pennsylvania
VICTIMS COMPENSATION
ASSISTANCE PROGRAM

Office of Victims' Services

Mailing Address:
P.O. Box 1167
Harrisburg, PA 17108-1167

Street Address:
3101 North Front Street
Harrisburg, PA 17110

Phone, Fax & Email:
(800) 233-2339
(717) 783-5153
(717) 787-4306 (FAX)
ra-davesupport@pa.gov

Website: www.pcv.pccd.pa.gov

You may either complete and mail this form to the address listed above or file online at https://www.dave.pa.gov

Victims Compensation Assistance Program Short Form

Please read the following before completing this form.

You may be eligible for compensation if:

- The crime occurred in Pennsylvania.
- The crime was reported to the proper authorities within 3 days.
- You cooperate with law enforcement authorities investigating the crime, the courts, and the Victims Compensation Assistance Program in processing the claim (some exceptions apply).
- Deadlines for filing may apply. Please visit www.pcv.pccd.pa.gov or call 1-800-233-2339 for additional information on filing requirements.
- Minimum loss requirements may apply. Please visit www.pcv.pccd.pa.gov or call 1-800-233-2339 for additional information on filing requirements.

You may be awarded compensation for:

Medical Expenses
Counseling Expenses
Loss of Earnings
Loss of Support
Relocation Expenses
Funeral Expenses
Crime Scene Cleanup
Transportation Expenses
Childcare
Home Healthcare Expenses
Stolen Cash (if your main source of income is Social Security Retirement, Disability Income, Supplemental Income, Survivor Benefits, Retirement/Pension(s), Disability, or Court Ordered Child/Spousal Support)

An overall maximum award shall not exceed $35,000; however, certain benefits, such as counseling and crime-scene cleanup, may be paid over and above the maximum. Monetary limits apply to most benefits.

The Program does not cover:

- Pain and suffering.
- Stolen or damaged property (except replacement of stolen or damaged medical equipment).

A claim may be determined ineligible or an award may be reduced if the conduct of the victim contributed to the injury.

Victims Compensation Assistance Program Short Form

Your cooperation with the Program and the submission of complete and accurate information will assist us in processing your claim in a timely manner.

IMPORTANT NOTE: You do not have to wait until the trial is over or all of your bills are received to file a claim. You may file a claim if there is no known offender or if an arrest has not been made.

General instructions for submitting your claim:

- Please print clearly.
- Complete only those sections that apply to your claim.
- Provide an accurate mailing address, a safe phone number or email address where you can be reached during the day.
- Provide as many of the requested documents as you can when filing your claim. You may submit your claim even if you do not have all the required documents. The Program may request additional information once the claim is received.
- Sign the **Acknowledgement and Reimbursement Agreement and Authorization to Obtain Information** and the **HIPPA Authorization and Release Agreement** (if applicable) sections on the back of the claim form.
- If you would like assistance in filing your claim you may contact the Victim Service Program listed on the back of this form. If no agency is listed, you may contact the Victims Compensation Assistance Program at (800) 233-2339 for assistance.

Please Note: It is important that you inform the Program if you change your mailing address, phone number or email address. To process your claim, we must be able to contact you.

The Victims Compensation Assistance Program is the payer of last resort. This means your award will be reduced by the monies you receive from any other source as a result of the crime, such as insurance, restitution, and civil suit settlements, including monies received for pain and suffering.

We will make every effort to process your claim as quickly and efficiently as possible.

Cut along this line and maintain this portion for your records. $

Victims Compensation Assistance Program Short Form Claim # _____

Victim Information

Name _____ Date of Birth _____/_____/_____ Soc Sec # _____
Address _____ City _____ State _____ Zip Code _____
County _____ Daytime Phone _____ Email _____

Claimant Information If victim is the claimant, check here: □ Claimant must be 18 years or older.

Name _____ Date of Birth _____/_____/_____ Soc Sec # _____
Address _____ City _____ State _____ Zip Code _____
County _____ Daytime Phone _____ Email _____
Relationship to Victim _____

Crime Information

Date of Crime _____/_____/_____ Date Reported to Police or PFA Filed _____/____/_____
Did it happen at work? □ Yes □ No Were the injuries caused by a motor vehicle? □ Yes □ No
Location of crime (street name and number)_____
City _____ State _____ County _____
Police Department _____ Police Incident Number _____
Person(s) who committed crime_____
Briefly Describe the crime and injuries: _____
_____

Please complete the section(s) for the benefits you are applying for and provide as much of the requested documents that you can at this time. The Program may request additional information once the claim is received.

Benefit: Medical/Counseling Expenses

Did you incur medical expenses? □ Yes □ No Did you incur counseling expenses? □ Yes □ No
Do you have insurance to cover your medical/counseling expenses? □ Yes □ No
Provide itemized medical or counseling bills and insurance benefit statements, if applicable.

Benefit: Funeral Expenses/Loss of Support

Did you incur funeral expenses? □ Yes □ No
Did you receive any monies due to the death? (life insurance, Social security death benefit) □ Yes □ No
Were you or others financially dependent on the deceased victim? □ Yes □ No
Provide copies of the itemized funeral bills/receipts and statements of any benefits received.

Benefit: Loss of Earnings

Dates you missed work _____/_____/_____
Employers name and address: _____
_____
Doctor's name and address who can verify you missed work because of the crime _____
_____

Benefit: Stolen Cash

Amount of money stolen? $_____
One of the following benefits must be your main source of income to file for stolen cash. Check all that apply.
□ Social Security benefit □ Retirement/Pension □ Disability □ Court ordered Child/Spousal support
Do you have homeowner's/renter's insurance? □ Yes □ No Are you required to file IRS tax returns? □ Yes □ No
Provide copies of your monthly benefit statement for the month/year of the crime, insurance declaration page and most recent tax returns, if applicable.

Benefit: Relocation, Crime Scene Cleanup, Transportation Expenses

Did you have to relocate due to the crime? □ Yes □ No
Did you incur crime scene cleanup expenses? □ Yes □ No
Did you incur transportation expenses? □ Yes □ No

Representation by Others

Are you represented in this matter by an attorney: In filing this compensation claim? □ Yes □ No
In a civil lawsuit? □ Yes □ No In an insurance action? □ Yes □ No

Victim Service Program Information

For assistance in filing your claim, please call the agency listed here. If no agency is listed, please call 800-233-2339 for assistance.

Acknowledgement & Reimbursement Agreements and Authorization to Obtain Information	The Acknowledgement and Reimbursement Agreement and Authorization to Obtain Information must be signed before a claim can be verified and processed for payment.

Acknowledgement and Reimbursement Agreement: The decision to approve my claim is that of the Program. I may object to all or part of the Program's decision in writing within 30 days from the date of the decision. I must prove the exact amount of my losses before the Program will consider awarding compensation from the Crime Victims Compensation Fund. I may later file for reimbursement of any additional expenses incurred relating to the crime. My claim may be denied if I do not cooperate fully with law enforcement agencies, the courts, and the Program, or maintain a valid address with the Program. Making a false claim would be a criminal offense under 18 P.S.§ 11.1303 of the Crime Victims Act. Making a false statement in this claim form with the intent to mislead the Program would be a criminal offense under 18 Pa. C.S. § 4904, Unsworn Falsification. Making a false statement which the Program relies upon to award compensation is a criminal offense under 18 Pa.C.S.§ 3922, Theft by Deception.

I understand that the Crime Victims Compensation Fund is the payor of last resort. I specifically agree to inform the Program of and repay to the Commonwealth any funds that I may receive from any other source that has not already been considered, as a result of the crime and to the extent of the award. That is, I agree to repay any funds that I receive from the offender or any other person or source, which compensates me for the injury I suffered, including proceeds from an insurance policy, as well as any award or settlement from a civil law suit, which was stems from the crime that is the basis for this claim. I further agree that if the claim is at any time determined to be in error, false or fraudulent, I will refund the Program all sums of money paid by the Program.

Authorization to Obtain Information: I hereby authorize any funeral director or other person who rendered related services, any employer of the victim or claimant, any police or government agency, including state or federal taxing authorities, any insurance company, or any organization having relevant knowledge to furnish to the Office of Victims' Services, Victims Compensation Assistance Program, any and all information in their possession with respect to the crime that is the basis for this claim

_____ _____

Claimant's Signature Date

HIPAA Authorization and Release Agreement	If applying for medical or counseling expenses, this acknowledgement must be signed before the claim verification process can begin.

I hereby authorize, in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 42 U.S.C. § 1320d, et seq.), any hospital, physician, health care provider or other person who attended, examined, or provided treatment to _____ (print name of victim) to furnish to the Office of Victims' Services, Victims Compensation Assistance Program any and all information in their possession with respect to the crime that is the basis for this claim. Copies of this authorization may be used in place of the original. **I understand that I may revoke this authorization at any time by providing the Office of Victims' Services, Victims Compensation Assistance Program, with a written, dated request to do so. Further, this authorization expires in 5 years from the date of my signature below or on the date that this claim is closed, whichever is sooner.

_____ _____

Claimant's Signature Date

Victim Statistical Information	Completion of this section is strictly optional. The following information is used for statistical purposes only.

Race/Ethnicity: □ White □ Black/African American □ Hispanic/Latino □ American Indian/Alaskan Native
□ Asian □ Native Hawaiian/Other Pacific Islander □ Some Other Race □ Multiple Races

Gender: _____ Primary Language: _____

How did you find out about the Program: □ Hospital □ Prosecutor □ Brochure □ Police □ Website/App
□ Victim Service Program □ Other _____

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