Application for Crime Victim Compensation

RECEIVED
FEB 24 2015
Crime Victim Compensation

STATE OF RHODE ISLAND OFFICE OF GENERAL TREASURER
GINA M. RAIMONDO

(Please print clearly and fill out both sides)

Claim # 21586

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

First Name	Middle Initial	Last name	Female ☒ Male ☐
[redacted]	[redacted]	[redacted]	

Date of birth	SSN	Home Phone ( )
[redacted] / 1990	[redacted]	
Mailing address		Cell Phone [redacted]
City Cranston	State RI	ZIP Code 02910
Email Address [redacted]		

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

First Name	Middle Initial	Last Name	Female ☐ Male ☐

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

Crime Information (please check type of crime)

☐Homicide ☒Assault ☐Child Sexual Assault ☐Sexual Assault ☐Kidnapping ☐Drunk Driving/DUI
☐Manslaughter ☐Arson ☐Child Physical Abuse ☐Domestic Violence ☐Robbery ☐Other:_____

Police Department Crime reported to Providence	Investigating Officer	
Date of Crime 01/01/2013	Date Crime Reported 01/01/2013	Date Crime Discovered 01/01/2013
Location of Crime Providence - Club Karma		
Person (s) Who Committed Crime Michael Williams		

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

Attorney's Name Erica O'Connell		
Phone 401-223-8990		
Address 56 Pine St Suit 250	City Providence	State & Zip Code RI

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

☑ Lost Wages for victim
☐ Counseling for the victim
☑ Medical expenses for victim
☑ Dental expenses
☐ 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

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

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

Disabled: ☐Yes ☐No **Age:** ☐17-Under ☐ 64-Over ☐18-63

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)_____

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 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 [redacted] / 70 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

Signature 2/24/15 **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

Seth Magaziner
General Treasurer

State of Rhode Island and Providence Plantations
CRIME VICTIM COMPENSATION PROGRAM
50 Service Ave, Warwick, Rhode Island 02886 Phone: (401) 462-7655 Fax: (401)462-7694

[redacted]
Cranston, RI 02910

March 2, 2015

Re: Claim 21586
Victim: [redacted]

Dear Ms. [redacted]:

NOTICE OF AWARD

We are pleased to inform you that your claim has been found eligible for assistance from the Crime Victim Compensation Program (CVCP). At this time, our office will start processing your requests for payment.

Please remember that eligibility for the program does not mean that your expenses are automatically eligible for compensation. Each expense must be submitted to our office for payment consideration and will be paid only if found eligible for compensation.

If you are seeking payment or reimbursement for crime-related expenses, please complete the enclosed Request for Expenses form and return to us at your earliest convenience along with copies of any outstanding medical bills or receipts.

Please note that property loss or damage, trial-related expenses, as well as pain and suffering are not eligible expenses and no compensation will be awarded for these expenses, even if they are crime-related.

If you have questions or concerns, please call us at (401) 462-7655. If your phone number or address changes, please let us know immediately. We look forward to working with you.

Sincerely,

Deputy Program Administrator
Crime Victim Compensation Program

Victim Name: [redacted] Claim #: 21586

REQUEST FOR EXPENSES

Please return this form to Crime Victim Compensation Program (CVCP) along with any bills/receipts.

I am requesting compensation for the following expenses: *(please check all that apply)*

1. ☐ MEDICAL, DENTAL OR COUNSELING EXPENSES

Providers: _____

_____

Do you have Health Insurance? ☐ YES ☐ NO Do you have Dental Insurance? ☐ YES ☐ NO
If yes, Insurance Name: _____ Policy No.: _____

If you do not have health insurance and are requesting compensation for hospital expenses, you must first apply for financial assistance at the hospital.

2. ☐ PRESCRIPTIONS OR COPAYS

Doctor prescribing medications related to crime: _____

Please request a prescriptions print-out from the pharmacy and submit to CVCP.

3. ☐ EMERGENCY RELOCATION

Do you have an emergency safety need to move right now due to the crime? ☐ YES ☐ NO

If yes, please submit copy of your new Lease Agreement, completed IRS Form W-9 signed by the landlord, and any other supporting documents.

4. ☐ LOSS OF EARNINGS FOR VICTIM OR FOR PARENT/GUARDIAN OF MINOR VICTIM

Were you employed on date of crime? ☐ YES ☐ NO (Eligible only if employed on date of crime)

If yes, Employer Name: _____
Address: _____ Telephone: _____

Are you self-employed? ☐ YES ☐ NO Dates Missed at Work: ___/___/___ to ___/___/___

Physician Who Can Verify Disability:
Name: _____
Address: _____ Telephone: _____

Please submit copy of your federal tax return for the year the crime happened. If that year is not yet available, please submit tax return for previous year. If self-employed, please submit tax return for year of crime and the two previous years.

I understand that CVCP may issue payment on my behalf directly to the above-referenced providers only if the expense owed to them is found eligible for victim compensation. If I do not want a particular provider (doctor, hospital, counselor, etc) to be paid by CVCP, I must let CVCP know in writing.

NAME OF CLAIMANT	SIGNATURE	DATE