Claimant Name:	**Date of Birth:**

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CRIME VICTIMS COMPENSATION PROGRAM (CVCP) APPLICATION

PART I – ELIGIBILITY

DATE APPLICATION FILED:

CLAIMANT NAME (*the person seeking compensation*):
If you are assisting someone in filling out this form, answer all questions as if you are the claimant.

Choose all that apply:

☐ I am the victim

☐ I am a secondary victim (please check the box that applies):
- ☐ I am the victim's spouse, child, grandchild, parent, sibling, parent-in-law
- ☐ I resided in the victim's household at the time of the crime
- ☐ I was wholly or partially dependent on the victim for care and support
- ☐ I paid the medical, funeral, or burial expenses caused by the crime
- ☐ I had close ties to the victim
- ☐ I witnessed the crime

Victim's name: _____

☐ I am filing on behalf of a victim

☐ I am filing on behalf of a secondary victim

My address:		
City:	State:	Zip:
Preferred phone:		Alternate phone:
Date of birth:		Email:
Primary Language:		Pronouns (optional):
Race:		

If you are filing on behalf of a victim or secondary victim, please provide their information:

Name:		
Address:		
City:	State:	Zip:
Phone:		Date of birth:

Relationship to victim/secondary victim: ☐ Parent ☐ Guardian ☐ Personal Representative ☐ Other _____(please describe relationship)

Claimant Name:	**Date of Birth:**

CRIME INFORMATION

Mark all crimes or attempted crimes that caused physical injury, emotional trauma or death to the victim or secondary victim.

☐ Arson	☐ Cruelty to children	☐ Kidnapping	☐ Riot	☐ Stalking	☐ Traffic offenses (Impaired, reckless, etc)
☐ Assault	☐ Destruction of property by an intimate partner	☐ Labor trafficking	☐ Robbery	☐ Terrorism	☐ Unlawful use of explosive
☐ Burglary	☐ Domestic violence	☐ Malicious disfiguring	☐ Sex trafficking	☐ Threats	☐ Voyeurism
☐ Carjacking	☐ Homicide	☐ Mayhem	☐ Sexual abuse or assault		☐ Weapon of mass destruction
☐ Cruelty to animals	☐ Destruction of property to your home or vehicle from someone shooting a gun		☐ Sexual performance using a minor	☐ Neglect, abuse or exploitation of a vulnerable adult or elderly person	

Date of crime:

Location of crime:
Please be as specific as possible.

Brief Description of Crime and Injuries:

Name of offender (if known):

DOCUMENTATION OF CRIME (must select at least one)
***Please include documents you check below if you have them*.**

☐ Police report Number: _____

Date of police report:

If reported more than 7 days after offense, explain why:

☐ Temporary or Final Civil Protection Order Case number:_____

☐ Temporary or Final Anti-Stalking Order Case number:_____

☐ Forensic medical examination

☐ Child neglect case filed

☐ Court order of early release of offender

If unable to obtain one of the above documents due to claimant's age, physical condition, psychological state, cultural or linguistic barriers, or other health or safety concern:

☐ other court order ☐ medical record

☐ law enforcement record; or

Claimant Name:	Date of Birth:

PART II – COMPENSATION

CHECK THE BOX FOR ANY ASSISTANCE YOU ARE REQUESTING	THEN COMPLETE
☐ Temporary Emergency Housing or Moving Expenses for Victims in Immediate Danger	Section 1
☐ Medical Expenses / Dental Expenses / Mental Health Services	Section 2
☐ Funeral Expenses	Section 3
☐ Loss of Earnings/Wages	Section 4
☐ Loss of Support for Survivors of Homicide	Section 5
☐ Compensation for any Secondary Victims or Dependents	Section 6
☐ Loss of Services and Expenses for Substitute Services	Section 7
☐ Replacement of Clothing held as Evidence	Section 8
☐ Security Measures for the Home	Section 9
☐ Crime Scene Clean-up	Section 10
☐ Transportation to Receive Services	Section 11
☐ Reimbursement for Alternate Transportation because Car Held in Evidence	Section 12
☐ Veterinary Expenses	Section 13
☐ Restitution Agreement (if the offender is ordered to pay you money in a criminal case)	Section 14
☐ Other (specify)	
ALL APPLICANTS MUST COMPLETE SECTION 15: COLLATERAL RESOURCES	

SECTION 1 – TEMPORARY HOUSING AND MOVING EXPENSES – Rule 29 Limit: up to $3,000 for temporary housing and up to $1,500 for moving expenses	
Are you requesting temporary housing?	☐ YES ☐ NO
Are you requesting moving expenses?	☐ YES ☐ NO If yes, submit a copy of lease.
A referral form must also be submitted.	☐ Check here if referral is attached

SECTION 2 – MEDICAL / DENTAL / MENTAL HEALTH INFORMATION- Rule 13, Rule 24
Limit: Mental Health up to $3,000 for Adults and up to $6,000 for Minors
Medical and Dental: up to $25,000 max (includes all other compensation award)

Did you receive medical/dental/or mental health treatment related to the crime? ☐ Yes ☐ No

Name of Doctor, Hospital, or Other Provider	Street Address	City/State/Zip	Phone number	Bill amount

Add additional providers on a separate piece of paper.
Submit copies of all available bills received to date.
Attach all insurance payment statements and rejections.
YOU WILL BE REQUIRED TO COMPLETE AUTHORIZATION AND RELEASE FORMS

Claimant Name:	**Date of Birth:**

SECTION 3 – FUNERAL EXPENSES – Rule 25 Limit: up to $10,000	
Name of Funeral Home / Phone No:	(Attach a copy of the bill)
Name of Cemetery/Phone No:	(Attach a copy of bill)
Total Amount of Funeral/Cemetery Bill: $	
Have the Funeral/Cemetery expenses been paid? If YES, by whom? _____ Please submit receipt	☐ YES ☐ NO

SECTION 4 – LOSS WAGES/EARNINGS -Rule 28 Limit: a total period of up to 52 weeks after the date of the crime, in an amount not to exceed the lesser of 80% of the victim's net pay or $10,000	
Was victim employed at the time of the crime? ☐ YES ☐ NO	Date of last employment:
Name of Victim's Employer (at the time of crime):	Supervisor's name:
Employer Street Address:	Employer phone number:
City, State, Zip Code:	
Gross Salary $_____ per: ☐ hour ☐ day ☐ week ☐ month ☐ year	
Hours Worked _____ per: ☐ day ☐ week	
Are you unable to work as a result of the crime/injuries? ☐ YES ☐ NO	
How long have you been unable to work as a result of the crime/injuries? From __/__/__ through ___/__/__ Mo. Day Yr. Mo. Day Yr.	
Name of doctor who can verify length of disability to work: (Please submit disability statement from the verifying doctor)	
Doctor's address:	
Doctor's phone number:	
Did you receive pay from you job when you were off work? ☐ YES ☐ NO	
Are you self-employed? ☐ YES ☐ NO If yes, you must attach a copy of your Federal Income Tax Returns for the last 12 months preceding crime.	

YOU WILL BE REQUIRED TO COMPLETE AUTHORIZATION AND RELEASE FORMS

EMERGENCY AWARD IF EMPLOYED AT TIME OF CRIME: Limit up to $1,000 – **Rule 37**

Are you experiencing a financial hardship as a result of lost wages? ☐ YES ☐ NO

NOTE: The emergency award will be deducted from any final award. If the emergency award is greater than the final award, the claimant must repay the difference. If compensation is not awarded, the claimant must repay the emergency award in its entirety.

SECTION 5 – LOSS OF SUPPORT FOR SURVIVORS OF HOMICIDE – Rule 30 Limit: $2,500 per dependent, not to exceed $7,500 per victimization	
Have you submitted a claim to Social Security Administration?	☐ YES ☐ NO
Did the victim have dependents? If yes, list dependents in section 6	☐ YES ☐ NO
Did the victim provide support? If yes, submit evidence of employment and/or child support	☐ YES ☐ NO

YOU WILL BE REQUIRED TO COMPLETE AUTHORIZATION AND RELEASE FORMS

Claimant Name:	**Date of Birth:**

SECTION 6 – SECONDARY VICTIMS and DEPENDENTS
Submit copies of birth certificates for children. Please list the victims' dependents and household members and indicate whether they will seek mental health counseling, because of this crime.

Please complete the following information about dependents. (Dependent means a person wholly or partially dependent upon a victim for care or support and includes a child of the victim born after the victim's death.)

Name	Date of Birth	Address	Seeking counseling due to crime?	Relationship to victim
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	
			☐ YES ☐ NO	

SECTION 7 – LOSS OF SERVICES AND EXPENSES FOR SUBSTITUTE SERVICES – Rule 31
Limit: up to $200.00 per week, not to exceed $2,500

Please list all services such as childcare and housekeeping that are no longer provided by the victim as a direct result of the crime.

SERVICES	EXPENSES INCURRED

SECTION 8 – CLOTHING REPLACEMENT – Rule 27
Limit: up to $100 (No reimbursement when victim is deceased)

Are any of the victim's clothes being held by law enforcement officials for evidence? ☐ YES ☐ NO
List items of clothing being held: _____

SECTION 9 – SECURITY MEASURES FOR THE HOME – Rule 32
Limit: up to $1,000

Are you seeking security measures for your home as a result of the crime? ☐ YES ☐ NO
Please submit bill or receipt for services.

SECTION 10 – CRIME SCENE CLEAN UP – Rule 26
Limit: up to $1,000

Are you seeking reasonable cost associated with cleaning up the crime scene? ☐ YES ☐ NO
Please submit bill or receipt for services.

SECTION 11 - TRANSPORTATION EXPENSES – Rule 35
Limit: up to $100 local travel and $500 necessary out of state travel

Do you need assistance with the cost of transportation to receive treatment or services as a result of the crime? ☐ YES ☐ NO

Claimant Name:	**Date of Birth:**

SECTION 12 - REIMBURSEMENT FOR ALTERNATE TRANSPORTATION (when victim or secondary victim's car is being held by the police as evidence or to collect evidence) – **Rule 33** Limit: up to $2,000
Was your car held as evidence by the police as a result of this crime? ☐ YES ☐ NO
Agency holding car as evidence:
Name and phone number of Law Enforcement Officer:
Please submit copy of transportation receipts.

SECTION 13 – VETERINARY EXPENSES Limit: up to $1000
Did your animal receive veterinary treatment as a result of animal cruelty? ☐ YES ☐ NO
Please submit copy of bill.

SECTION 14 – RESTITUTION & DAMAGES If a court ever orders payment to you because of the crime, you must inform the Crime Victims Compensation Program.
Has a judge ordered payment to you (victim or claimant) because of the crime? ☐ YES ☐ NO
Court case #:

SECTION 15 – INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION				
The Crime Victims Compensation Program must consider all collateral resources (other assistance available to you) when reviewing a compensation application. **YOU MAY BE REQUIRED TO COMPLETE SEPARATE AUTHORIZATION AND RELEASE FORMS FOR DOCUMENTATION OF YOUR COLLATERALL SOURCES**				
Source	YES	NO	Status of Application	Amount Paid
Health Insurance	☐	☐		
Automobile Insurance	☐	☐		
Workman's Compensation	☐	☐		
Medicare	☐	☐		
Medicaid	☐	☐		
Veteran's Administration	☐	☐		
TANF	☐	☐		
Vacation/Annual/Sick/Pay	☐	☐		
Food Stamps	☐	☐		
Disability Benefits	☐	☐		
Dental Insurance	☐	☐		
Life Insurance	☐	☐		
Burial Insurance	☐	☐		
Unemployment Benefits	☐	☐		
Social Security	☐	☐		
Child and Family Services Agency (Payment of Counseling Expenses)	☐	☐		
Section 8/HUD Housing	☐	☐		
Veterinary insurance	☐	☐		

Claimant Name:	**Date of Birth:**

DECLARATION AND AFFIRMATION

- I understand CVCP will obtain official law enforcement records or court documents related to my claim.
- I understand that I cannot receive reimbursement until CVCP verifies costs and treatment for injuries or trauma from the crime.
- CVCP will notify me if my claim is approved or denied.
- I must also notify CVCP if I sue the offender or if the court orders the offender to pay me restitution. I understand that if I get any money from a lawsuit related to the crime or the court orders restitution, I may have to repay funds I received from CVCP also relating to the same crime.
- If the District of Columbia chooses, it can file its own lawsuit against the offender to recover the money CVCP paid. If the District of Columbia sues the offender to get the funds back, I must fully cooperate with the lawsuit.

I HEREBY CERTIFY THAT I WILL NOTIFY THE CRIME VICTIMS COMPENSATION PROGRAM IN THE EVENT THAT I FILE SUIT AGAINST THE OFFENDER OR THE COURT ORDERS THE OFFENDER TO MAKE RESTITUTION TO ME.

I UNDERSTAND THAT IT IS A MISDEMEANOR TO KNOWINGLY SUBMIT FALSE INFORMATION CONCERNING A CLAIM, AND I CERTIFY THAT THE INFORMATION CONTAINED IN THIS ELIGIBILITY APPLICATION, THE COMPENSATION APPLICATION AND ANY DOCUMENT SUBMITTED FOR A CRIME VICTIMS COMPENSATION AWARD IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. *See* D.C. Code § 4–513.

_____

Signature of Victim/Secondary Victim or Person Filing on Behalf of Victim/Secondary Victim

_____

Date

☐ **Check here if photo ID attached**

If no ID provided, a staff member will contact you for another way to confirm your identity.

Please submit completed application by email to CVCPapplications@dcsc.gov or by mail or in person to 515 5th Street, NW #109, Washington, D.C. 20001; or see remote sites.

Please allow 5 business days for a CVCP team member to review your compensation application. If you have any questions, please call 202 879-4216.