INDIANA CRIMINAL JUSTICE INSTITUTE
VIOLENT CRIME COMPENSATION FUND
402 West Washington Street, Room W469
Indianapolis, Indiana 46204
Telephone: 1-800-353-1484
E-mail: ViolentCrimeCompensation@cji.in.gov

The Indiana General Assembly created the Indiana Violent Crime Victim Compensation Fund to provide financial assistance to victims of violent crime, and charged the Indiana Criminal Justice Institute (ICJI) with managing the fund. Victims and, in some cases, their dependents may be eligible to receive assistance with certain costs as a direct result of a violent crime. Below are the eligibility requirements, compensation categories, and payment limits. Please refer to Indiana Code 5-2-6.1 for additional eligibility requirements.

Eligibility Requirements

1. The claimant must be a victim, surviving spouse, or a dependent child of a victim of an eligible violent crime.
2. The crime must have occurred in Indiana.
3. The crime must have been reported to law enforcement within seventy-two (72) hours of the incident. In addition, the victim and/or claimant must cooperate with law enforcement during the investigation and prosecution of the crime.
4. The victim must have incurred a minimum of $100 in expenses as a result of the crime.
5. The victim must not have contributed to the crime or to their injury.
6. The application for benefits must be filed with the Indiana Criminal Justice Institute no later than one hundred eighty (180) days after the date of the crime. Certain exceptions can be made for exigent circumstances and for victims of child sex crimes.
7. If the claimant is less than eighteen (18) years old, a parent or legal guardian must sign and date the application.

For special circumstances, claimants should contact ICJI for eligibility information.

Compensation Categories and Payment Limits may include:

1. Medical, dental and mental health counseling-related expenses (not to exceed $15,000).
2. Potential loss of income if the victim was employed at the time of the incident. Loss of income is only available if the claimant has not reached the statutory $15,000 maximum payout.
3. Loss of financial support which was provided by victim. Appropriate documentation required. Loss of financial support is only available if the claimant has not reached the statutory $15,000 maximum payout.
4. Funeral, burial and cremation expenses not to exceed $5,000.

Note: Please notify ICJI of all changes in name, address or telephone number.

Reset Form

APPLICATION FOR BENEFITS FROM VIOLENT CRIMES COMPENSATION FUND

State Form 23776 (R13 / 5-21)

** This information is voluntary and is for statistical purposes only and will have no effect on the eligibility of the claimant.

Questions or concerns: Please contact the Indiana Criminal Justice Institute at 1-800-353-1484 or e-mail at ViolentCrimeCompensation@cji.in.gov.

VICTIM INFORMATION

Is the victim the claimant? ☐ Yes ☐ No

Who is submitting the claim? ☐ Victim ☐ Claimant ☐ Advocate

Name of victim *(first, last, middle initial)*

Gender ☐ Male ☐ Female

Race ** ☐ African American ☐ Caucasian ☐ Hispanic ☐ Indian ☐ Multiracial ☐ Native American ☐ Pacific Islander ☐ Other _____

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Date of birth *(month, day, year)*

Date of crime *(month, day, year)*

Address of victim *(number and street)*

E-mail address

City, state, and ZIP code

Telephone number ( )

CLAIMANT INFORMATION *(If the same as the victim, leave blank.)*

Name of claimant *(if different from the victim / first, last, middle initial)*

Gender ☐ Male ☐ Female

Address of victim or claimant *(number and street)*

City, state, and ZIP code

Telephone number ( )

Relationship to victim

E-mail address

CRIME SPECIFIC INFORMATION

Is this an automobile accident? ☐ Yes ☐ No

If yes, name of auto insurance for: Suspect: Victim:

Does the victim have physical injuries? ☐ Yes ☐ No

Name of medical facility for treatment

What forms of compensation are you requesting?
☐ Medical/Dental/Counseling ☐ Funeral/Burial ☐ Loss of Income ☐ Loss of support ☐ Other _____

Indicate which of the following covered any of the expenses related to the injury:
☐ Medicaid ☐ Health Insurance ☐ Worker's Compensation ☐ Life Insurance Benefits ☐ Medicare ☐ County Trustee ☐ Social Security Benefits ☐ Charity ☐ Other _____

Were you employed at the time of the incident? ☐ Yes ☐ No

Name of employer

Address of employer *(number and street, city, state, and ZIP code)*

Telephone number of employer ( )

Time crime occurred ☐ AM ☐ PM

Date reported to police *(month, day, year)*

Crime type

City and county where crime occurred

Name of suspect

Relationship to victim

Has the suspect been arrested? ☐ Yes ☐ No

Are you willing to assist law enforcement with prosecution? ☐ Yes ☐ No

If not willing to prosecute *(please explain why)*

Explanation of crime:

Police agency reported to

Name of officer

Police report number

Prosecuting agency

Cause number

RELEASES AND CERTIFICATION

Initial	
	RELEASE OF LIABILITY I do hereby release the State of Indiana and the Indiana Criminal Justice Institute 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 Indiana Criminal Justice Institute from any and all liability beyond the amount actually paid to me from the fund.
Initial	**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 Indiana Criminal Justice Institute 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.
Initial	**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 the use and/or disclosure of my protected health information described below. I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, covered health care providers, or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I hereby authorize any hospital, physician, undertaker or other person who rendered services to or for the below named individual; any employers of the below named individual; 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 below named individuals 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.

Name of individual whose records are to be released

Name of service providers, persons, or organizations authorized to release information

Protected health information or records to be used and/or disclosed

ENTITIES AUTHORIZED TO USE OR DISCLOSE:

Name or specifically identify the persons or organizations who you are authorizing to make use of and/or disclose the protected health information described above:

Indiana Criminal Justice Institute

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 Indiana Criminal Justice Institute as prescribed in IC 5-2-6.1-40.

Signature of claimant	Date *(month, day, year)*