

CRIME VICTIMS COMPENSATION APPLICATION

STATE OF ILLINOIS
COURT OF CLAIMS



STATE OF ILLINOIS
ATTORNEY GENERAL

PLEASE READ ATTACHED INSTRUCTION SHEET AND USE BLACK INK OR TYPE.

For HELP call the Attorney General's Office at 312-814-2581 or 1-800-228-3368.

SECTION I. – CLAIMANT & VICTIM INFORMATION (See Instructions for Section I.)

CLAIMANT (IF NOT VICTIM)

Claimant's Name: _____ Date of Birth: _____ Male Female
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Work/Other Daytime Telephone(s): _____
Social Security No.: _____ Relationship to Victim: _____

VICTIM

Victim's Name: _____ Date of Birth: _____ Male Female
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Telephone: _____ Work/Other Daytime Telephone(s): _____
Social Security No.: _____ Marital Status: Single Married Divorced Widowed

Does the victim suffer from an actual or perceived disability that substantially limits activity? Yes No

THE FOLLOWING INFORMATION IS USED FOR STATISTICAL PURPOSES ONLY IN COMPLIANCE WITH FEDERAL REGULATIONS. PROVIDING THIS INFORMATION IS VOLUNTARY AND WILL NOT AFFECT YOUR APPLICATION.

Ethnic Group: Black (not Hispanic) White (not Hispanic)
 Hispanic (any Spanish culture) American Indian or Alaskan Native
 Asian or Pacific Islander (including Indian subcontinent)

How did you learn about Crime Victims Compensation? _____

SECTION II. – CRIME INFORMATION (See Instructions for Section II.)

Date of Crime: _____ Date Crime Reported: _____ Police Report No.: _____
Street Address where crime occurred: _____
City: _____ County: _____
Name of Agency/Department crime reported to: _____
City: _____ County: _____

Describe crime: _____

Name of offender, if known: _____ Was offender arrested? ___ Yes ___ No ___ Unk

Has offender been charged in court? ___ Yes ___ No ___ Unk If so, what is the charge? _____

Criminal Case No.: _____ Circuit Court of: _____ County Court Date: _____

SECTION III. – MEDICAL INFORMATION & BENEFITS (See Instructions for Section III.)

Are medical expenses claimed? ___ Yes ___ No Are counseling expenses claimed? ___ Yes ___ No

Describe the injuries: _____

List the names and addresses of all doctors, hospitals, counselors or other medical service providers who treated the victim for injuries arising from the crime as described above.

Medical Provider	Address	Date(s) of Service	Amount of Bill

Are further medical expenses anticipated? ___ Yes ___ No

Please indicate what sources of payment are available to cover the above listed charges:

Source	Unk	No	Yes	Benefit Provider's Name
Private, Group, Employer, or Union Health Insurance				
Public Aid or AFDC				
Medicare or Medical Assistance				
Workers Compensation				
Veterans Administration, Champus				
SSI or SSDI				
Proceeds of Personal Injury or other Litigation				

If the victim has received or may receive direct payment from any of the following sources, please list:

Source	Yes	No	Monthly Amount	Paid From (date)	Paid To (date)
Public Aid or AFDC					
SSI or SSDI					
Other (specify)					

Table continued on Page 3.

Workers Compensation					
Unemployment Compensation					
Private, Group, or Employers' Health Plan					
Union or other Disability Plan					
Other (specify)					

List any other sources of payment : _____

SECTION IV. – FUNERAL & BURIAL INFORMATION & DEATH BENEFITS (See Instructions for Section IV.)

A. Funeral and Burial

Are funeral and/or burial expenses claimed? ___ Yes ___ No If so, in what amount? \$ _____

Have these expenses been paid? ___ Yes ___ No Name of person who paid: _____

Relationship, if any, between victim and person who paid: _____

B. Insurance

If any dependent(s) of the victim have received or may receive accident or life insurance, please list below:

Name of Insurance Company	Name of Beneficiary	Amount Paid or Due

C. Loss of Support

At the time of death, did the deceased victim contribute financial support for any dependants? ___ Yes ___ No

If so, in what amount per month? \$ _____

Please list minor (18 years or under) dependents and any other dependents of victim:

Name of Dependent	Relationship to Victim	Date of Birth	Name of Legal Guardian

SECTION V. – EMPLOYMENT INFORMATION (See Instructions for Section V.)

Are lost wages claimed? ___ Yes ___ No

If so, was the victim employed during the six (6) months immediately prior to the crime? ___ Yes ___ No

Please list all employment during the six (6) months prior to the crime:

Name of Employer	Address	Phone No.	Victim's Job Title	Victim's Net Mo. Wages

Did the victim miss time from work due to the crime? ___ Yes ___ No

If so, did the victim receive disability benefits or sick pay? ___ Yes ___ No

Has the victim returned to work? ___ Yes ___ No If so, date: _____

SECTION VI – TUITION (See Instructions for Section VI.)

Is tuition reimbursement claimed? ___ Yes ___ No

If so, list name of school/college/university: _____

Address: _____ Phone: _____

Semester(s) missed: _____ Amount of tuition paid and unused: \$ _____

SECTION VII – SUBROGATION RIGHTS (See Instructions for Section VII.)

740 ILCS 45/17, the Illinois Crime Victims Compensation Act, requires every applicant to subrogate to the State his or her rights to collect damages from the assailant or other liable third parties.

Has a civil law suit been filed against any party with regard to this incident? ___ Yes ___ No

If so, please provide case number and county: _____

Has restitution been ordered against an offender? ___ Yes ___ No If so, how much? \$ _____

SECTION VIII. – CERTIFICATION & RELEASES (See Instructions for Section VIII.)

Certification of Application: I hereby certify, subject to the penalties of perjury, that all of the information that I have provided in this application is true, accurate and complete to the best of my knowledge.

Release of Information: I hereby authorize any hospital, physician, mental health provider, funeral director, municipal, county or State authority, employer or union, insurance company, social service administrator, Social Security office or any other individual, company or agency to release any and all information requested by the Attorney General's Office in connection with this application.

Acknowledgment of Subrogation: I have read and understand Section VII, above, with regard to subrogation.

Applicant's Signature	Date Signed
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740 ILCS 45/12 PROHIBITS LEGAL COUNSEL FROM CHARGING FEES FOR PRESENTING THIS FORM TO THE COURT OF CLAIMS. IF, HOWEVER, THE APPLICANT IS REPRESENTED BY COUNSEL FOR THIS CLAIM, PLEASE PROVIDE THE FOLLOWING:

Name of Attorney: _____ Address: _____

Phone: _____ ARDC No.: _____

NOTE: Please list an alternate contact address and/or telephone number where you may be reached:

Name: _____ Address: _____

Phone: _____

Please return completed application to the Crime Victims Compensation Bureau
Office of the Attorney General Lisa Madigan, 100 West Randolph Street, Chicago, Illinois 60601