Summary of Proposed Amendment of 802 KAR 3:010. Crime Victims Compensation.

- Amends 802 KAR 3:010, which governs the procedures and certain eligibility criteria for filing a claim with the Crime Victims Compensation Board.
- Adds definitions for sexual relationships, certain familial categories, and mental states of reckless and wanton for purposes of motor vehicle accident-related claims.
- Establishes criteria for the Board to find that an offender acted recklessly or wantonly when convicted of a motor vehicle offense that injures a victim.
- Clarifies which blood relatives fall within second degree of consanguinity for purposes of claim eligibility.
- Clarifies who counts as a personal representative for purposes of claim eligibility.
- Establishes eligibility criteria for filing a claim when the victim and claimant are not married but maintain a sexual relationship.
- Establishes that only two (2) of the victim's primary caregivers are eligible for an award.
- Permits claimants to file through the online claim portal and track claim progress.
- Provides guidance on processing lump sums for claims involving a delay in testing sexual assault kits.
- Clarifies that incarcerated claimants may file upon release from incarceration.
- Enumerates factors in deciding claims based on contributory conduct.
- Outlines the appeal process.
- Informs claimants of their right to obtain counsel of their choosing.
- Incorporates by reference the updated Claim Form and new Subpoena form.

Crime Victims Compensation Board - Crime Victim Compensation Form
500 Mero Street, Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

This form must be legibly written, typed, or printed, and must be signed. Incomplete submissions may not be considered. All answers may be supplemented with additional explanatory pages. You have the right to retain, at your own expense, a lawyer to represent and assist you in your claim.

Section 1: Victim Information

Victim's Name: _____ SSN or Gov't ID#: _____

Date of Birth: ____/____/____ Male ____ Female ___ Age at time of Crime _____

Telephone #: (Primary) _____ (Other) _____

E-Mail: _____

Current address: _____

_____

Address at time of crime (if different from above):_____

_____

Section 2: Claimant Information (if other than victim)

Claimant's Name: _____ SSN or Gov't ID#: _____

Relationship to Victim _____ Date of Birth: ____/____/____

Telephone #: (Primary) _____ (Other) _____

E-Mail: _____

Current address: _____

_____

Address at time of crime (if different from above):_____

_____

If not the victim, did you reside with the victim at the time of the crime? Yes ____ No ___

Section 3: Crime Information

☐ Arson
☐ Assault (Domestic)
☐ Assault (Non-Domestic)
☐ Burglary
☐ Child Physical Abuse/Neglect
☐ Child Sexual Abuse
☐ Child Pornography
☐ DUI/DWI
☐ Fraud/Financial Crimes
☐ Hit and Run
☐ Homicide (Murder)
☐ Human Trafficking
☐ Kidnapping
☐ Other Vehicular
☐ Reckless or Wanton Driving
☐ Robbery
☐ Sexual Assault (Adult)
☐ Sexual Assault (Child)
☐ Stalking
☐ Strangulation
☐ Suicide
☐ Terrorism

☐ Other _____

Section 4. Emergency Award

Are you requesting an emergency award? Yes ____ No ____

If yes, please complete, sign, and date the attached Emergency Award Request Form and attach it to your claim form.

Section 5: Financial Information

Employment at time of crime: Full_____ Part _____ Self _____ Unemployed _____

Time missed from work as a result of crime: Yes ____ No ____

Are you applying for lost wages? Yes ____ No ____

Are you applying for loss of support? Yes ____ No ____

Income or payment sources **before** incident:

- Wages $_____
- Social Security $_____
- Worker's Compensation $_____
- Insurance $_____
- Medicare $_____
- Medicaid $_____
- Veteran's Benefits $_____
- Other $_____ (please specify) _____

Total monthly income **before** incident: $_____

Income or payment sources **after** incident:

- Wages $_____
- Social Security $_____
- Worker's Compensation $_____
- Insurance $_____
- Medicare $_____
- Medicaid $_____
- Veteran's Benefits $_____
- Other $_____ (please specify) _____

Total monthly income **after** incident: $_____

Section 6: Crime Incident Information

Date of incident _____/_____/_____ Time of incident __:__ a.m./p.m.

Location where the incident occurred: _____

_____

(Please be specific so as to provide exact location)

Date reported _____/_____/_____ Reported To: _____

(Law Enforcement Agency)

Describe the incident:

_____

_____

_____

_____

Describe any injuries:

_____

_____

_____

_____

Offender Information

1) Offender Name:_____

Was the Offender charged with a crime? Yes_____ No_____

If yes, what charge? _____

Court Name: _____

2) Offender Name:_____

Was the Offender charged with a crime? Yes_____ No_____

If yes, what charge? _____

Court Name: _____

3) Offender Name:_____

Was the Offender charged with a crime? Yes_____ No_____

If yes, what charge? _____

Court Name: _____

Section 7: Expenses

Each expense must be listed below to be considered. Each must be a direct result of the crime, and documentation must include date, type, and charge for service. If you need additional space, please attach a separate page. You must include documentation of the expense, such as itemized bills, receipts, service contracts, invoices, or other proof of payment and/or balance due.
Total awards shall not exceed $50,000.

7a. Medical Expenses

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

7b. Mental Health Expenses (Not to exceed two (2) years)

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

7c. Funeral Expenses (Maximum award: $10,000)

Provider Name	Total Amount Charged	Amount Insurance, Donations, or Other Source Covered	Claimant/Victim Out of Pocket	Current Balance

Benefits available and amounts:

Life Insurance: $_____

Funeral/Burial Insurance: $_____

Estate: $_____

Other: $_____

Worker's Compensation: $_____

Social Security: $_____

Donations (incl. crowd-funding websites): $_____

7d. Relocation Expenses (Maximum award: $2,000)

Provider Name	Description	Total Amount Charged	Amount Covered by Other Sources	Claimant/Victim Paid Out of Pocket	Current Balance
	Moving Expenses				
	Security Deposit				
	1st Mortgage Payment/1st Month's Rent				
	Utility Deposit/First Month's Utilities				
	Other				

Reason for relocation:

_____

_____

Other persons to relocate:

1. Name_____
2. Name_____
3. Name_____
4. Name_____

7e. Temporary Housing Expenses

Provider Name	Description (Residence, Hotel, etc.)	Total Amount Charged	Amount Covered by Other Sources	Claimant/Victim Paid Out of Pocket	Current Balance
	Lodging				
	Necessities of Daily Life				
	Other				

Reason for temporary housing:

_____

_____

Other persons to temporarily house:

1. Name_____
2. Name_____
3. Name_____
4. Name_____

7f. Tattoo Removal (Human trafficking only) (Maximum award: $4,000)

Provider Name	Total Amount Charged	Amount Covered by Other Sources	Claimant/Victim Paid Out of Pocket	Current Balance

7g. Reimbursement for Items Seized by Police as Evidence of Crime (Maximum award: $500 per item)

Provider Name	Item Description	Purchase Price	Amount Covered by Other Sources (Insurance, Donations, etc.)	Current Balance

7h. Replacement/Repair of Windows and Locks (Maximum award: $1,500)

Provider Name	Item Type	Total Amount Charged	Amount Covered by Other Sources	Claimant/Victim Paid Out of Pocket	Current Balance

7i. Rehabilitative or Wellness Practices (Maximum award: $1,000 per year, not to exceed two (2) years)

Provider Name	Total Amount Charged	Amount Covered by Other Sources	Claimant/Victim Paid Out of Pocket	Current Balance

7j. Expenses Related to Court Proceedings

Provider Name	Description	Total Amount Charged	Amount Covered by Other Sources	Claimant/Victim Paid Out of Pocket	Current Balance
	Lodging				
	Travel				
	Parking				
	Meals				
	Other				

7k. Expenses Related to Sexual Assault More Than Ten (10) Years Ago (Maximum award: $5,000)

Provider Name	Total Amount Charged	Amount Covered by Other Sources	Claimant/Victim Paid Out of Pocket	Current Balance

Section 8. Federal Government Information (*optional/for statistical use only)*

Ethnic Group (Victim)
- ☐ Caucasian
- ☐ African American
- ☐ American Indian or Alaskan Native
- ☐ Hispanic / Latino
- ☐ Multiracial
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ Other

Are you (please check all that apply)
- ☐ U.S. Citizen
- ☐ Handicap
- ☐ Kentucky Resident

Who referred you to the compensation program?
- ☐ Attorney
- ☐ FBI
- ☐ Friend
- ☐ Funeral Home
- ☐ Hospital
- ☐ Judge
- ☐ Law Enforcement
- ☐ Law Enforcement Victim Advocate
- ☐ Other _____
- ☐ Parent
- ☐ Prosecutor
- ☐ Prosecutor Victim Advocate

Is this a Federal Crime?
- ☐ Yes
- ☐ No

Section 9. Restitution and Civil Lawsuit

Has the victim or claimant filed or plans to file a civil suit relating to the injury received as a result of the crime? ☐ Yes ☐ No
If yes:

Attorney Name: _____

Attorney Address: _____

Attorney Telephone: _____ Attorney E-mail: _____

Has the Offender been ordered by a court to pay restitution to the victim or claimant? ☐ Yes ☐ No

If Yes: Amount: $_____ How is it to be paid?: _____

Has the victim received any of the ordered restitution? ☐ Yes ☐ No

If Yes: Amount: $_____

Section 10. Authorization and Subrogation

I hereby certify, subject to penalty, fine, or imprisonment that the information contained in this form and all attachments is true and correct to the best of my knowledge.

SUBROGATION: In consideration of the payment received from the Crime Victims Compensation Board, in the event I recover damages or compensation from the offender or from any other public or private source as a result of the injuries or death which was the basis of my claim for compensation from the fund, I agree to repay such amount up to the full amount I received from the fund. I understand that compensation from any other public or private source includes but is not limited to: receipt of insurance, Medicare, Medicaid, Workers Compensation, disability pay, etc. I further agree and understand that no part of recovery due the Crime Victims Compensation Board may be diminished by any collection fees or for any other reason whatsoever.

Should I choose to recover damages or compensation for the injury or death from any sources, I agree to promptly notify the Crime Victims Compensation Board by sending copies of any pleadings, settlement proposals, and any other documents relative thereto. I further agree to fully cooperate with the Crime Victims Compensation Board should the Board decide to institute an action against any person or entity for the recovery of all or any part of the compensation I received from the fund.

MEDICAL/PSYCHIATRIC/EMPLOYMENT RELEASE: I hereby authorize any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility, or any other person or firm to release any and all information requested by the Crime Victims Compensation Board. I understand and acknowledge that my mental health records may contain confidential remarks made by me, information regarding drug or alcohol abuse, HIV status, or other personal data. I further agree and hold blameless any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility or any staff person of any and all liability for the release of these records.

YOUR SIGNATURE: _____ DATE: _____

Attorney's Name*: _____ Address: _____

Telephone: _____ E-mail Address: _____

Attorney's Signature: _____ Date: _____

**You are <u>not</u> required to have an attorney assist in submitting your application. However, if an attorney does assist you, the attorney must sign the application as well.*

Page 1 of 1

Commonwealth of Kentucky
Public Protection Cabinet
Office of Claims & Appeals
kycc.ky.gov

CIVIL
☐ SUBPOENA
☐ SUBPOENA DUCES TECUM

Case No. _____

Crime Victims Compensation Board

IN RE:

_____ CLAIMANT

***Pursuant to KRS 49.020(7)(b), and the authority granted therein*:**

Name _____
Address _____
_____

You are to appear at: _____
_____

on the _____ day of _____, 2_____ at _____ ☐ a.m. OR ☐ p.m. ☐ Eastern ☐ Central Time

☐ To testify in behalf of _____
☐ To produce _____
_____
☐ To give depositions

You are commanded to produce and permit inspection and copying of the following documents or objects (or to permit inspection of premises): _____
_____
_____
on the _____ day of _____, 2_____ at _____ ☐ a.m. OR ☐ p.m. ☐ Eastern ☐ Central Time
at the following address: _____

_____
Issuing Officer

By:_____

_____
Name of Requesting Attorney/Pro-Se Party

_____
_____
Address

Phone # _____
E-mail: _____

PROOF OF SERVICE

This subpoena was served by delivery of a true copy to: _____
_____
This _____ day of _____, 2_____ By: _____
_____ **Title**

Print Form **Reset Form**

Crime Victims Compensation Board
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

EMPLOYMENT VERIFICATION

Complete only if applying for lost wages/ loss of support.
To be completed and signed by EMPLOYER only*. This form must be NOTARIZED*.

Employee's Name: _____ Social Security #: _____

Date of Crime: _____ Victim was employed at the time of crime ( ) Yes ( ) No

If SELF-EMPLOYED, attach copies of State and Federal taxes for the two-year period prior to the crime.

Employer's Name: _____ Telephone: _____

_____
Address City State Zip Code

Victim missed time from work because of injuries related to the crime: ( ) Yes ( ) No

If yes, from _____ to _____

The items listed below are to be **weekly amounts:**
Gross Earnings: $_____ Net Take Home Earning Per Week: $ _____

Federal Tax Withheld: $ _____ State Tax Withheld : $ _____ Social Security Withheld: $ _____

Other Deductions (itemized): $ _____ Typical days worked per week: M T W TH F Sat Sun
Attach additional pages if necessary.

Please Circle
Victim has returned to work: ( ) Yes ( ) No Victim's wage continued while off work: ( ) Yes ( ) No

If the victim's wage continued while off work, complete the following:

Deductions	Amount Per Week	Starting Date	Ending Date
Workers Comp	$		
Unemployment	$		
Insurance – Health	$		
Insurance – Other	$		
Vacation	$		
Sick	$		
Employers Group	$		
Disability	$		
Union	$		
Other	$		

_____ _____
Employer's Name and Title Employers Signature

The following must be completed by a Notary:

SUBSCRIBED AND SWORN TO BEFORE ME BY _____

THIS _____ DAY OF _____. 20____

MY COMMISSION EXPIRES: _____

Signature: _____

Seal or Stamp affixed here

Revised August 2020

Crime Victims Compensation Board
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

PHYSICIAN STATEMENT

Complete only if applying for lost wages/ loss of support.
To be completed and signed by PHYSICIAN only.

Victim / Patient Name: _____

Type of Injury: _____

Date of Injury: _____ Date(s) victim/patient unable to work: _____to _____

Victim/Patient suffered permanent disability: ( ) Yes ( ) No

If yes, please state the victim's percentage of permanent disability to the body as a whole in accordance with the AMA Guidelines:

_____

Description of injury/trauma resulting from crime and comments:

Name of Physician: _____ Specialty: _____

Office Address: _____
Address City State Zip Code

Telephone: _____ State License Number: _____

_____ _____
Physician's Signature Date

Crime Victims Compensation Board
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

MENTAL HEALTH COUNSELOR'S REPORT

Complete only if applying for mental therapy or where applicable for lost wages.
To be completed by COUNSELOR only. *Treatment plan must be attached.*

Victim/Claimant receiving treatment: _____

Date of crime: _____ Date(s) victim/claimant unable to work: _____ to _____

The trauma and treatment is a direct result of this crime ( ) Yes ( ) No

Presenting Complaint: _____

Diagnosis of Record:

_____

Description of psychological trauma resulting from crime:

Health Insurance: _____
Company Name Phone Number/ Extension

_____
Address City State Zip Code

****PLEASE ATTACH PATIENT TREATMENT PLAN****

Name of Physician/Therapist/Counselor: _____ Specialty: _____

Office Address: _____
Address City State Zip Code

Telephone: _____ State License Number: _____

_____ _____
Physician/Therapist/Counselor Signature Date

Revised August 2020