| City of Norfolk | Administrative General Order – 473 | Crime Victim Compensation |
|---|---|---|
| | **Department of Police General Order** | |
| | **CALEA:** | 55.2.3 |
| | **VLEPSC:** | ADM.23.02.a |

| LEGAL REVIEW DATE: | 1-5-11 | PRESCRIBED DATE: | 1-19-11 |
|---|---|---|---|
| City Attorney: | | City Manager/Director of Public Safety: | |
| APPROVED BY THE AUTHORITY OF THE CHIEF OF POLICE: | | | |

Office of Preparation: Strategic Management Division / acb

Purpose

The purpose of this order is to outline the policies and procedures related to the Commonwealth of Virginia Crime Victims' Compensation Program.

Policy

In order to comply with § 19.2-368.17, Code of Virginia, it is the policy of this Department to advise crime victims or other potential claimants of their right to file a claim for loss of earnings and certain expenses resulting from the crime.

Supersedes:

1. G.O ADM-473, dated May 14,2009
2. Any previously issued directive conflicting with this order

Order Contents:

I. Workers Compensation Commission notice

Officers preparing Incident Reports (IBR) will give a copy of the Criminal Injuries Compensation Fund Claim Form (Attachment A) to each of the following:

A. Victims physically injured during a crime.

B. Victims injured trying to prevent a crime or an attempted crime, or trying to apprehend a person who committed a crime in their presence.

C. Individuals whose mother, father, guardian, wife or husband was killed as a result of a crime or attempting to stop a crime.

II. Filing Assistance

For local filing assistance, victims/claimants will be referred to the Commonwealth's Attorney's Victim/Witness Assistance Program, 800 City Hall Ave., Suite 500, Norfolk, Virginia, 23510.

The forms are available at the Property and Evidence Unit. Commanding officers will ensure that an adequate supply is maintained at their respective commands.

III. Division of Crime Victims' Compensation (CALEA 55.2.3) (VLEPSC ADM.23.02.a)

A. Officers/investigators receiving a form letter (Attachment B) from the Crime Victims' Compensation asking for certain information will comply with the request without delay; additionally, they will complete the Police/Sheriff's Report (Attachment C) which is included with the Director's request.

B. Personnel will prepare a duplicate copy of all paperwork submitted and forward the copies to the Commonwealth's Attorney Victim/Witness Assistance Program.

Related Document:

G.O. OPR-415: Incident Based Reporting (IBR)

Attachments:

A. Criminal Injuries Compensation Fund Claim Form
B. Crime Victims' Compensation Form Letter
C. Police/Sheriff's Report

# Claim Form

Before you fill out this application, please read the information below.

Criminal Injuries Compensation Fund
Easing the Burden for Crime Victims

## You may qualify to receive payment if:

**The victim**

- suffered physical injury or was killed as the result of a criminal act
- suffered emotional injury as the result of a felony
- cooperated with law-enforcement agencies and the courts
- was not involved in any illegal activity at the time of the crime
- did not provoke or willingly take part in the incident

**The crime**

- was committed in Virginia, or a country where Virginia residents are not eligible for compensation
- was the result of a terrorist act
- was reported to a law enforcement agency within 120 hours (5 days), unless there is a good reason for the delay

**You**

- paid or are responsible for paying the victim's funeral bill
- are a surviving family member who suffered emotional injury due to the murder of a parent, spouse, sibling, child or grandchild

**This claim**

- is being filed within one year from the date of the crime, unless there is a good reason for the delay
- is filed only after you have exhausted all other financial resources (except income from your salary)

## You cannot be paid for:

- pain, suffering, or property loss
- injuries resulting from vehicular accidents (unless the driver was under the influence of alcohol)
- attorney fees
- missed doctor's appointments

## Legal considerations:

- you are required to cooperate with all law-enforcement agencies including prosecuting attorneys
- while your claim is pending, healthcare providers are prohibited by law from initiating collections action against you.

## Before you complete this application

1. **If the victim is a minor or is mentally incompetent**
   - provide proof you are the adult responsible for the victim's welfare (either parent, guardian or legal custodian)
2. **If the victim is covered by any insurance program**
   - make sure you have first filed a claim with: the health care insurance provider; Medicare; private health plan; homeowner's or renter's insurance agency; employer's or union group's insurance plan; or automobile insurance company
3. **If the victim was treated at a hospital but not covered by insurance**
   - make sure you contacted your local department of Social Services to apply for State and Local Hospitalization (SLH) and contacted the hospital to apply for charity care – all within 30 days after the patient's release

## How to complete this application

1. **If you need help filling out this application:**
   - call toll-free, 1-800-552-4007
   - e-mail cicfmail@vwc.state.va.us
   - contact your local victim witness program
2. **Attach all bills** (itemized statements for services rendered); receipts; and insurance or benefit statements to this application.
   * If you receive additional bills and/or benefit statements for continuing treatment, you may mail them to CICF at a later date.
3. **Mail this completed application form, along with all attachments, to:** Criminal Injuries Compensation Fund; P.O Box 26927; Richmond, Virginia 23261.

## 1. Claim summary

### Check all desired compensation.

☐ **Medical expenses**
payment or reimbursement for crime-related expenses with a hospital, physician, dentist, radiologist, or other medical provider

☐ **Mental health expenses**
mental health counseling for the victim of the crime

☐ **Mental health expenses (up to $2,500)**
grief counseling for dependents and survivors of homicide victims

☐ **Funeral or burial expenses (up to $5,000)**
payment or reimbursement for the victim's burial, cremation and/or headstone

☐ **Loss of wages**
compensation for the victim who lost wages due to the crime, as verified by a medical provider

☐ **Loss of financial support**
compensation for dependents of homicide victims, and for victims of domestic violence or child sexual assault when the offender is removed from the home

☐ **Crime scene clean-up**
cleaning of items damaged as a result of the crime

☐ **Moving expenses (up to $1,000)**
reimbursement for the cost of professional movers, moving equipment rental, temporary storage, first month's rent, and loss of a security deposit

☐ **Mileage**
reimbursement of mileage to and from doctors' appointments; mileage to and from court appearances, if the victim is a minor

☐ **Prescriptions**
reimbursement for medication that was prescribed as a result of the crime

☐ **Home security**
reimbursement for replacement of doors, locks and windows

☐ **Other**
reimbursement for replacement of eye glasses, hearing aids, dentures or other medically necessary aids

**A. Who referred you to the Criminal Injuries Compensation Fund?**

☐ Police/sheriff's office ☐ Victim Witness Program

☐ Attorney's office ☐ Medical doctor

☐ Commonwealth's attorney office ☐ Hospital

☐ Other Name of contact, if known _____

**B. Will there be a *civil* lawsuit filed against the person or place responsible for the injury?** Yes ☐ No ☐

Name of attorney _____ Phone number of attorney _____

Address _____

### (Optional)

**Victim's ethnic group**

☐ African-American/Black ☐ Asian or Pacific Islander ☐ Caucasian/White

☐ American Indian/Alaskan native ☐ Bi-racial ☐ Hispanic

**Description of the victim at the time of the crime**

☐ Married ☐ Divorced ☐ Male

☐ Single Age _____ ☐ Female

Handicapped prior to crime? ☐ Yes ☐ No How? _____

## 2. Claim information

**A. Victim's name** _____
First Middle Last

Social security number _____ Date of birth _____

Street address _____ County _____

City, state, zip _____

Home phone number _____ Work phone number _____

**B. Complete only if you are applying on behalf of the victim**

Applicant's name _____

Social security number _____ Date of birth _____

Street address _____

City, state, zip _____

Home phone number _____ Work phone number _____

Relationship to victim Spouse ☐ Parent ☐ Sibling ☐ Child ☐ Other _____

**C. Who referred you to the Criminal Injuries Compensation Fund?**

☐ Police/sheriff's office ☐ Victim Witness Program ☐ Attorney's office

☐ Commonwealth's attorney office ☐ Hospital ☐ Medical doctor

☐ Other Name of contact, if known _____

## 3. Crime summary

**A. Check type of crime**

☐ Assault ☐ Child abuse ☐ Homicide

☐ Child sexual assault ☐ Sexual assault on adult ☐ Robbery

☐ Driving under the influence ☐ Kidnapping ☐ Other crime; describe

Is the victim related to the offender? Yes ☐ No ☐ Relationship _____

**B. Date of the crime** _____ **Date crime was reported** _____

Law enforcement agency reported to _____

Name of officer _____ Incident report number _____

**C. Name of offender(s)** Social security number of offender(s), if known

_____ _____

_____ _____

**D. Location of the crime** _____
Street Address City/County

**D. What is the status of the criminal case?**

_____

## 4. Medical expenses

**A. If the victim was insured, or has Medicare:**
- **Fill in the information below, and**
- **Attach a copy of the insurance card**

| **Name of carrier** | Address | Group number | Policy number |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**B. If the victim was not insured and was treated at a hospital, was the Department of Social Services contacted within 30 days, as required?** Yes ☐ No ☐

If no, why not? _____

If yes, in which city/county did you apply? _____

**C. Check any applications filed.**

☐ Social security ☐ Social services ☐ State/Local Hospitalization (SLH)

☐ Medicaid ☐ Worker's compensation ☐ Other: _____

**D. Complete if the crime involved motor vehicles.**

Victim's auto insurance company name _____

Address _____

Suspect's auto insurance company name _____

Address _____

**E. List all medical facilities, doctors, dentists, licensed counselors, and other medical providers who treated the victim for injuries resulting from the crime. Attach a separate sheet of paper listing additional providers, if necessary.**

**Name** _____ Specialty _____

Street address _____ City, state, zip _____

**Name** _____ Specialty _____

Street address _____ City, state, zip _____

**Name** _____ Specialty _____

Street address _____ City, state, zip _____

Did the crime occur at your place of employment? ☐ Yes ☐ No

## 5. Loss of wages

If filing for lost wages, complete the information below:

Employer's name _____Phone #_____

Mailing address_____

City, state, zip _____

## 6. Homicide claim

**A. Date of Death** _____/_____/_____ (Attach copy of signed funeral contract and copy of death certificate.)

**B. List the victim's dependent(s). Attach another sheet of paper, if necessary.**

| Name | Relationship | Date of birth | Social security number |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**C. If the victim was contributing financial support to any dependents at the time of death, what was that monthly amount?** $ _____

**D. Check any fund that will pay dependent(s) and specify the amount.**

☐ Social Security $ _____ ☐ Worker's compensation fund $ _____

☐ Auto insurance $ _____ ☐ Name other fund _____ $ _____

☐ Victim's estate $ _____

Name of licensed mental health counselor _____

**E. Did the victim have life or burial insurance?** Yes ☐ No ☐

| If yes, Name of Insurer | Address | Coverage amount | Beneficiary |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

**F. What is the funeral cost? $** _____ Have funeral expenses been paid? Yes ☐ No ☐

If yes, by whom?

Name _____Phone #_____

Street address _____

## 7. Notarized agreement

**These terms are set forth fully in Virginia Code 19.2-368. Your application will not be processed unless this form is signed on each of the signature lines and witnessed by a Notary Public.**

### Collections

I agree that the CICF may pay any award directly to the person to whom the payment is owed. I understand the Criminal Injuries Compensation Fund will pursue payment of the award from the person responsible for the crime. I further agree that if I later recover money from any other source as a result of the crime, or sue the person responsible for this crime and recover damages, I will immediately repay the CICF award.

### Oath

I affirm that I filled out this form and understood its contents. I swear it is true and complete to the best of my knowledge. I understand that if any information I submit is false, or if I have not fully cooperated with all law enforcement agencies, including the criminal prosecution, the claim may be denied or revoked and collected.

### Authorization:

I authorize any hospital, physician, counselor, funeral director, or other person who attended or examined _____ (name of victim) and any municipal authority, employer or union, insurance company, social service bureau, Social Security office, or any other person, firm, agency or organization to furnish to the Criminal Injuries Compensation Fund, or its representative, any information requested, including tax data and prior police records, needed to complete the climant's or victim's claim for benefits. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization is for the collection of information related only to this claim.

**I HAVE READ, UNDERSTOOD AND AGREE TO THE INFORMATION IN SECTION 7.** I swear or affirm that I am the Claimant; I have read and understand the contents of the Claim Form and it is true and complete to the best of my knowledge and belief. I understand that submitting false information is a felony under §19.2-368.16 of the *Code of Virginia*.

_____ _____

Print Claimant's Name Claimant's Signature

City/County of _____, Commonwealth/State of _____

Subscribed and sworn before me this _____ day of _____, _____

_____

Signature of Notary Public

My commission expires the _____ day of _____, _____

*Please note that the Criminal Injuries Compensation Fund is a division of the Workers' Compensation Commission, which is exempt from HIPAA, and for HIPAA purposes, the Fund is a "payer" to which disclosures may be made without prior authorization.*

**MARY VAIL WARE**
DIRECTOR

Criminal Injuries Compensation Fund
Easing the Burden for Crime Victims

*Post Office Box 26927 • Richmond, VA 23261 • 800.552.4007 • 877.349.1719 (Fax)*

March 7, 2011

**Claim No.**
**Claimant:**
**Victim:**
**Address:**

**Date of Crime:**
**Type of Crime:**
**Location:**

**Accused:**
***Incident Report No.***

Dear :

Please be advised that a claim has been filed with the Criminal Injuries Compensation Fund (CICF) as a result of a crime committed against the above-named victim. Pursuant to §§ 19.2-368.3 and §19.2-368.6 of the Code of Virginia, we are requesting investigative results, information and data as will enable the Fund to determine if, in fact, a crime was committed or attempted, and the extent, if any, to which the victim or claimant was responsible for his own injury. This information should include:

☑ copy of the incident report, all continuation sheets and supplements, and witness statements
☑ Police/Sheriff Report form that has been completed in its entirety by the investigating officer

We are grateful for your assistance in resolving this claim.

Sincerely,

Staff/
Criminal Injuries Compensation Fund

Enclosure

Please return **ORIGINAL** form to Criminal Injuries Compensation Fund, Post Office Box 26927, Richmond, Virginia, 23261

# Police/Sheriff Report

Name of Victim[NAME OF VICTIM] CICF Claim No. [CICF CLAIM NUMBER]

Type of Offense _____ Incident Report No.[INCIDENT REPORT NO.]

Date of Offense_____/_____/_____ Time of Offense_____:_____ A.M. _____:_____ P.M.

Date of Report _____/_____/_____ Time of Report _____:_____ A.M. _____:_____ P.M.

**WAS VICTIM RESPONSIBLE IN PART FOR THE INJURIES? Yes ☐ No ☐ Undetermined ☐ (please answer to the best of your ability and provide details on the back of this form)** §19.2-368.3.2

Description of Crime/Motive for Offense_____

_____

_____

➤ ➤ ➤ IF YOU HAVE ADDITIONAL COMMENTS, PLEASE USE THE BACK OF FORM ➤ ➤ ➤

Name of Suspect(s):_____

Have arrests been made? Yes ☐ No ☐

Social Security Number(s):_____

Investigating Officer:_____ Telephone(_____)_____ ext._____

If we have any questions, what is the best way to contact you? ☐ Telephone ☐ E-Mail_____

**If other than a death case, was victim cooperative with you during investigation? Yes ☐ No ☐** §19.2-368.10.3

Was case forwarded to the Commonwealth's Attorney's Office for prosecution? Yes ☐ No ☐

Court Case will be heard in: ☐ J&DR ☐ GDC ☐ CC County/City: _____

Disposition of Case:_____

_____

Name of Agency_____ Telephone (_____)_____ext._____

Signature_____ Date_____/_____/_____

Type or Print Name_____ Title_____