NJ Victims of Crime Compensation Office
Claim Information and Application Instructions

New Jersey has a Crime Victim's Compensation Fund to help with costs related to injuries received in a violent crime. To find out more, read this information sheet or call the Victim/Witness Office in your County Prosecutor's Office. A link to the list can be found on the VCCO's website www.njvicitm.org.

How much help can I get from the New Jersey Victims of Crime Compensation Office (VCCO)?

If you qualify, these are some of the expenses that can be paid.

- Mental Health counseling
- Loss of support or earnings
- Hospital, physician and physical therapy
- Nursing care
- Care of child or dependent
- Funeral expenses up to $5,000
- Emergency Relocation Costs
- Attorney fees for assistance in filing a claim and representing you in the appeal process

How do I qualify for financial help?

If you are a victim or claimant (person filing for a victim or dependents of the victim), you must show that:

- You are a resident of the State of New Jersey or the crime occurred in this State.
- You have financial losses as a result of injuries you received as a result of a violent crime or certain other crimes.
- The crime was reported to law enforcement within 3 months, and you submitted this application within 2 years from the date of the crime. Consideration will be taken if "good cause" exists for delayed filing.
- You cooperated with the police and prosecutor's office. However, eligibility is not dependent upon conviction or prosecution of the offender.
- You or your immediate family member have incurred, or will incur, medical, counseling, funeral bills, lost time from work and/or other losses because of injuries directly resulting from the crime.
- Insurance and other payment sources such as restitution paid by the offender will not cover the bills submitted.
- You did not contribute to your injuries, provoke the incident, and were not responsible for or participated in the crime that caused your injuries.
- You do not have any outstanding VCCO assessments imposed for convictions. If you cannot provide proof to the VCCO that they were paid, the outstanding amount will be deducted from your compensation award.

What losses are not covered?

- Property damage or loss, except crime scene cleanup.
- Pain and suffering.

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New Jersey Victims of Crime Compensation Office Claim Application Instructions

Read the following instructions and fill out the attached claim application. Also include copies of as much related information (i.e. copies of itemized receipts, bills, insurance statements) as you have.

The more information we have now, the sooner your application can be processed. You can send more itemized bills later as you receive them.

The VCCO will send you a letter when your application is received. If you have not received a letter after four weeks, please call the VCCO. Keep in touch. If you move or if your phone number changes, please let us know.

How can I get help with this application?

Help can be found through law enforcement agencies, your County Office of Victim/Witness Advocacy or by contacting us at 1-877-658-2221.

SECTION 1: VICTIM INFORMATION
Print the name of the person injured at the crime scene. This should be the same person listed as the "Victim" on the law enforcement report. Complete the rest of this section with information about the victim.

SECTION 2: CLAIMANT INFORMATION
Print the name of the person applying for compensation if different than the victim. This person may also be the adult assuming responsibility for the crime-related bills or the financially responsible person (e.g. parent, guardian, spouse) of a minor, incapacitated or incompetent person injured as a result of the crime.

SECTION 3: ADDITIONAL INFORMATION
Print the name of a person that the VCCO may contact if we are unable to reach you.

SECTION 4: CRIME INFORMATION
Print details about the crime here. Attach a copy of the incident report. If you don't have one, the VCCO will request one from the police and/or prosecutor. The law enforcement incident report on the crime is necessary to determine your eligibility and process the claim.

SECTION 5: EXPENSE INFORMATION
List the names of doctors, hospitals and others who have provided services. If you already have itemized bills, please send copies with your application. If you have not received bills, do not wait on them. You may send copies later as you receive them. The VCCO can only pay for counseling from a licensed counselor. The VCCO will send your counselor a psychological assessment form to be completed relating the mental health treatment to the crime. This form must be completed by your counselor.

SECTION 6: INSURANCE INFORMATION
If you have insurance that may cover some of your crime-related bills, list your insurance information here.

SECTION 7: EMPLOYMENT INFORMATION
List your job information if you have not been able to work because of crime-related injuries or to take care of someone with crime related injuries. Your employer will need to complete an Employer's Questionnaire, giving us your average weekly wage and time missed from work. The doctor treating the Victim will need to complete the Physician's Certification, telling us that the absence from work is medically necessary because of the crime.

SECTION 8: CIVIL ACTION INFORMATION
If you hired a lawyer to represent you in this claim before the VCCO or to settle an insurance claim or file a lawsuit related to this crime, complete this section.

SECTION 9: REFERRAL SOURCE INFORMATION
Print the name of the victim advocate or other professional who assisted you with this application.

SECTION 10: LEGAL RESPONSIBILITY AND SIGNATURE INFORMATION
This application is a legal document that must be read and signed by the adult Claimant.

SECTION 11: AUTHORIZATION TO OBTAIN RECORDS INFORMATION
This Authorization to Obtain Records is necessary to obtain information from your doctors, hospital, employer, police and prosecutor, so that the VCCO can process your claim.

SECTION 12: ASSIGNMENT OF INTEREST INFORMATION
This is a legal agreement that must be signed in order for the VCCO to pay compensation to you.

SECTION 13: AUTHORIZATION FOR RELEASE OF INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT INFORMATION
This authorization is necessary to obtain information from your health care providers under a new federal law. It must be completed, signed and dated in order for the VCCO to process your claim.

New Jersey Office of the Attorney General
Victims of Crime Compensation Office
50 Park Place • Newark • New Jersey 07102
973-648-2107 • www.njvictims.org

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FOR OFFICIAL USE ONLY
Application No. ____________
Claim No. ____________
☐ Death ☐ Personal Injury
E.S.C. ____________

Claim Application

SECTION 1: VICTIM INFORMATION

The victim is the same person listed as a victim on the crime incident report. *(complete a separate application for each victim)*
The claimant is the person applying for compensation. Do not complete SECTION 2 if the victim is the claimant.

◯ Mr. ◯ Mrs. ◯ Ms. *(Choose One)*

Full Legal Name of Victim ______________________________

Name as it appears on the incident report ______________________________

Social Security Number ______ - _____ - ________ Date of Birth _____ / _____ / _____

Check if Victim is: ◯ Deceased (Date of death _____ / _____ / _____) ◯ Under 18 ◯ Incompetent ◯ Disabled

Relationship of victim to the offender, if any ______________________________

Home Mailing Address ______________________________

City ______________ County ____________ State ______ Zip Code ________

Home Phone (_____) ______ - ________ Work Phone (_____) ______ - ________

Cell Phone (_____) ______ - ________ Email ______________________________

Check services requested: ◯ Medical ◯ Mental Health Counseling ◯ Lost Wages/Support ◯ Funeral ◯ Emergency Relocation ◯ Dental ◯ Other ______________

OPTIONAL INFORMATION *(for statistical purposes)*

Sex: ◯ Male ◯ Female

Race: ◯ Caucasian ◯ African American ◯ Latino ◯ Native American ◯ Asian or Pacific Islander ◯ Other ______________

SECTION 2: CLAIMANT INFORMATION

◯ Mr. ◯ Mrs. ◯ Ms. *(Choose One)*

Full Legal Name of Claimant ______________________________

Social Security Number ______ - _____ - ________ Date of Birth _____ / _____ / _____

The Claimant is the Victim's ◯ Spouse ◯ Parent ◯ Sibling ◯ Child ◯ Other ______________

Home Mailing Address ______________________________

City ______________ County ____________ State ______ Zip Code ________

Home Phone (_____) ______ - ________ Work Phone (_____) ______ - ________

Cell Phone (_____) ______ - ________ Email ______________________________

SECTION 3: ADDITIONAL CONTACT

A person that the Victim/Claimant is comfortable with the VCCO reaching out to if the Victim/Claimant is not available.

Name ____________________

Relationship: ◯ Parent ◯ Sibling ◯ Friend ◯ Attorney ◯ Other ____________

Address ____________________

City ____________ County ____________ State ________ Zip Code ________

Phone (______) ______ - ________ Work Phone (______) ______ - ________

Cell Phone (______) ______ - ________ Email ____________________

SECTION 4: CRIME INCIDENT INFORMATION

Attach a copy of the law enforcement incident report, if available.

Date of Crime _____ / _____ / _____ Date Reported _____ / _____ / _____

Name of Law Enforcement Agency ____________________

Location/Address of Crime ____________________

City ____________ County ____________ State ________ Zip Code ________

Police Complaint Number ____________ Prosecutor's File Number ____________

Type of Crime: ◯ Assault ◯ Homicide ◯ Sexual Assault ◯ DWI ◯ Domestic Violence

◯ Other ____________________

Brief Description of Incident: ____________________

____

____

Please describe your injuries: ____________________

____

____

____

Name(s) of Offender(s), if known: ____________________

____

If the crime was not reported to law enforcement within three months or if this claim was not filed within two years after the crime please explain why: ____________________

____

SECTION 5: CRIME-RELATED EXPENSE INFORMATION

Attach copies of itemized bills and additional pages as necessary. Indicate the type and quantity of items attached:

◯ Doctor Bills ______ ◯ Mental Health Bills ______ ◯ Funeral Home Bills ______

◯ Hospital Bills ______ ◯ Relocation Expenses ______ ◯ Loss of Earnings/Support ______

SECTION 6: HEALTH INSURANCE/BENEFITS INFORMATION

List Health, Life and Automobile Insurance policies including Medicaid and Medicare with policy or identification number.

◯ Health Insurance ______________________ Policy No. ______________________

◯ Life Insurance ______________________ Policy No. ______________________

◯ Auto Insurance ______________________ Policy No. ______________________

◯ Medicaid/Medicare ______________________ Policy No. ______________________

If you checked life insurance, was there a double indemnity clause? ◯ Yes ◯ No

If Yes, what was the amount paid out under that portion of the policy? $ ____________

If you do not have insurance, did you apply for charity care? ◯ Yes ◯ No

SECTION 7: LOST WAGES/SUPPORT INFORMATION

Complete if you have lost time from work because of your injuries or to take care of an injured victim.
(If more than one employer, please attach additional sheets)

Employee Name ____

Company Phone (______) ______ - ________ Company Fax (______) ______ - ________

Company/Business Name ____

Company/Business Address ____

City ______________ County ______________ State ______ Zip Code ______

Dates absent from work due to crime related injuries: _____ / _____ / _____ to _____ / _____ / _____

If injured on the job, does your employer have Worker's Compensation? ◯ Yes ◯ No

Have you applied for State or Private Disability for reimbursement for lost wages? ◯ Yes ◯ No
If YES, supply all notices received from State Disability or a private disability plan.

Is your household losing income/paychecks due to the crime? ◯ Yes ◯ No

Are you missing work to care for the victim? ◯ Yes ◯ No

- If available, please supply your pay stubs from the week before the crime, the week you returned to work and a letter from your doctor stating your period of disability.
- If you are self-employed, you must supply copies of your income tax returns and business tax returns for the last 2 years before the crime.
- Loss of support may be awarded for dependents of homicide victims. Please supply copies of the victim's income tax returns for the last three years.

SECTION 8: ATTORNEY INFORMATION

A. Have you hired an attorney to represent you in this claim? ◯ Yes ◯ No

Name of Attorney ______________________________

Address ______________________________

City ______________ County ______________ State ________ Zip Code ____________

Home Phone (________) ________ - ____________

B. Have you hired an attorney to represent you in a civil suit or with an insurance company? ◯ Yes ◯ No

Name of Attorney ______________________________

Address ______________________________

City ______________ County ______________ State ________ Zip Code ____________

Phone (________) ________ - ____________ Docket Number (if available) ____________

C. I intend to file a lawsuit at a later date ◯ Yes ◯ No

D. Has restitution been ordered? ◯ Yes ◯ No

SECTION 9: REFERRAL INFORMATION

Who referred you to the VCCO? ◯ Police ◯ Friend/Relative ◯ Prosecutor ◯ Victim Witness Coordinator ◯ Domestic Violence/Rape Crisis Center ◯ Hospital ◯ Funeral Home ◯ Other ____________

SECTION 10: LEGAL AUTHORIZATION AND SIGNATURE

This is a legal document which must be signed by an adult.*

Program Qualification:
I understand that I am responsible for all bills and the compensation program is designed to pay certain costs not covered by another source. Submitting this application does not entitle me to benefits.

Reimbursement:
I agree to repay the VCCO if I receive money from another source up to the amount paid on my behalf. This includes any payment I may receive from the offender, any insurance policy or settlements, judgments, or civil law suits.

The information I have provided in this application is true and correct to the best of my knowledge under penalty of law

X ______________________________ Date ______________

Signature of Victim/Claimant

** Legal representative must sign if the victim is under 18, legally declared incompetent or deceased.*

SECTION 11: AUTHORIZATION TO OBTAIN RECORDS

I, ____, authorize the NJ Victims of Crime Compensation Office (VCCO) or its agent, representative or bearer to inspect, review and make copies, including photostatic copies, of all medical records and records pertaining to employment, earnings, income or grant from any agency, attendance and any other records pertaining to or related to employment or economic assistance, and police and prosecutors reports necessary to determine qualification for my claim for compensation. *Photocopies of this authorization will be considered as valid as the original.*

X ____ Date ______________________________

Signature of Victim/Claimant

Legal representative must sign if the victim is under 18, legally declared incompetent or deceased.

SECTION 12: ASSIGNMENT OF INTEREST

I, ____, understand that New Jersey law requires me to reimburse the NJ Victims of Crime Compensation Office (VCCO) for any monies I may receive from other sources. I shall contact the VCCO upon receipt of such additional monies from the offender, civil law suit, restitution, insurance program, or any other governmental or private agency.

I further assign and give to the VCCO the right to be directly reimbursed for two-thirds of the VCCO's award to me from the proceeds of any civil law suit I have started or will start arising out of this incident.

I also assign and give to the VCCO the right to be reimbursed from Probation, the Juvenile Justice Commission, the Department of Corrections for the amount to be paid to me in the way of restitution ordered by the court in any criminal proceedings related to the incident. Reimbursement to the VCCO shall be limited to expenses for which the VCCO has awarded me compensation.

I certify that I am signing this Assignment of Interest freely and voluntarily. I understand that this Assignment must be signed in order to receive compensation. I further certify that if at any time I initiate a civil lawsuit, I will provide a copy of this Assignment of Interest to my attorney with the instruction that my attorney is bound by its terms. I understand that VCCO is relying in good faith on this Assignment in order to pay compensation to me.

X ____ Date ______________________________

Signature of Victim/Claimant

Legal representative must sign if the victim is under 18, legally declared incompetent or deceased.

SECTION 13: AUTHORIZATION FOR RELEASE OF INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Patient's Name ______________________ Social Security Number _____ - ____ - ______

Date of Birth ____ / ____ / ____ Phone (_____) _____ - ______

Address ____

City ______________ County ______________ State ______ Zip Code ______

I authorize the use and disclosure of health information about me as described below

Facility Authorized to Release my Health Information: ______________________

Agency or Individual(s) Authorized to Receive my Health Information: ***NJ Victims of Crime Compensation Office***

Health Information that may be used/disclosed is limited to the following:

- ◯ Discharge Summary
- ◯ Consultation(s)
- ◯ Pathology Report
- ◯ Lab
- ◯ History & Physical
- ◯ Operative Notes(s)
- ◯ Imaging/X-ray
- (X) Entire Record
- ◯ Other (specify) ______________________

Health information that may be used/disclosed is limited to the following Treatment Dates: ______________________

____

Health information to be released to the above named agency/individual is to be used/disclosed for the following purpose(s) (include Research or Marketing, if appropriate): To determine the amount of compensation the patient is entitled to receive, including the payment of any outstanding bills for services rendered by the facility to the patient.

Health information identifies you (the patient) by name, and includes other demographic information about you. Health information may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc. I hereby discharge the releasing facility its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPPA) privacy regulations.

Patient's or Authorized Personal Representative's Signature X	Date	Time ◯ A.M. ◯ P.M.
Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter, if utilized	
Witness Signature X	Expiration Date or Event	