For Office Use Only

Claim #_____

APPLICATION FOR CRIME VICTIM COMPENSATION

STATE OF RHODE ISLAND
OFFICE OF GENERAL TREASURER JAMES A. DIOSSA

(Please print clearly and fill out both pages)

Victim Information (for person who was injured. MUST answer ALL questions to process application)

First Name	Middle Initial	Last name

Date of birth / /	SSN - -	Home Phone ( )
Mailing address		Cell Phone ( )
City	State	ZIP Code
Email Address		

Claimant Information (for minor victim or survivor of a deceased victim. MUST answer ALL questions to process application)

First Name	Middle Initial	Last Name

Date of birth / /	SSN - -	Home Phone ( )
Mailing address		Cell Phone ( )
City	State	ZIP Code
Email Address		Relationship to Victim

Crime Information

Please describe crime and your injuries:

Police Department Crime reported to		Police Report Number
Date of Crime / /	Date Crime Reported / /	Date Crime Discovered / /
Location of Crime		
Person (s) Who Committed Crime		

Are you represented by a private attorney in a civil law suit or insurance action? ☐Yes ☐No ☐ Not at this time

Attorney's Name		Phone
Address	City	State & Zip Code

Expenses (check for which expenses you are requesting compensation) PLEASE SUBMIT COPIES OF BILLS

☐ Lost Wages for victim (if employed at time of crime)
☐ Counseling for the victim
☐ Medical expenses for victim
☐ Dental expenses for the victim
☐ Loss of earnings for parent/guardian of minor victim
☐ Relocation Expenses

HOMICIDE CLAIMS
☐ Funeral/burial
☐ Crime scene Clean-up
☐ Loss of support for dependent of a deceased victim
☐ Counseling for family of homicide victim
☐ Relocation Expenses

Insurance Information ☐ Health ☐ Medicaid/Medicare ☐ Works Comp ☐ None ☐ Other_____

General Information (the following information is optional; it is used for statistical purposes only)

Gender: ☐ Male ☐ Female ☐ Other **Disabled**: ☐ Yes ☐ No **Age:** ☐ 17-Under ☐ 18-63 ☐ 64-Over

Race: ☐ White ☐ Black ☐ American Indian ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other

Who Referred You ☐ Police ☐ Office of the Attorney General ☐ Funeral Home ☐ Hospital ☐ Victim Services ☐ Other (specify)_____

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Agreement, Consent & Disclaimer (This section MUST be signed and dated to process application)

REPAYMENT AGREEMENT

I understand the Victim Compensation Fund is a FUND OF LAST RESORT. I understand that Rhode Island law requires me to contact and repay the Crime Victim Compensation Program if I receive payments from the offender, a civil law suit, and insurance program, Government of private agency, or any other source after I receive payment from the Crime Victim Compensation Program. I agree to notify the Crime Victim Compensation Program if I hire an attorney to represent me in any action related to this crime.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize any hospital, medical facility, doctor, mental health provider, employer, insurance company, person or agency to give needed information to the Crime Victims Compensation Program. I understand that the information will only be used to determine compensation benefits. I understand that any records are protected under the federal confidentiality regulations and under the general laws of the state of Rhode Island and cannot be disclosed without my written consent except as otherwise provided by law. Any information released or received as a result of this consent shall not be further relayed in any way to any other person, organization, entity or other, without an additional written consent by me. I may withdraw this consent by giving written notification to the above party at any time prior to the disclosure or the release of the information. I authorize that a Photostat copy of the original of this authorization be accepted with the same authority as the original.

I certify that the information and supporting documentation contained in this application is true and accurate to the best of my knowledge.

BCI DISCLAIMER

Pursuant to Rhode Island General Laws 12-25-19(d), the Criminal Injuries Act of 1999, this office may deny an award for compensation if the victim committed violent felonious criminal conduct within the past five years or subsequent to his or her injury.

I, _____, my date of birth is ___/____/_____ hereby direct and authorize the Bureau of Criminal Identification of the RI Department of Attorney General to make available to the Crime Victim Compensation Program any criminal record that the Bureau of Criminal Identification has on file in reference to me.

I hereby waive and release any and all manner of actions, causes of actions and demands of every kind, nature and description, arising from any release of criminal records and requests there from, whatsoever against the State of Rhode Island, Bureau of Criminal Identification, the Attorney General and employees of the Attorney General's Office and the Office of the General Treasurer in both law and equity which I may now have or in the future may have.

MUST SUBMIT A COPY OF A VALID PHOTO ID

The Office of the General Treasurer does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, national origin, or disability.

Signature **Date**

Return completed Application to:

CRIME VICTIM COMPENSATION PROGRAM
Office of the General Treasurer
50 Service Avenue, 2nd Floor
Warwick, RI 02886
Phone 401-462-7655 Fax 401-462-7694
www.treasury.ri.gov