

CLAIMS PROCESS OVERVIEW

Eligibility:

When the claim is received by mail at the Victims Compensation Assistance Program, pertinent data is entered into the **Dependable Access for Victim's Expenses (DAVE)** computer system and then assigned a claim number by the system. The claim form may also be submitted electronically through the DAVE computer system by selected Victim Service Programs throughout the Commonwealth. Additionally, a victim or claimant may submit a claim online at www.pacrivevictims.org. For electronically filed claims, the claimant can sign the form electronically. However, those submitting paper claims, the claimant must sign the Acknowledgement and Reimbursement Agreement and the Authorization to Obtain Information on the back of the claim before the processing of the claim begins. The claim is then assigned to a VCAP staff member who will handle the claim throughout the entire process. The staff member will review the claim form and supporting documents for **eligibility** determination.

Eligible Claims:

When it is determined that the claim **meets the basic eligibility requirements**, the claim is "accepted" and an acknowledgement letter is sent to the claimant. This letter will either state that no further information is needed from the claimant at this time; or that additional information is required from the claimant, and a checklist will be attached.

Eligible claims, where *no verifiable out-of-pocket expense or loss is received by the VCAP within 5 years* from the date of filing of the claim, will be closed with no further right of appeal (exception for minors). The VCAP will attempt to notify the claimant in writing 6 months prior to closing of the claim.

Cannot Determine Eligibility:

If there is **insufficient information to determine whether a claim has met the basic eligibility requirements**, a checklist will be sent requesting additional information from the claimant. These claims are kept in **Information Collection** status until the requested information is received.

Please Note: If sufficient information is not provided to the VCAP to *determine eligibility within 2 years* from the date of the filing of the claim, the claim will be closed with no further right of appeal. The VCAP will attempt to notify the claimant in writing 6 (six) months prior to the closing of the claim.

Verification:

Once a claim has been accepted (met the basic eligibility requirements), staff initiate the **verification process**. The Program is required by law to investigate each claim to verify the accuracy of the claim, to ensure that all requirements of the law are met and to make a determination as to whether the claim should be paid and the amount that should be awarded.

Depending on the type of claim and the documentation that was submitted with the claim, the assigned staff member will determine what entities need to be contacted for further information and verification. These verification requests are sent at the same time that the acknowledgement letter is sent to the claimant. If the requested information is not received within 30 days, the Program may issue a subpoena for the requested information. A letter is sent to the claimant and to the victim service program notifying them of the Program's attempts to obtain the required information. If after sending a subpoena the VCAP still does not receive the necessary information, the claim may be made inactive.

If a victim is applying for multiple benefits, such as medical expenses and loss of earnings, however verification is received only for the medical expenses, VCAP may pay the medical expenses and consider the lost earnings once the required documentation is received.

If there is a known offender, the Program will verify the status of court proceedings and restitution.

The acknowledgement letter will indicate the name and phone number of the VCAP staff assigned to the claim. VCAP also has Client Service Representatives who answer the phone Monday through Friday, during business hours, who can also help to answer questions that you may have about a claim. **A VICTIM SERVICE PROGRAM WHO ASSISTED A VICTIM IN FILING A CLAIM WILL BE COPIED ON ALL CORRESPONDENCE SENT TO THE CLAIMANT.**

Verification requests are most commonly sent to the following:

Police Departments – The program requires a police report (unless a PFA was filed) to determine:

- An eligible crime was committed.
- The crime was reported within 72 hours.
- The victim did not engage in conduct that caused the injury.
- The victim cooperated with the investigation and prosecution.

Medical/Public Assistance – The Program may access the Medical Assistance/Public Assistance office database to determine whether the victim was/is eligible for benefits (Medical, Cash, or Food Stamps).

Hospitals – The Program may contact a hospital to verify charges or, when necessary, to request medical records to verify that services directly relate to crime.

Doctors – The Program may contact a doctor to verify charges, verify that services relate directly to crime, and types of supplies or medications prescribed as a result of the crime. If the victim is requesting loss of earnings, VCAP requires the doctor complete the verification form related to the victim’s disability period. If the victim sought mental health, physical therapy, or chiropractic services, a treatment form is attached for the doctor or licensed professional to certify what percentage of the treatment is directly related to the crime.

Dentists - The Program may contact dentists to verify the charges, the percentage of services that directly relate to the crime, any medications or supplies prescribed, specific teeth requiring treatment, and dental records if necessary.

Funeral Homes – The Program will send a verification form to the funeral home to verify payments made, who the payments were made by, and balance due.

Employers – Employers are requested to complete the verification form indicating the dates the victim/claimant lost time from work, regularly scheduled day/weekly hours, and any reimbursements received, i.e., sick, vacation or disability pay.

Contribution/Denial Determinations:

If the assigned staff person decides that a contribution assessment or a denial may be warranted, the claim is forwarded to a Claims Review Officer for review.

If the Claims Review Officer determines that the claim should be denied, a letter explaining the reason for the denial will be prepared and sent to the claimant and a copy to the advocate who assisted with the filing of the claim. If the claim is a homicide, a phone call is made to the claimant advising of such prior to mailing the denial.

If the Claims Review Officer determines that a claim should be reduced for contribution, an assessment amount is determined, and the claim is forwarded to Legal Counsel for review and advice. The claimant will be notified of the assessment in the Report and Determination (Award Decision). If the claim is a homicide and is assessed, a phone call is made to the claimant advising of such prior to the award being processed.

If the Claims Review Officer determines that a claim should not be reduced for contribution or denied, the claim is returned to the assigned staff member to continue the processing of the claim.

Report and Determination (Award Decision):

When sufficient verification has been received, the assigned staff member will review all documents, determine the payable losses, and process a **Report & Determination**. The Report and Determination will either be reviewed and approved by the staff member’s Second Reviewer, or it will be system-approved by the DAVE System. (A percentage of claims

approved by the DAVE system are post audited by Second Reviewers within a week so that in the event that an error is found, corrections can be made before a check is mailed by the Treasury Department.)

Once second approved, the Report & Determination is sent to the claimant. If money is due directly to the claimant, a check will also be enclosed (up to \$5,000) from VCAP's Advancement Account. Any remaining balance to the claimant, as well as any amount due a provider, will be processed and mailed from the Treasury Department within approximately three to five weeks. All checks due a provider will be mailed directly to the provider.

Please Note: The Treasury Department does not mail checks for claims where contribution was assessed. Treasury mails the checks to VCAP where they are held until the 30-day appeal time has lapsed with no response from the victim/claimant.

Appeals:

If a claimant does not agree with the Program's decision, he or she may file a **Request for Reconsideration** within 30 days of the date of the Report & Determination. If the victim/claimant received a check from the Program, it must be returned with the Request for Reconsideration. The Request for Reconsideration is reviewed by the Claims Review Officer and additional follow-up is done as necessary. A decision is then made to either change the original decision or reaffirm it. If after the Reconsideration determination the claimant still disagrees with the decision, he or she has the right to file a **Request for Hearing** within 30 days of the date of the reconsidered decision.

NOTE: A Request for Reconsideration must be completed and signed by the claimant. An advocate may assist the claimant in writing the appeal, however, the claimant must sign.

Report and Determination (Supplemental Decision):

If a claimant incurs additional bills related to the crime, these bills may be considered on a Supplemental Decision. **A new claim form is not required.** The bill(s) can be sent to the VCAP with the original claim number written on it. These bills will be assigned to the same staff member as the initial award and the claim follows the same process as a new claim.