

Maximum Payout of One Month's Net Benefit Entitlement

Victims Compensation Assistance Program
Office of Victims' Services

FOR OFFICIAL USE ONLY

Claim #



CLAIM FORM FOR STOLEN BENEFIT CASH CLAIMS ONLY

**IF EARNINGS FROM EMPLOYMENT ARE YOUR MAIN SOURCE OF INCOME,
YOU ARE NOT ELIGIBLE FOR THIS BENEFIT.**

If filing for Medical Expenses the Standard Claim Form must be utilized.

SECTION 1. VICTIM INFORMATION		Victim's Name	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	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 Phone # ()

Filing on behalf of the victim? Please provide your contact information in the spaces below.

Name			
Street Address			
City	State	Zip Code	Phone # ()

Victims Compensation Assistance Program

Mailing Address:

P.O. Box 1167
Harrisburg, PA 17108-1167

Street Address:

3101 North Front Street
Harrisburg, PA 17110

Phone and Fax Numbers:

(800) 233-2339
(717) 783-5153
(717) 787-4306 (FAX)

SECTION 2. CRIME INFORMATION		Date of Crime / /	Date Reported to Police / /	If not reported to Police within 72 hours attach explanation.
Location of Crime (Street Name and Number, if known)				
City		County		State
Name of Police Department			Police Incident #	
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 the crime in your own words.				

SECTION 3. STOLEN BENEFIT CASH	Maximum Payout of One Month's Net Benefit(s) Entitlement
Amount of Cash Stolen \$ _____	
Type(s) of Benefit(s). These Benefit(s) Must Be Your Main Source of Income.	
<input type="checkbox"/> Social Security Retirement	<input type="checkbox"/> Supplemental Security Income
<input type="checkbox"/> Disability	<input type="checkbox"/> Retirement/Pension(s)
<input type="checkbox"/> Social Security Survivor Benefits	<input type="checkbox"/> Court Ordered Child/ Spousal Support
	<input type="checkbox"/> Social Security Disability Income
Is This Benefit(s) Your Main Source of Income? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(Attach a copy of your benefit statement(s) which apply to month of the crime.)	

SECTION 3. STOLEN BENEFIT CASH (Continued)

Do You Have Homeowner's or Renter's Insurance? Yes No
(If yes, attach statement showing coverage or rejection.)

Are You Required to File IRS Tax Returns? Yes No
(If yes, attach copies including all schedules.)

VICTIM STATISTICAL INFORMATION

The following information is used for statistical purposes only.
The submission of information for this section is strictly voluntary.

Race
 White Black Hispanic American Indian/Alaskan Native

Asian/Pacific Islander Other

Country of Birth

Do you have a Disability?

Yes No If yes, nature of disability Physical Mental Developmental

REPRESENTATION BY OTHERS

VICTIM SERVICE PROGRAM INFORMATION

Who referred you to the Victims Compensation Assistance Program?

Hospital Prosecutor Poster/Brochure Police Victim Service Program

Other (Identify) _____

Did a Victim Advocate assist you in completing this form? Yes No

Name of Victim Service Program to receive copies of claim correspondence:

Name of Victim Advocate who assisted in filing this claim form:

Street Address

City State Zip Code

Phone # Fax # (If Known)

() ()

**ACKNOWLEDGEMENT/
REIMBURSEMENT AGREEMENTS**

The Acknowledgement /Reimbursement and Authorization Agreements must be signed before the claim verification process will begin.
(2 signatures required)

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 an 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.

Claimant's Signature

Date

**AUTHORIZATION TO OBTAIN
INFORMATION**

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, 42USC§§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.

Claimant's Signature

Date