes ☐ No

The Reparations Board may provide "loss of support" to dependents of deceased victims who were employed at the time of the incident. The person seeking this loss of support must be the guardian of any dependents for which you are requesting benefits. Complete the following in order to be considered for loss of support.

Dependent's Name	Date of Birth	Social Security Number	Relationship to Victim

Do/did you receive income from any of the sources listed below? ☐ Yes ☐ No

	Amount per month		Amount per month
Social Security	$	Aid to Dependent Children	$
Welfare	$	Social Security Disability	$
Other (list source)	$	Other (list source)	$

■ Section G—Request for Assistance with Crime Scene Clean Up

☐ Check here if this section does not apply to this victim/applicant at this time.

NOTE: Only survivors/dependents of homicide victims may apply for assistance with crime scene clean up. Receipts or supporting documentation must be attached to this application.

"Crime scene clean up" means to remove, or attempt to remove, from the crime scene blood, dirt, stains, or other debris caused by the crime or the processing of the crime scene. Reasonable expenses include, but are not limited to, cleaning supplies, equipment rental, labor, and hazardous waste removal. The location of a crime scene may include a structure or automobile; however, a distinction exists between cleaning and property replacement. Property replacement is prohibited.

Are you seeking reimbursement for expenses incurred during crime scene clean up? ☐ Yes ☐ No

Was an agency hired to perform the crime scene clean up? ☐ Yes ☐ No

Do you have receipts or other documentation verifying expenses incurred during crime scene clean up? ☐ Yes ☐ No

■ Section H—Miscellaneous Expenses

There may be other expenses eligible for reimbursement from the Arkansas Crime Victims Reparations Board. You may wish to speak with a representative of the Board to determine whether your unique expense is eligible for reimbursement. Other expenses that may be eligible for reimbursement include, but are not limited to:

- Purchase and installation of locks and windows following a sexual assault or act of domestic abuse occurring within the victim's primary residence.
- Travel and lodging resulting from a criminal justice proceeding related to the victimization.
- The application for guardianship of minors following the death of a victim.

AUTHORIZATION TO RELEASE INFORMATION

For Office Use Only: ACVRB Claim Number: _____ Victim: _____

I voluntarily authorize disclosure (including by paper, oral communication, and electronic interchange):

I. OF WHAT: Information about my health maintained in a patient file, medical records or elsewhere, including any charts, notes, x-rays, operative reports, lab and medication records, copies of all prescriptions, and all other medical information about me including medication history, diagnosis, testing and test results, prognosis, and treatment of any physical condition, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, communicable disease or disorders; sexually transmitted diseases; genetic information and test results, domestic abuse information; drug, alcohol, or other substance abuse information, including information about treatment or therapy; mental, psychiatric or psychological condition including diagnoses, treatment plans and medications prescribed *(including notes by a mental health professional analyzing or documenting conversations during private therapy sessions).*

II. FROM WHOM: Any licensed physician, medical practitioner, clinic or other medical or medically related facility, or other organization, institution or person who has treated me or consulted with other providers regarding my health during the last _____ years. The providers below may have records relating to my victimization but should not be considered an exhaustive list from which records may be obtained:

III. TO WHOM: The Arkansas Crime Victims Reparation Board and the agents or employees of the Victims Program hereafter "Crime Victims Program."

IV. FOR WHAT PURPOSE: _____

V. EXPIRES WHEN: _____ (One year or until an award of denial of reparation is made by the board, including any and all appeals, whichever is longer.)

VI. I further agree to or acknowledge the following:

- I authorize the use of a copy (including an electronic copy) of this form for the disclosures requested above.
- I understand that I have the right to revoke this authorization at any time by sending a written statement to **Crime Victims Reparations Board at #1 State Police Plaza Drive, Little Rock, AR 72209** or by providing written notice to the source of the information disclosed, such as my doctor. However, the revocation will not be effective if the source of the information already has disclosed the information to the Crime Victims Program. A revocation of this authorization will also serve to revoke the applicant's request for reparations.
- Any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct the persons and organizations identified above to release and disclose all my information without restriction.
- A health care provider or health plan subject to the HIPAA federal privacy laws cannot refuse to provide me services based on my failure to sign this authorization.
- Information disclosed by a provider or health plan covered by HIPAA privacy laws is no longer covered by HIPAA once it is disclosed to the Crime Victims Program pursuant to this authorization, and the Crime Victims Program may redisclose the information if allowed by law.

I understand that I, or my personal representative, have the right to receive a copy of this Authorization.

_____ _____
Signature of Individual or Personal Representative Date Required

_____
If Representative give relationship to Individual

_____ _____
Print Name of Individual Address of Individual/ City, State, ZIP

_____ _____
Print Name of Representative (if applicable) Address of Representative/ City, State, ZIP

It is important that you list the names of the providers where expenses have been incurred that are directly related to this victimization and for which you are seeking assistance from the Arkansas Crime Victims Reparations Board. Thank you.

ALL APPLICANTS MUST SIGN

Read Before Signing

CERTIFICATION OF APPLICATION: I hereby certify, subject to the penalty of fine and imprisonment, that the information contained in this application is true and correct to the best of my knowledge. I understand that if I knowingly file a false claim or provide false information or fail to provide material facts or circumstances necessary to substantiate the claim, I may not at a later date file a correct claim. NOTE: A.C.A. §16-90-704 and ACVRB Rule No. 2.14 provide that filing a false claim for reparations shall constitute a Class D felony.

REPAYMENT OF CRIME VICTIM'S COMPENSATION AWARD: You must repay the Crime Victims Reparations Board if you receive payments from the offender (restitution or civil action), insurance, or any other government or private agency as reimbursement for this injury or death after receipt of payment from the Reparations Board.

SUBROGATION AGREEMENT: I hereby agree to notify the Arkansas Crime Victims Reparations Board in the event that additional benefits become available to me in payment of the same expenses for which I receive reimbursement from the Crime Victims Reparations Board. I further agree to retain, as trustee for the Crime Victims Reparations Board, so much of the recovered funds as necessary to reimburse the Reparations Board to the extent of the compensation awarded to me.

X _____ _____

Signature of Applicant/Claimant Date

Relationship to victim if applicant/claimant is other than victim _____

IMPORTANT NOTICES

SUPPLEMENTAL RULE - In accordance with ACVRB Rule No. 2.12, please be advised that additional expenses (called supplemental expenses) that are submitted to the program in the event that a claim is awarded, must be submitted within one year from the date of treatment or payment by a collateral source in order to be considered.

FINANCIAL OBLIGATION REQUIREMENT - In accordance with ACVRB Rule No. 2.13, please be advised that payments shall not be disbursed on an eligible claim if the victim/claimant owes a financial obligation ordered or imposed as a result of a criminal conviction. Such financial obligation includes parole and probation fees.

MAXIMUM LIMITS - In accordance with Arkansas Code Annotated 16-90-702, the maximum reparations allowed for eligible victims is $10,000. However, for those victims whose injuries are catastrophic and result in a total and permanent disability, the maximum reparations allowed is $25,000. In addition, the Board has established ceilings on eligible expenses through their Rules and Regulations.

The Crime Victims Reparations Board acknowledges no responsibility for the expenses submitted to the program until a final decision has been made on a claim and the victim/claimant has complied with any conditions made by the Board. As there is no guarantee of payment by this program, a victim/claimant is responsible to service providers for the expenses that have been incurred as a result of a victimization. In addition, it is the victim/claimant's responsibility to notify service providers of the Board's decision on a claim.