



**INDIANA CRIMINAL JUSTICE INSTITUTE  
VIOLENT CRIME COMPENSATION FUND**

302 W. Washington St., Rm. E209  
Indianapolis, Indiana 46204-2767  
Telephone: (317) 232-7103

In 1978, the Indiana General Assembly enacted a law which, for the first time in Indiana, provided for financial assistance to victims of violent crimes.

- 1 The claimant must be a victim, surviving spouse or a dependent child of a victim of violent crime, including cases where there is evidence of drunk driving.
  - 2 The crime must have occurred within the State of Indiana.
  - 3 The crime must have been reported to police within forty eight (48) hours after its occurrence and the victim and/or claimant must cooperate with the law enforcement officials in connection with the crime.
  - 4 The victim must have incurred a minimum of \$100.00 in medical expenses as a result of the crime. Such expenses as counseling, lost income and funeral expenses may be considered after the minimum has been met. (*The maximum benefit available is \$10,000.00*)
  - 5 The victim must not have contributed to the crime.
  - 6 Where special circumstances arise, claimants are advised to contact the Division or their attorneys for information as to eligibility.
- 
- 1 The application for benefits must be filed with this agency no later than 180 days after the date crime occurred. It is necessary that the victim/claimant fill out the application and include their signature.
  - 2 The application must be filed either in person or by certified mail with return receipt requested. The return receipt is your evidence of filing your application.
  - 3 In the event the claimant is a minor child (*under 18 years of age*), a parent or legal guardian must sign. For a minor, a certified copy of the guardianship order must be attached.
  - 4 Send original application to the Division at the address listed above.
  - 5 **PLEASE NOTIFY THE DIVISION OF ALL CHANGES IN NAMES, ADDRESS OR TELEPHONE NUMBER.**

For more information please contact the office at the above listed telephone



# APPLICATION FOR BENEFITS FROM VIOLENT CRIMES COMPENSATION FUND

State Form 23776 (R9 / 3-97)

\* This state agency is requesting disclosure of Social Security numbers that are necessary to accomplish the statutory purpose of this state agency according to IC 4-1-8.

\*\* This information is for statistical purposes only and will not effect the eligibility of the claimant.

## VICTIM INFORMATION

Name of victim ( <i>last, first, middle initial</i> )			Marital status		
*Social Security number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth	**Race <input type="checkbox"/> White <input type="checkbox"/> Black	<input type="checkbox"/> Hispanic <input type="checkbox"/> Asian	<input type="checkbox"/> American Indian <input type="checkbox"/> Other
Name of victim's dependents					

## CLAIMANT INFORMATION

Name of claimant ( <i>if different from the victim/last, first, middle initial</i> )	* Social Security number
Address of victim or claimant ( <i>number and street</i> )	Work telephone number (    )
City, state, ZIP code	Home telephone number (    )
Claimant's relationship to victim	

## INJURIES TO VICTIM

What injuries did the victim sustain as a result of the victimization?
Hospital for medical treatment
Address ( <i>number and street, city, state, ZIP code</i> )
Name attending physician
Address ( <i>number and street, city, state, ZIP code</i> )

## CRIME AND PROSECUTION

Date of crime	Location of crime ( <i>city, state, county</i> )			
Briefly give a description of the crime				
Date and time police report was filed	<input type="checkbox"/> AM <input type="checkbox"/> PM	Name of law enforcement agency	Name of detective	Case number ( <i>if known</i> )
Name of suspect (s)	Victim's relationship to suspect			
Has suspect been arrested? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Were you willing to pursue prosecution? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "No", please explain:				
Cause number ( <i>if known</i> )				

**INSURANCE**

Were the injuries you sustained covered by any of the following?

 Medicare       Medicaid       Worker's Compensation       County Trustee

Medical and / or car insurance amount \$ \_\_\_\_\_

Carrier(s) \_\_\_\_\_

Health Maintenance Organization carrier: \_\_\_\_\_ Coverage \_\_\_\_\_

Are you receiving any of the following as a result of the victimization:

Social Security disability \$ \_\_\_\_\_ Per Month

Social Security survivors benefit \$ \_\_\_\_\_ Per Month

Life insurance death benefits \$ \_\_\_\_\_ TOTAL

Were you the beneficiary ?       Yes       No

Worker's compensation benefits \$ \_\_\_\_\_ Per Week

Employer disability benefits \$ \_\_\_\_\_ Per Week / Month

**EMPLOYMENT INFORMATION**

Victim's employment name

Telephone number

(    )

Address (number and street, city, state, ZIP code)

**RELEASE**

I do hereby release the State of Indiana and the Violent Crimes Compensation Division from any and all liability which might be connected with the processing and payment of this claim. In the event the fund from which the award is paid, if the claim is allowed, is such that it is necessary to prorate the payment of the claim, I do hereby release and discharge the State of Indiana and the Violent Crimes Compensation Division from any and all liability beyond the amount actually paid to me from the fund.

**SUBROGATIONS**

The claimant hereby certifies that no release has been or will be given in settlement or for compromise with any third party who may be liable in damages to the claimant; and the claimant, in consideration of any payment and/or award by the Violent Crime Compensation Division in accordance with IC 5-2-6.1-22, here subrogates the State of Indiana to the extent of any such payment and/or award to any right or cause of action occurring to the claimant against any third person, and agrees to accept any such payment and/or award pursuant to the provisions of the statute. The claimant hereby authorizes the State of Indiana to sue in his/her name, but at the cost of the State of Indiana, pledging full cooperation in such action, to execute and deliver all papers and instruments, and do all things necessary to secure such right to a cause of action.

**CONSENT TO PAY PROVIDERS**

I do hereby consent and agree that if an award is made, money due and owing to any provider of medical services and due to any other qualified person or entity, including any attorney's fees allowed to my attorney, may be paid direct to said provider, entity or attorney by the agency and need not be paid to me.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize any hospital, physician, or other person, who attended or examined \_\_\_\_\_ any undertaker or other person who rendered services; any employers of the victim; any police or other municipal authority or agency, or public authority; any insurance company or organization, or its representative, to release any and all information with respect to the incident resulting in the victim's personal injury or death, and the claim made herewith for benefits. A photocopy of this authorization will be considered as effective and valid as the original.

I the undersigned Claimant, hereby certify under the penalties of perjury that the statements made herein are true to the best of my knowledge and belief and were made for the purpose of inducing the State of Indiana to award benefits to me for losses incurred as described above through the Violent Crime Victims Compensation Fund as prescribed in IC 5-2-6.1-40.

Signature of claimant

Date