Office of the Attorney General

BUREAU OF

VICTIM COMPENSATION

VICTIM COMPENSATION CLAIM FORM

Address: PL-01, The Capitol, Tallahassee, FL 32399-1050 • Website: MyFloridaLegal.com • Web Portal: https://VANext.MyFloridaLegal.com
Email: VCIntake@MyFloridaLegal.com • Information and Referral: (800) 226-6667 • Fax: (850) 414-6197
Bill Status for Providers: (850) 414-3331 • Persons with Hearing Difficulties Call Florida Relay: (800) 955-8771

The Bureau of Victim Compensation regrets that you faced circumstances which have prompted you to seek the application for financial compensation. We recognize the devastating impact of crime and encourage you to reach out to a victim advocate at your local law enforcement agency or victim service center for assistance with completing this form. Be advised that claim and benefit determinations are guided by statutes and administrative rules which govern the qualifications of each claim type. This application and future correspondences will contain legal and technical language. To see if you qualify, please carefully read the types of compensation offered, Basic Eligibility Requirements and Limitations before completing this form.

Section One - INSTRUCTIONS

To expedite the processing of your application, please follow these instructions.

1. Fill out this form completely (please print), sign and date your signature.
2. Attach acceptable proof of crime, such as the incident report from law enforcement or other proper authorities.
3. Attach any supplemental documentation required as stated within each section below for the benefits you are requesting.
4. Submit the completed application and all required documentation via email, fax, or mail to the Bureau of Victim Compensation.
5. If you change your mailing address, phone numbers, or email, you must provide notice to the department to prevent delays in processing your claim or benefits.

Section Two - SELECT THE TYPE OF COMPENSATION YOU ARE REQUESTING

You may apply for up to five different claim types using this application, and you will be provided separate claim numbers for each.

VICTIM COMPENSATION (VC)

These benefits are available if you were physically injured or killed as the result of a compensable crime, received a psychiatric or psychological injury from a forcible felony, or were diagnosed by a psychologist or physician with a mental injury from child abuse. For each expense selected within the Victim Compensation program, attach itemized bills and/or required documentation. Note that payments accepted by in-state providers on behalf of victims are considered payment-in-full per Florida Statute.

☐ **FUNERAL/BURIAL**

☐ **LOSS OF SUPPORT**
For the dependent(s) of a deceased victim who was employed at the time of the crime. (See Section Eleven.)

☐ **GRIEF COUNSELING**
For the spouse, parent, child, sibling or dependent of a deceased victim. (See Section Eleven.)

☐ **CRIME SCENE CLEANUP**
Available if you incurred costs for the removal and disposal of biohazardous and/or biochemical substances.

☐ **MEDICAL**

☐ **MENTAL HEALTH**

☐ **DENTAL**

☐ **EMERGENCY REIMBURSEMENT**
Reimbursement for out-of-pocket compensable expenses. Provide itemized bills and receipts with your application.

☐ **DISABILITY**
Available if you suffered a permanent whole-body disability as the result of a crime. Attach a completed Treatment Disability Statement (BVC409). (See Section Twelve.)

☐ **WAGE LOSS**
Available if you lost wages by being excused from work due to crime related physical injuries. Attach a completed Wage Loss Employment Report (BVC405) and Treatment Disability Statement (BVC409). (See Section Twelve.)

☐ **PROPERTY LOSS (PL)**
Available if you lost tangible personal property that diminishes your quality of life, provided that at the time of the criminal or delinquent act you were at least 60 years of age or disabled. Reimbursement is limited to the maximum benefit amount listed on the Schedule of Benefits for any one claim, provided the lifetime maximum of $1,000 has not been previously paid. Victims under the age of 60 are required to attach proof of disability prior to the date of crime from the Department of Veterans Affairs, Social Security Administration, or a Property Loss Disability Verification Form (BVC410). Victims must attach a receipt or written estimate from a vendor or merchant identifying the comparable replacement value. Compensable items must be identified in the incident report.

☐ **RELOCATION FOR DOMESTIC VIOLENCE (DV)**
Available if you need immediate assistance to escape a domestic violence environment. The Relocation Certification Worksheet (BVC106) certified by a domestic violence center in the State of Florida is required and must be received within 30 days after the domestic violence crime occurred.

☐ **RELOCATION FOR SEXUAL BATTERY (RS)**
Available if you need to relocate due to a reasonable fear for his or her safety. The Relocation Certification Worksheet (BVC106) certified by a rape crisis center in the State of Florida is required and must be received within three years after the sexual battery crime occurred.

☐ **RELOCATION FOR HUMAN TRAFFICKING (HT)**
Available if you have an urgent need to escape from an unsafe environment directly related to a sexual human trafficking offense. The Certification Worksheet (BVC106) certified by a domestic violence or rape crisis center in the State of Florida is required and must be received within 45 days of the crime or last identifiable threat communicated with the proper authorities.

Section Three - BASIC ELIGIBILITY REQUIREMENTS

Additional qualification criteria, deadlines, and exceptions not listed may apply.

- ✓ APPLICATION: If your application package is not complete when received by the Bureau of Victim Compensation, it will not be processed timely and may be denied.
- ✓ REPORTING: The crime must be reported to local law enforcement or other proper authorities within 120 hours. If the crime was not reported in a timely manner, you will need to provide good cause for the delay.
- ✓ FILING: The Bureau of Victim Compensation must receive your application within three years after the date of crime, the crime related death, or after the death is determined to be the result of a crime. Alternatively, the application must be received within five years, and you will need to provide good cause for the delay. Exceptions apply to victims who are minors. Different filing time requirements may apply.
- ✓ COOPERATION: While it is not necessary for the identity of the offender to be known, you are required to cooperate fully with law enforcement officials, State Attorney's Office, and the Attorney General's Office.
- ✓ UNLAWFUL ACTIVITY AND CONTRIBUTORY CONDUCT DISQUALIFIERS: If law enforcement or other proper authorities identify that you were engaged in an unlawful activity or contributed to the situation that caused your injury or death, your claim will be denied.
- ✓ PROOF OF CRIME: The Bureau of Victim Compensation requires information from law enforcement or the proper authorities to determine if you have been a victim of a compensable crime. If an insufficient report is received which does not establish a compensable crime occurred, your claim will be denied. Acceptable documentation for proof that a compensable crime occurred includes a law enforcement report; affidavit charging an individual with a crime filed by law enforcement; information report filed by a state attorney; indictment by a grand jury; written communication from any federal law enforcement agency; cybercrime investigator certification for purposes of s. 960.197, Fla. Stat.; or Law Enforcement Information Reporting Form BVC430. For assistance with collecting acceptable documentation, please contact your local law enforcement agency, the agency where the crime was reported, the referral source, or your local State Attorney's Office.

Section Four - LIMITATIONS

Navigating the availability of resources and limitations for each claim type can be difficult to understand. Victims/applicants are referred to victim advocates at local law enforcement agencies, State Attorney's Offices, or victim service centers, to seek alternative resources when qualifications for compensation are not met.

- CRIMINAL HISTORY RECORD CHECK: Compensation is not available to anyone who, at the time of the crime, was confined or in custody in a county or municipal facility, a state or federal correctional facility, or a juvenile detention commitment or assessment facility; or was previously adjudicated as a habitual felony offender, habitual violent offender, or violent career criminal; or, adjudicated guilty of a forcible felony offense.
- PAYMENT LIMITATIONS: The Bureau of Victim Compensation is the payor of last resort which means that financial assistance may be paid to or on behalf of qualified crime victims only after all other sources of payment have been exhausted. Payment authorizations cannot be preapproved nor guaranteed. The total amount paid on any one claim is limited by the Schedule of Benefits, may be paid below the maximum, and can be reduced without prior notice based on the availability of funding.
- RELOCATION PAYMENT LIMITATIONS: A standard housing contract or a Notification of Residential Agreement (BVC110) is required at the time of application. Relocation benefits are only for short-term interim shelter and rental agreements or long-term leases for where you have relocated. Payments are made in care of the certifying domestic violence or rape crisis center and must be accepted within 30 days from the payment issuance date. Once accepted by you, you are required to submit receipts or other documentation to the Bureau of Victim Compensation within 45 days from the date the funds were issued. Receipts or other documentation must prove how funds were used to satisfy the housing contract or residential agreement. Total relocation benefits on any one claim is limited by the Schedule of Benefits, and a lifetime maximum of $3,000 on all claims for that benefit type.

Section Five - VICTIM INFORMATION

Please provide information about yourself or the individual identified by the proper authorities as the victim.

VICTIM STATUS (check one) ☐ Adult ☐ Disabled Adult ☐ Minor ☐ Minor Witness Not Injured ☐ Incompetent Adult ☐ Deceased

VICTIM'S NAME (first, middle, last)		DATE OF BIRTH (mm/dd/yyyy)	
SOCIAL SECURITY NUMBER	EMAIL ADDRESS	WOULD YOU LIKE CORRESPONDENCE SENT BY EMAIL? ☐ YES ☐ NO	
STREET ADDRESS	CITY	STATE	ZIP CODE
PRIMARY TELEPHONE NUMBER	ALTERNATE TELEPHONE NUMBER	OCCUPATION	

THIS INFORMATION IS COLLECTED FOR FEDERAL REPORTING PURPOSES AND IS OPTIONAL

RACE/ETHNICITY (check one) ☐ AMERICAN INDIAN/ ALASKA NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC/ LATINO ☐ NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER ☐ WHITE NON-LATINO/ CAUCASIAN ☐ ASIAN ☐ OTHER ☐ MULTIPLE

GENDER ☐ MALE ☐ FEMALE ☐ OTHER | NATIONAL ORIGIN

Section Six - APPLICANT INFORMATION

Complete this section if you are filing on behalf of a minor, minor witness not injured, incompetent adult, or deceased victim. When requesting compensation on behalf of a disabled adult or incompetent adult victim, proof of legal guardianship must be attached.

RELATIONSHIP TO THE VICTIM

APPLICANT'S NAME (first, middle, last)		DATE OF BIRTH (mm/dd/yyyy)
SOCIAL SECURITY NUMBER	EMAIL ADDRESS	WOULD YOU LIKE CORRESPONDENCE SENT BY EMAIL? ☐ YES ☐ NO

STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY TELEPHONE NUMBER	ALTERNATE TELEPHONE NUMBER	OCCUPATION

Section Seven - CRIME INFORMATION

This section is required. Please provide acceptable proof of the crime. (See Section Three.)

LAW ENFORCEMENT AGENCY CRIME WAS REPORTED TO	COUNTY WHERE CRIME OCCURRED

TYPE OF CRIME AS SPECIFIED ON THE INCIDENT REPORT (list all violations)	DATE OF CRIME (mm/dd/yyyy)	DATE REPORTED TO LAW ENFORCEMENT (mm/dd/yyyy)

LAW ENFORCEMENT REPORT NUMBER	NAME OF LAW ENFORCEMENT OFFICER

IF THE OFFENDER IS KNOWN, HAS THE OFFENDER BEEN ARRESTED? ☐ YES ☐ NO	NAME OF OFFENDER (first, middle, last)

NAME OF PROSECUTING ASSISTANT STATE ATTORNEY (if applicable)	STATE ATTORNEY CASE NUMBER/CLERK OF COURT CASE NUMBER

Section Eight - GOOD CAUSE

Identify explanations for delays in reporting the crime to the proper authorities within 120 hours from the incident, filing the application within three years from the date of crime, and/or reasons why you were unable to cooperate with the proper authorities.

WAS THE CRIME REPORTED TO LAW ENFORCEMENT WITHIN 120 HOURS OF THE INCIDENT? ☐ YES ☐ NO
IF NO, PLEASE EXPLAIN. A REPORTING TIME EXPLANATION FORM (BVC103) CAN ALSO BE USED.
(Failure to provide an acceptable explanation will result in a denial of benefits.)

IS THE APPLICATION BEING SUBMITTED WITHIN THREE YEARS FROM THE DATE OF THE CRIME? ☐ YES ☐ NO
IF NO, PLEASE EXPLAIN. A FILING TIME EXPLANATION FORM (BVC102) CAN ALSO BE USED.
(Failure to provide an acceptable explanation will result in a denial of benefits.)

DID YOU COOPERATE WITH THE PROPER AUTHORITIES DURING THE INVESTIGATION, AND THROUGHOUT PROSECUTION, IF APPLICABLE?
☐ YES ☐ NO

IF NO, PLEASE EXPLAIN. A NON-COOPERATION EXPLANATION FORM (BVC104) CAN ALSO BE USED.
(Failure to provide an acceptable explanation will result in a denial of benefits.)

Section Nine - INSURANCE/COLLATERAL SOURCE INFORMATION

Identify all insurance carriers below. If your claim is determined eligible for the Victim Compensation and/or Property Loss Programs, you may be exempt from the insurance deductible or co-payment provisions of your insurance policy(ies). Attach a separate sheet if additional space is needed. Attach a copy of your insurance card or policy declaration.

TYPE OF INSURANCE/COLLATERAL SOURCE AVAILABLE (check all that apply)

☐ MEDICARE ☐ MEDICAID ☐ HEALTH ☐ DENTAL ☐ DISABILITY ☐ HOSPITALIZATION

☐ AUTOMOBILE ☐ RENTAL ☐ ACCIDENT ☐ VISION ☐ PROPERTY ☐ WORKERS COMPENSATION

COMPANY NAME	POLICY NUMBER	IS THIS AN HMO OR A FEDERAL POLICY?

STREET ADDRESS	CITY	STATE	ZIP CODE

COMPANY NAME	POLICY NUMBER	IS THIS AN HMO OR A FEDERAL POLICY?

STREET ADDRESS	CITY	STATE	ZIP CODE

Section Ten - OTHER COMPENSATION, SETTLEMENT, AND ATTORNEY INFORMATION

Identify if you have received or anticipate receiving compensation or any benefits from any other source because of the crime; and/or, if you are planning to hire an attorney to represent you as a result of the crime.

PLEASE CHECK IF YOU HAVE OR PLAN TO FILE FOR (check all that apply)

☐ UNEMPLOYMENT COMPENSATION ☐ RESTITUTION ☐ SETTLEMENT ☐ LAWSUIT/CIVIL ACTION

CIVIL ATTORNEY'S NAME (first, middle, last)	FIRM	HAVE YOU RECEIVED ANY FUNDS AS OF THE DATE OF THIS FILING? ☐ YES (HOW MUCH?) ☐ NO

STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY TELEPHONE NUMBER	ALTERNATE TELEPHONE NUMBER	EMAIL ADDRESS

Section Eleven - LOSS OF SUPPORT AND GRIEF COUNSELING DEPENDENT INFORMATION

Provide the name(s), date(s) of birth, and relationship to the deceased victim for any surviving spouse, parent, child, sibling, or dependent. For persons under the age of 18, indicate who has guardianship of the minor. Also attach income tax returns showing earnings for one to three years preceding the date of the crime, or a Victim Compensation Wage Loss Employment Report (BVC405) to document earnings preceding the crime. Dependency can be established based upon the victim's federal income tax return, marriage certificate, birth or death certificate, copy of approval for Social Security Administration survivor benefits, or court order for support. Attach a separate sheet if additional space is needed to identify dependents who are requesting Loss of Support and/or Grief Counseling.

DEPENDENT NAME (first, middle, last)	DATE OF BIRTH (mm/dd/yyyy)	RELATIONSHIP TO VICTIM	IS THE APPLICANT IDENTIFIED IN SECTION SIX THE LEGAL GUARDIAN OF THIS DEPENDENT? ☐ YES ☐ NO
DEPENDENT NAME (first, middle, last)	DATE OF BIRTH (mm/dd/yyyy)	RELATIONSHIP TO VICTIM	IS THE APPLICANT IDENTIFIED IN SECTION SIX THE LEGAL GUARDIAN OF THIS DEPENDENT? ☐ YES ☐ NO
DEPENDENT NAME (first, middle, last)	DATE OF BIRTH (mm/dd/yyyy)	RELATIONSHIP TO VICTIM	IS THE APPLICANT IDENTIFIED IN SECTION SIX THE LEGAL GUARDIAN OF THIS DEPENDENT? ☐ YES ☐ NO

Section Twelve - DISABILITY AND WAGE LOSS EMPLOYMENT/PHYSICIAN INFORMATION

For disability or wage loss benefits, attach a completed Victim Compensation Treatment Disability Statement (BVC409) signed by a doctor, dentist, psychiatrist, or chiropractor, identifying the permanent whole-body disability expressed as a percentage or the dates excused from work due to physical injuries relating to the crime. For wage loss benefits, also attach a completed Victim Compensation Wage Loss Employment Report (BVC405). If you are self-employed or work for a family member, please attach a copy of your latest filed income tax return and applicable IRS schedule forms instead of the wage loss report.

NAME OF TREATING PHYSICIAN PROVIDING DISABILITY/WORK EXCUSE	PHYSICIAN'S PRIMARY PRACTICE FACILITY NAME

PHYSICIAN'S TELEPHONE NUMBER	PHYSICIAN'S FACSIMILE NUMBER	PHYSICIAN'S EMAIL ADDRESS

NAME OF EMPLOYER/COMPANY/BUSINESS	SUPERVISOR'S NAME

SUPERVISOR'S TELEPHONE NUMBER	SUPERVISOR'S FACSIMILE NUMBER	SUPERVISOR'S EMAIL ADDRESS

Section Thirteen - REFERRAL SOURCE INFORMATION

Individuals who assisted you with or filled out any sections of this application are required to provide referral information below. If you receive assistance with completing the application, please review all sections before the application is signed. (Treatment providers who offer referrals can request training about the claim types that are available by contacting the Bureau of Victim Compensation, which is recommended prior to becoming a referral source.)

NAME OF APPLICATION ASSISTANT (first, middle, last)	NAME OF AGENCY/ORGANIZATION

AGENCY'S STREET ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS	TELEPHONE NUMBER

Section Fourteen - AUTHORIZATION TO SPEAK WITH OTHER REPRESENTATIVE

If you would like to give permission to a family member, friend, or other person to discuss and/or make decisions regarding your claim, please provide their information.

NAME OF SPEAKER (first, middle, last)	TELEPHONE NUMBER	RELATIONSHIP TO VICTIM

Section Fifteen - CONFIDENTIALITY, DISCLOSURES, LEGAL ACKNOWLEDGEMENTS, AND SIGNATURE

CONFIDENTIALITY: If you are the victim of a sexual battery, aggravated child abuse, aggravated stalking, harassment, aggravated battery, or domestic violence, you have the right to have information about your home address and telephone number, employment address and telephone number, and your personal assets, kept confidential for a period of five years. If you are the victim of any of these crimes, please mark one of the following statements. Your response will not affect the processing of your claim(s).

☐ I want the information to be confidential. ☐ I do NOT want the information to be confidential.

NOTE: If you are not the victim of a sexual battery, aggravated child abuse, aggravated stalking, harassment, aggravated battery, or domestic violence, your information may be subject to disclosure pursuant to a public records request, regardless of your selection above.

SOCIAL SECURITY NUMBER DISCLOSURE: The Bureau of Victim Compensation collects and uses Social Security numbers for the purpose of performing imperative duties and responsibilities which may include the following: searching criminal history records, identity management, billing and payments, benefit processing, and reporting to authorized state and federal government agencies. Failure to provide this optional information may delay the processing of your application or benefits. Federal and State laws require the Bureau to protect Social Security numbers from disclosure to unauthorized parties. Absent a waiver from you or your legal representative, Social Security numbers will be redacted, unless the agency receives a court order to turn over a non redacted file.

CRIMINAL HISTORY DISCLOSURE: A criminal history records search will be conducted on all victims/applicants. I hearby authorize and understand that criminal history reports will be analyzed to determine if eligibility qualifications are met.

REPAYMENT REQUIREMENT: I understand that I must notify the Bureau of Victim Compensation before a civil settlement, restitution order, and/or any proceeds are obtained by any source. I acknowledge that the Bureau of Victim Compensation is the payor of last resort and that I must repay the Crimes Compensation Trust Fund if I receive compensation and also receive payment from another source as a result of the same criminal incident. Other sources include, but are not limited to, any payment from the offender, insurance policy, settlement, agreement, judgment, or an award in a third-party lawsuit. I also understand that if eligibility is rescinded or withdrawn, I must repay any amount received or paid on my behalf by the Crimes Compensation Trust Fund.

SERIOUS FINANCIAL HARDSHIP: I certify that I have a serious financial hardship because of crime-related expenses that cannot be paid by any other source, and that this loss adversely affects my quality of life.

RELEASE OF INFORMATION: I give permission to any hospital, doctor, dentist, mental health counselor, or other treatment provider, banking institution, social service agency, law enforcement agency, corrections agency, State Attorney's Office, insurance carrier, attorney or employer to provide information that is requested concerning any treatment rendered, employment, insurance, third-party payer, or law enforcement investigative information to the Bureau of Victim Compensation for use in processing my claim. I give permission to the Bureau to release information about the status of my claim to any treatment provider, law enforcement agency, or State Attorney's Office.

VICTIM: Must be signed and dated by the victim if filing as a competent or disabled adult.

PRINTED NAME: _____

SIGNATURE:_____ DATE: _____

Under penalty of perjury or fraud, the information I have provided is true and correct to the best of my knowledge

APPLICANT: Applicant signature is required if filing as the parent, legal guardian, or individual authorized to administer a victim's estate. This includes applicants applying on behalf of a minor, minor witness not injured, incompetent adult, or deceased victim.

PRINTED NAME: _____

SIGNATURE:_____ DATE: _____

Under penalty of perjury or fraud, the information I have provided is true and correct to the best of my knowledge