



**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**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Arson                        | <input type="checkbox"/> Assault (Domestic)     | <input type="checkbox"/> Assault (Non-Domestic)     | <input type="checkbox"/> Burglary          |
| <input type="checkbox"/> Child Physical Abuse/Neglect | <input type="checkbox"/> Child Sexual Abuse     | <input type="checkbox"/> Child Pornography          | <input type="checkbox"/> DUI/DWI           |
| <input type="checkbox"/> Fraud/Financial Crimes       | <input type="checkbox"/> Hit and Run            | <input type="checkbox"/> Homicide (Murder)          | <input type="checkbox"/> Human Trafficking |
| <input type="checkbox"/> Kidnapping                   | <input type="checkbox"/> Other Vehicular        | <input type="checkbox"/> Reckless or Wanton Driving | <input type="checkbox"/> Robbery           |
| <input type="checkbox"/> Sexual Assault (Adult)       | <input type="checkbox"/> Sexual Assault (Child) | <input type="checkbox"/> Stalking                   | <input type="checkbox"/> Strangulation     |
| <input type="checkbox"/> Suicide                      | <input type="checkbox"/> 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: \$ \_\_\_\_\_

Worker's Compensation: \$ \_\_\_\_\_

Funeral/Burial Insurance: \$ \_\_\_\_\_

Social Security: \$ \_\_\_\_\_

Estate: \$ \_\_\_\_\_

Donations (incl. crowd-funding websites): \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

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**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				
	1 <sup>st</sup> Mortgage Payment/1 <sup>st</sup> Month's Rent				
	Utility Deposit/First Month's Utilities				
	Other				

**Reason for relocation:**


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**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:**


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**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 not 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.*

