

**In most cases the maximum award may not exceed \$35,000**



**Victims Compensation Assistance Program  
Office of Victims' Services  
CLAIM FORM**

FOR OFFICIAL USE ONLY	
Claim #	

Check as many as apply. **Most types of expenses have a monetary limit.**

Personal Injury
  Death
  Stolen Benefit Cash

**Sections 1, 2, and 3 must be completed for all claims. It is okay to skip sections as not all sections will apply to you.**

SECTION 1. VICTIM INFORMATION		Victim's Name			
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM/DD/YY / /	Age at Time of Crime	Marital Status	Social Security #	
Current Street Address				County	
City		State	Zip Code	Safe Daytime Phone # ( )	Other Safe Phone # ( )
Employer at Time of Incident		Street Address			
City		State	Zip Code	Employer Telephone # ( )	

SECTION 2. CLAIMANT INFORMATION		If victim is the claimant, write "SAME." If someone other than the victim is filing, complete the entire section.			
<b>Relationship to Victim _____ (Check all that apply)</b>					
<input type="checkbox"/> Parent of a Minor Child	<input type="checkbox"/> Legal Guardian of Victim (Attach Guardianship Papers)	<input type="checkbox"/> Person Responsible for Funeral Expenses		<input type="checkbox"/> Person Filing for Counseling Expenses	
<input type="checkbox"/> Person Financially Responsible for Victim	<input type="checkbox"/> Person Filing for Crime-Scene Cleanup				
Claimant's Name		Current Street Address			
City		State	Zip Code	County	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM/DD/YY / /	Safe Daytime Telephone # ( )	Other Safe Phone # ( )	Social Security #	
Name of Employer		Street Address			
City		State	Zip Code	Employer Telephone # ( )	

SECTION 3. CRIME INFORMATION		Date of Crime MM/DD/YY / /	Date Reported to Police or Date PFA Filed MM/DD/YY / /		
Location of Crime (street name and number if known)		City	County	State	
Did it happen at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was this crime related to domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No If PFA Order was filed, attach copy.	Did the crime involve a motor vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Police Department		Police Incident #		<b>If Not Reported to Police Within 72 Hours Attach Explanation</b>	
Name of Person(s) Who Committed Crime (if known) _____ <input type="checkbox"/> Adult <input type="checkbox"/> Juvenile _____ <input type="checkbox"/> Adult <input type="checkbox"/> Juvenile					

**Briefly describe crime and injuries.**

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<b>SECTION 4a. MEDICAL EXPENSES</b>	Monetary limits apply. <b>If filing for medical expenses, attach the following and complete section 4b below.</b>
<p>■ <b>ALL ITEMIZED MEDICAL BILLS RELATED TO CRIME.</b> Medical Bills must be in the name of the claimant and each bill <b>must</b> show name, address and telephone number of the provider and dates and type of service.</p> <p>Medical expenses could include hospital, doctor, ambulance, dentist, medications, medical supplies, home care, childcare, and replacement services.</p> <p>■ <b>COPIES OF CANCELLED CHECKS AND/OR RECEIPTS FOR ANY BILLS PAID BY VICTIM/CLAIMANT.</b></p> <p style="text-align: center;"><b>If victim is covered by an insurance plan or medical assistance, he/she must utilize authorized participating providers.</b></p>	

<b>SECTION 4b. MEDICAL INSURANCE INFORMATION</b>	Name of Insurance Company/Benefit Plan _____
<b>All bills must be submitted to your insurance or benefit plan before submitting to the Program.</b>	
<p>Were you covered by insurance at the time of the crime?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Are you covered by insurance now?                                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Type of Insurance or Benefit Plan(s):</p> <p><input type="checkbox"/> Medical Assistance                                      <input type="checkbox"/> Vision Benefit Plan                                      <input type="checkbox"/> Discount Prescription Card</p> <p><input type="checkbox"/> Medicare    <input type="checkbox"/> Workers' Compensation                                      <input type="checkbox"/> Dental Benefit Plan</p> <p><input type="checkbox"/> Health Insurance Plan                                      <input type="checkbox"/> Other (specify) _____                                      <input type="checkbox"/> None</p> <p style="text-align: center;"><b>ATTACH INSURANCE STATEMENTS OF ALL PAYMENTS AND/OR REJECTIONS FOR CORRESPONDING BILL(S).</b></p>	

<b>SECTION 4c. COUNSELING EXPENSES</b>	<b>Complete if filing for counseling expenses.</b> Monetary limits apply.
<p>Are Counseling Expenses being filed for the victim? <input type="checkbox"/> Yes    <input type="checkbox"/> No      If yes, provide all itemized counseling bills related to the crime. (must be in the name of the claimant)</p> <p>Are Counseling Expenses being filed for a person other than the victim? <input type="checkbox"/> Yes    <input type="checkbox"/> No      If yes, complete the remainder of Section 4c. in its entirety.</p> <p>Under which categories? (check all that apply)</p> <p><input type="checkbox"/> Family member _____ (relationship to the victim)      <input type="checkbox"/> Engaged to victim</p> <p><input type="checkbox"/> Individual residing in the victim's household      <input type="checkbox"/> Witness of a violent crime _____ Name if other than claimant</p> <p><input type="checkbox"/> Person who discovered the homicide victim</p> <p><input type="checkbox"/> Dependent(s) or minor siblings of victim requesting counseling expenses</p> <p>Name _____ Date of Birth MM/DD/YY ___/___/___ Relationship to Victim _____</p> <p>Name _____ Date of Birth MM/DD/YY ___/___/___ Relationship to Victim _____</p> <p>Name _____ Date of Birth MM/DD/YY ___/___/___ Relationship to Victim _____</p> <p><b>If additional dependents or minor siblings, please attach a separate sheet.</b></p> <p style="text-align: center;"><b>ATTACH ALL ITEMIZED COUNSELING BILLS RELATED TO CRIME (must be in the name of the claimant).</b> (Each bill <b>must</b> show name, address and telephone number of the provider and dates and type of service.)</p>	

<b>SECTION 5. LOSS OF EARNINGS</b>	<b>Complete if victim or claimant is filing for loss of earnings.</b> Monetary limits apply.
<p>Were you employed when the crime occurred? <input type="checkbox"/> Yes    <input type="checkbox"/> No      (If yes, complete the employer information in Section 1 or 2 on page 1)</p> <p><input type="checkbox"/> Part-time      <input type="checkbox"/> Full-time</p>	
<p>As a result of the crime:</p> <p>Did you miss work and lose pay due to crime-related injuries?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Did you miss work and lose pay due to court appearances?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Did you miss work and lose pay due to trauma related to a homicide?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p>Dates absent from work. MM/DD/YY:</p> <p>FROM ___/___/___      THRU ___/___/___</p>



**SECTION 8. LOSS OF SUPPORT****This section is for death claims only. Complete if filing for loss of support.**  
Monetary limits apply.

Provide copies of the following:

1. Victim's most recently filed IRS tax returns, including all schedules.  
If unavailable, copies of the victim's W-2 statements **OR** last four pay stubs, **OR** a printout from the employer covering these pay periods, **OR** a Court Order showing child/spousal support.
2. A **certified** death certificate.
3. Social Security benefit statements for claimant and/or dependents.
4. Statement(s) for any benefit(s) received as a result of the death, such as life insurance, veteran's benefit(s), pension survivors benefit(s), or other benefit statement(s).
5. Birth certificates for dependent children.
6. If someone other than the parent is filing as a claimant, submit guardianship papers for minor child(ren).

Dependents' Names

Date of Birth MM/DD/YY

Relationship to Victim

_____	___/___/___	_____
_____	___/___/___	_____

**If additional dependents, attach a separate sheet.**Are you aware of any other person(s) who were financially dependent on the victim at the time of the incident?  Yes  No

If yes, please provide their name, address and phone number, if available.

**Please make sure that the employer information is completed in Section 1 on page 1.****SECTION 9. RELOCATION EXPENSES****Complete if filing for relocation expenses.**  
Monetary limits apply.**ATTACH COPIES OF ALL ITEMIZED BILLS AND/OR RECEIPTS RELATED TO RELOCATION (must be in the name of the claimant).**  
(Each bill must show name, address and telephone number of the provider and dates and type of service.)

What date did you relocate? MM/DD/YY \_\_\_/\_\_\_/\_\_\_

Do you have homeowner's or renter's insurance? (If yes, attach statement showing coverage and/or rejection.)

 Yes  No

Address prior to your relocation

City	State	Zip Code
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Eligible Expenses	Amount	Eligible Expenses	Amount
Rent		Car/Truck Rental (up to \$30 per day)	
Utility connection fees		Moving company charges or van rental	
Telephone connection fee		Mileage for use of private vehicle	
Lodging while in transit (up to \$75 a night)		Common carrier fares	
Storage expense		Tolls and parking	
Rental of post office box		Mileage (current state rate)	
Childcare		Round trip mileage _____	

**Please provide a verification letter explaining that the immediate need for relocation is necessary to protect the safety and health of the victim and individuals residing in the same household from one of the following: human service agency, law enforcement agency, or medical provider. If a letter cannot be furnished, please identify the agency we may contact to verify this need related to relocation.**

Agency Name

Contact Name

Telephone #

( )

Street Address

Fax #

( )

City

State

Zip Code

<b>SECTION 10. CRIME-SCENE CLEANUP EXPENSES</b>	<b>Complete if filing for crime-scene cleanup expenses.</b> Monetary limits apply.	
<b>ATTACH COPIES OF ALL ITEMIZED BILLS AND/OR RECEIPTS RELATED TO CRIME-SCENE CLEANUP (must be in the name of the claimant).</b> (Each bill must show name, address and telephone number of the provider and dates and type of service.)		
Do you have homeowner's or renter's insurance? (If yes, attach statement showing coverage and/or rejection.) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Provide address where crime-scene cleanup expenses were incurred (if other than current address listed in Section 1 or 2).		
Street Address		
City	State	Zip Code

<b>SECTION 11. TRANSPORTATION EXPENSES</b>	<b>The following categories may be eligible for transportation expenses:</b> Monetary limits apply.			
Attach more sheets if necessary				
<ul style="list-style-type: none"> <li>■ If the victim/claimant is requesting compensation for miles traveled to providers, pharmacies, or counseling sessions.           <ul style="list-style-type: none"> <li>● Please submit receipts from the victim/claimant's use of public transportation, including date of service; pharmacy receipts, if applicable; medical/counseling bill(s) or a letter from the provider verifying the dates(s) of treatment; and the roundtrip mileage.</li> </ul> </li> </ul>				
Provider Name	Round Trip Miles	Dates of Service		
<ul style="list-style-type: none"> <li>■ If the victim/claimant traveled 50 miles or more from their home to a provider and is requesting compensation for meals or overnight accommodations.           <ul style="list-style-type: none"> <li>● Please provide the date/time of departure and date/time of return to home for meal reimbursement; medical/ counseling bill(s) or letter from the provider showing date(s) of treatment; and an itemized bill for overnight accommodations.</li> </ul> </li> </ul>				
Provider Name	Date	Departure Time	Date	Return Time
<ul style="list-style-type: none"> <li>■ If the claimant is filing for mileage for making funeral/burial arrangements.           <ul style="list-style-type: none"> <li>● Please submit a copy of the funeral bill(s) showing the claimant as the person responsible for funeral expenses.</li> </ul> </li> </ul>				
Roundtrip Mileage	Funeral Home Name			
<ul style="list-style-type: none"> <li>■ If the claimant is requesting compensation for transportation costs, meals, or overnight accommodations for the purpose of accompanying the deceased to another city/state/country.           <ul style="list-style-type: none"> <li>● Please provide the name of the individual designated by the family to accompany the deceased to another city/state/country and receipts for transportation costs including airfare and overnight accommodations.</li> </ul> </li> </ul>				
Date	Departure Time	Date	Return Time	

**If you need assistance in filing a compensation claim,  
please contact a Victim Service Provider in your county,  
your county District Attorney's Office,  
or call the Victims Compensation Assistance Program at  
(717) 783-5153 or toll free at (800) 233-2339.**

<b>REPRESENTATION BY OTHERS</b>			Who referred you to the Victims Compensation Assistance Program? <input type="checkbox"/> Hospital <input type="checkbox"/> Prosecutor <input type="checkbox"/> Poster/Brochure <input type="checkbox"/> Police <input type="checkbox"/> Victim Service Program <input type="checkbox"/> Other (Identify)		
<b>ATTORNEY INFORMATION</b>			<b>VICTIM SERVICE PROGRAM INFORMATION</b>		
Are you represented in this matter by an attorney In filing a claim?    In a civil lawsuit?    In an insurance action? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			Did a Victim Advocate assist you in completing this form? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Attorney			Name of Victim Service Program to receive copies of claim correspondence:		
			Name of Victim Advocate who assisted in filing this claim form:		
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code
Telephone #	Fax # (if known)		Telephone #	Fax # (if known)	
<b>VICTIM STATISTICAL INFORMATION</b>			The following information is used for statistical purposes only. The submission of information for this section is strictly voluntary.		
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other			Country of Birth _____		
Do you have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, nature of disability <input type="checkbox"/> Physical <input type="checkbox"/> Mental <input type="checkbox"/> Developmental					
<b>ACKNOWLEDGEMENT AND REIMBURSEMENT AGREEMENTS</b>			The Acknowledgement, Reimbursement and Authorization Agreements must be signed before the claim verification process will begin.		
<b>In most cases two signatures are required. If the victim is age 14 or older, then he/she must also sign and then three signatures are required</b>					
My signature below signifies I understand each of the following statements or points of law: The decision to approve my claim is that of the Program's. I may object to all or part of the Program's decision in writing within 30 days from the date of the decision. I must prove the exact amount of my losses before the Program will consider awarding compensation from the Crime Victim's Compensation Fund. I may file for reimbursement for additional expenses incurred relating to the crime. My claim may be denied if I do not cooperate fully with law enforcement agencies, the courts, and the Program or maintain a valid address with the Program. If I were to make a false claim, it would be a criminal offense punishable as a misdemeanor under Section 11.1303 of the Crime Victims Act. If I were to make a false statement in this claim form with the intent to mislead the Program, it would be a criminal offense punishable as a misdemeanor under 18 Pa. C.S. §4904. I understand that the Crime Victim's Compensation Fund is the payor of last resort. I specifically agree to inform the Program of and repay to the Commonwealth any funds that I may receive from any other source that has not already been considered, as a result of the crime and to the extent of the award. That is, I agree to repay any funds that I receive from the offender, any other person or source, which compensates me for the injury I suffered, including any award for pain and suffering. I further agree that if the claim is at any time determined to be in error, false or fraudulent, I will refund to the Program all sums of money paid by the Program.					
<b>X</b> _____ Claimant's Signature			_____ Date		
<b>AUTHORIZATION TO OBTAIN INFORMATION</b>			This acknowledgement must be signed before the claim verification process will begin.		
I hereby authorize in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 42 USC§§1320d et seq.) any hospital, physician, health care provider or other person who attended or examined (Name of Victim) _____; any funeral director or other person who rendered related services; any employer of the victim or claimant; any police or governmental agency, including state or federal taxing authorities; any insurance company; or any organization having relevant knowledge, to furnish to the Office of Victims' Services, Victims Compensation Assistance Program, any and all information in their possession with respect to the incident that is the basis for this claim. Copies of this authorization may be used in place of the original.					
<b>X</b> _____ Claimant's Signature			_____ Date		
_____ Date			_____ Date		
<b>Victim's Signature (if age 14 or over)</b>					

**Victims Compensation Assistance Program**

**Mailing Address:**  
P.O. Box 1167  
Harrisburg, PA 17108-1167

**Street Address:**  
3101 North Front St.  
Harrisburg, PA 17110

**Phone and Fax Numbers**  
(800) 233-2339  
(717) 783-5153  
(717) 787-4306 (FAX)