For Office Use Only:

Claim No._____

Department of Labor and Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520
Email: CrimeVictimsProgramM@LNI.WA.GOV
Fax: (360) 902-5333

Crime Victim's Application for Benefits – Injury Claim

Visit our website at www.crimevictims.lni.wa.gov for information

Victim Information

Preferred Language (If not English)	Email Address
Name (First, Middle, Last)	
Social Security Number (Optional)	Telephone Number
Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female
Mailing Address	
City / State / Zip Code	

If victim is a minor, provide the full name of the parent or guardian applying on the victim's behalf.

Name _____ Relationship _____

Who has permission to call CVCP on your behalf?

Name	Relationship
Telephone Number	Email Address

Other Information

How did you find out about the CVCP? Check the box that applies: Police/Law Enforcement ☐ Prosecutor's Office ☐

Victim Assistance Program Advocate ☐ Victim Witness Service ☐ Hospital ☐ Health Care Provider ☐ Other ☐

What is your marital status? Check the box that applies: Married ☐ Single ☐ Domestic Partner ☐ Divorced ☐ Separated ☐

What is your country of origin? _____

What is your ethnicity? Check the box that applies.

☐ African American ☐ Asian ☐ Pacific Islander
☐ Caucasian ☐ Hispanic ☐ Native American
☐ Other: _____

Do you have a disability? ☐ No ☐ Yes

Was the disability caused by the crime? ☐ No ☐ Yes

Is the disability ☐ Physical ☐ Mental ☐ Both

What benefits are you applying for?

☐ Medical ☐ Dental ☐ Mental Health ☐ Wage Loss

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Crime Information

NOTE: The crime must be reported to a police agency

Date of Incident (mm/dd/yyyy)	Date Reported (mm/dd/yyyy)	Time Incident Occurred ☐ AM ☐PM
Crime Location Address		
City	State	Zip Code

Did the crime occur on the job? ☐ Yes ☐ No

What law enforcement agency did you report the crime to? Check the box that applies.

☐ Police ☐ Washington State Patrol ☐ Federal Bureau of Investigations ☐ Sheriff ☐ Tribal Police

Officer's Name	Telephone Number	Report Number

Type of Crime

☐ Assault ☐ Civil commitment ☐ DUI ☐ Failure to secure load
☐ Sexual assault ☐ Domestic violence ☐ Vehicular assault ☐ Robbery/Burglary

Brief Description of the Crime

Weapon Used	Area of the Body Injured	Offender's Name

Was the offender living with you when the incident occurred? ☐ Yes ☐ No

If you were involved in a civil commitment proceeding of a sexually violent predator, when were you contacted about the proceedings?

Date	Who Contacted You?	Telephone Number

Have you filed or do you intend to file a civil suit? ☐ Yes ☐ No ☐ Unsure

Attorney Information

Do you have an attorney representing you?	Yes ☐	No ☐

If you have an attorney representing you, check the box that applies:
Attorney is representing me for the crime victim claim ☐ Attorney is representing me for a personal injury claim (auto insurance) or lawsuit ☐ Attorney is representing me for both the crime victim claim and a personal injury claim (auto insurance) or lawsuit

NOTE: If the attorney represents you on your crime victim claim, all department correspondence will go to your attorney.

Attorney Name	Email Address
Telephone Number	Address (Street, City, State, Zip)

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Wage Information

For wage loss benefits, you must have been employed on the date of the injury.

Please fill out this section only if you were employed or self-employed at the time of the crime and are applying for wage loss benefits. We may contact your employer if necessary. If you have concerns about this, please call us.

Were you employed on the date of the crime? ☐ Yes ☐ No

If yes and you are requesting wage replacement benefits, provide the following employer information:

Employer Name	Contact Name
Employer Address	
City State Zip Code	
Telephone Number	Date Last Worked
Have you returned to work? ☐ Yes ☐ No	If yes, date you returned to work
Rate of pay $ ☐ Hour ☐ Day ☐ Week ☐ Month	
Hours worked per day	Days worked per week
Additional Earnings $	Additional Earning From ☐ Piecework ☐ Tips ☐ Commission ☐ Bonuses
Did you use sick/vacation leave or disability benefits? ☐ Yes ☐ No	
Annual Income Level (Select One) ☐ $0 – $20,000 ☐ $20,001 – $50,000 ☐ $50,001 – $75,000 ☐ $75,001 – $100,000 ☐ $100,000 or more	

Insurance Information

Providing this information will ensure proper payment of medical expenses.

Note: You are required to use any available private or public insurance you have first. The Crime Victims Compensation Program is the last payer of benefits. If you have private or public insurance, your providers must bill your insurer first. Please provide accurate information about any insurance you have to ensure bills are paid correctly.

Do you have insurance? ☐ No ☐ Yes

The Crime Victims Compensation Program is the payer of last resort. Providers should bill your primary insurance first. Please list all available coverage to include: health insurance, dental insurance, vision insurance; HCA/Medicaid, Veteran, Social Security, DSHS/public assistance, workers' compensation, Indian Health, automobile insurance (victim and offender), motorcycle insurance, life insurance, home insurance, renter's insurance. CVCP can only pay benefits after your insurance pays. Attach additional pages if needed.

If yes, provide the following information:

Insurance Company Name	
Telephone Number	Policy Holder Name
Provide one of the following: Policyholder ID, Group No., or SSN	Date of Eligibility

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Provide one of the following: Policyholder ID, Group No., or SSN	Date of Eligibility

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Provider Information

If you have already seen a medical or other provider, or are completing this form in a medical office or hospital, please ask the medical professional seeing you to complete the section below.

Provider Name	Provider's L&I Provider Number
Facility Name	Telephone Number
Address	
City State Zip code	

Date Patient First Treated for Crime Injury
Diagnosis Codes
Description of Injury

Will the patient lose time from work due to their injuries? ☐ No ☐ Yes

Wage loss certified from: _____ _____

Provider Signature _____ Date _____

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Authorization to Release Confidential Information

NOTE: The victim or legal guardian must sign this form to be valid

I hereby authorize any hospital, physician, funeral director, or other person who provided services; any employer of the victim; any law enforcement agency or other government agency, including state and federal services; any and all insurance companies or any other agency having knowledge necessary for the determination of eligibility of this claim for benefits to furnish to the Crime Victims Compensation Program or its representatives any and all information, including but not limited to, documents generated by themselves and others, specifically pertaining to this claim. Other information may be required to determine whether conditions are related to the crime. I understand this may include results of HIV and other sexually transmitted disease testing, alcohol, drug, and psychiatric treatment.

I understand that if I receive any recovery of my losses through court-imposed restitution or civil lawsuit against the offender, any insurance settlement, or moneys from any other government or private agency, I shall reimburse the State of Washington Crime Victims Compensation Program for any compensation paid out under this claim.

By signing below, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

If victim is a minor, parent or legal guardian, please sign. If you are the legal guardian, please send the Crime Victims Compensation Program a copy of guardianship documentation.

Print Name	Signature	Date

Note to Medical Providers:

RCW 7.68.145: Release of information in performance of official duties.

Notwithstanding any other provision of law, all law enforcement, criminal justice, or other governmental agencies, or hospital; any physician or other practitioner of the healing arts; or any other organization or person having possession or control of any investigative or other information pertaining to any alleged criminal act or victim concerning which a claim for benefits has been filed under this chapter, shall, upon request, make available to and allow the reproduction of any such information by the section of the department administering this chapter or other public employees in their performance of their official duties under this chapter.

Your disclosure of this information is allowed under the Health Insurance Portability and Accounting Act (HIPAA). This disclosure is required by Washington State law. You may disclose health information under HIPAA without an authorization if that disclosure is required by law, 45 CRF § 164.512(a). Also, since your disclosure is required by law it is not subject to HIPAA's minimum necessary standard, 45 CFR § 164.502(b)(2)(v).

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