OFFICE OF THE ATTORNEY GENERAL

BUREAU OF VICTIM COMPENSATION CLAIM FORM

PL-01, The Capitol, Tallahassee, FL 32399-1050 • Information and Referral: (800) 226-6667 • Fax: (850) 414-6197
Bill Status Information for Providers: (850) 414-3331 • Hearing Impaired Users May Call Through Florida Relay: (800) 955-8771
Website: MyFloridaLegal.com • Web Portal: https://VANext.MyFloridaLegal.com • Email: VCIntake@MyFloridaLegal.com

Instructions

Please read the Eligibility Requirements to see if you qualify for this program. Fill out this form completely (please print), attach all required documentation, and submit to the above address. If you change your mailing address, phone numbers, or email, you are required to notify this office.

CHECK THE TYPE OF VICTIM COMPENSATION BENEFITS YOU ARE REQUESTING:

☐ **DISABILITY** - compensation for the victim who suffered a permanent disability. (Attach documentation as outlined in Section 3.)

☐ **WAGE LOSS** - compensation for the victim who lost wages due to crime related physical injuries. (Attach documentation as outlined in Section 3.)

☐ **LOSS OF SUPPORT** - compensation for the dependent(s) of a deceased victim who was employed at the time of the crime. (Attach documentation as outlined in Section 4.)

☐ **EXPENSES** - payment or reimbursement for funeral/burial, medical, dental, mental health, and/or grief counseling treatment expenses directly related to the crime. (Attach itemized bills and receipts for selected expenses.)

☐ FUNERAL/BURIAL ☐ MEDICAL* ☐ MENTAL HEALTH

☐ GRIEF COUNSELING** ☐ DENTAL

☐ **EMERGENCY ASSISTANCE** - reimbursement for documented wage loss and out-of-pocket expenses related to the crime. (Attach receipts.)

*Includes prescriptions, eyeglasses, dentures and prosthetic devices **For individuals whose relationship with the deceased is a spouse, parent, child, sibling or dependent

CHECK ALL OTHER TYPES OF BENEFITS YOU ARE REQUESTING: (Separate claim numbers will be assigned.)

☐ **PROPERTY LOSS** - for the victim over the age of 60 or disabled adult who suffered the loss of tangible personal property as the result of a criminal or delinquent act. Attach proof of disability prior to the date of crime from the Department of Veteran Affairs, Social Security Administration, or a Property Loss Disability Verification Form (BVC410), and a receipt or written estimate from a vendor or merchant identifying the comparable replacement value. Compensable items must be identified by the law enforcement report.

☐ **SEXUAL BATTERY RELOCATION ASSISTANCE** - for the victim of sexual battery seeking assistance to relocate due to a reasonable fear for his or her safety. A completed Relocation Certification Worksheet (BVC106) from a certified rape crisis center must be received.

☐ **DOMESTIC VIOLENCE RELOCATION ASSISTANCE** - for the victim of domestic violence seeking assistance to relocate to a safe environment. A completed Relocation Certification Worksheet (BVC106) from a certified domestic violence center must be received within 30 days from the date of crime.

☐ **HUMAN TRAFFICKING RELOCATION ASSISTANCE** - for the victim of sexual trafficking with an urgent need to relocate. A completed Relocation Certification Worksheet (BVC106) from a certified rape crisis or domestic violence center must be received within 45 days of the crime or last identifiable threat.

Section 1. Victim and Applicant Information

VICTIM'S NAME (last, first, middle)			DATE OF BIRTH / /
SOCIAL SECURITY NO.	E-MAIL ADDRESS	WOULD YOU LIKE ALL CORRESPONDENCE SENT BY EMAIL?	☐ YES ☐ NO
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER ( )	OCCUPATION	

THIS INFORMATION IS COLLECTED FOR FEDERAL REPORTING PURPOSES AND IS OPTIONAL.

RACE/ETHNICITY: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC or LATINO ☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER ☐ WHITE NON-LATINO/CAUCASIAN ☐ OTHER RACE ☐ MULTIPLE RACES

GENDER: ☐ Male ☐ Female	NATIONAL ORIGIN	WAS VICTIM DISABLED BEFORE THE CRIME OCCURRED? ☐ YES ☐ NO

The applicant filing on behalf of a victim is required to provide claimant information below. When requesting compensation on behalf of an incompetent adult victim, proof of legal guardianship must be attached, and the applicant's signature on the claim form must be witnessed by a Notary Public.

IS THE VICTIM (check one) ☐ DECEASED ☐ INJURED MINOR ☐ MINOR WITNESS - NOT INJURED ☐ INCOMPETENT

APPLICANT NAME (last, first, middle)			DATE OF BIRTH / /
SOCIAL SECURITY NO.	E-MAIL ADDRESS	WOULD YOU LIKE ALL CORRESPONDENCE SENT BY EMAIL?	☐ YES ☐ NO
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER ( )	ALTERNATE PHONE NUMBER ( )	RELATIONSHIP TO VICTIM	OCCUPATION

Section 2. Referral Source Information

Individuals who assisted with or filled out any sections of this application are required to provide referral information below. By signing this application, the victim/applicant affirms that all information provided is true and correct, and thus, all sections should be reviewed before the application is signed. (Treatment providers can request training on the Victim Compensation Program, which is recommended prior to becoming a referral source.)

NAME OF PERSON ASSISTING WITH APPLICATION (last, first, middle) | E-MAIL ADDRESS

NAME OF AGENCY/ORGANIZATION

AGENCY/ORGANIZATION'S ADDRESS (address, city, state, zip code) | TELEPHONE NUMBER ( )

Section 3. Disability or Lost Wages Information

When requesting compensation for wage loss, attach a completed Victim Compensation Wage Loss Employment Report (BVC405), or if you are self-employed or work for a family member, attach a copy of your latest filed income tax return and applicable IRS schedule forms. If more than 40 hours of work were missed, attach a completed Victim Compensation Treatment Disability Statement (BVC409). When requesting permanent disability compensation, attach a completed Victim Compensation Treatment Disability Statement (BVC409).

SUPERVISOR'S NAME | TELEPHONE NUMBER ( )

NAME OF COMPANY/BUSINESS
(if more than one [1] employer, please attach additional sheet)

COMPANY ADDRESS
(address, city, state, zip code)

IS WAGE LOSS COVERED BY INSURANCE? ☐ YES ☐ NO | IS VICTIM DISABLED AS A RESULT OF THE CRIME? ☐ YES ☐ NO

IS WAGE LOSS COVERED BY WORKER'S COMPENSATION? ☐ YES ☐ NO

Section 4. Loss of Support and/or Grief Counseling Information

Indicate the name(s), date(s) of birth, and relationship to the deceased victim for any surviving spouse, parent, child, sibling, or dependent. For persons under the age of 18, also indicate who has guardianship of the minor. Attach income tax returns showing earnings for one to three years preceding the date of the crime, or alternatively a Victim Compensation Wage Loss Employment Report (BVC405) to document earnings preceding the crime. Also attach proof of dependency established based upon the victim's federal income tax return, marriage certificate, birth or death certificate, copy of approval for Social Security Administration survivor benefits, or court order for support.

DEPENDENT/MINOR CLAIMANT NAME(S)	DATE OF BIRTH	RELATIONSHIP TO VICTIM

Section 5. Insurance Information

Victims who are determined eligible for the Victim Compensation and Property Loss Programs may be exempt from the insurance deductible or co-payment provisions of their insurance policy(ies).

IS INSURANCE OR MEDICAID AVAILABLE TO ASSIST WITH THESE EXPENSES? ☐ YES ☐ NO MEDICAID NUMBER: _____

If yes, provide the following for all insurance policies, including Medicaid, Medicare, life, homeowner's, automobile, or major medical. Attach all related insurance Explanation of Benefits statement(s).

1. COMPANY NAME | POLICY NUMBER | TELEPHONE NUMBER ( )

ADDRESS | CITY | STATE | ZIP CODE

2. COMPANY NAME | POLICY NUMBER | TELEPHONE NUMBER ( )

ADDRESS | CITY | STATE | ZIP CODE

Section 6. Other Compensation, Settlement, and Attorney Information

You must notify this office if you have received, or if you anticipate receiving compensation or any benefits from any other source as a result of this incident. You must also notify this office if you have or are planning to hire an attorney to represent you as a result of the incident.

STATE THE SOURCE AND DATE RECEIVED (IF APPLICABLE) | ARE YOU REPRESENTED BY LEGAL COUNSEL? ☐ YES ☐ NO | ATTORNEY'S NAME

ADDRESS | E-MAIL ADDRESS

CITY | STATE | ZIP CODE | TELEPHONE NUMBER ( )

Section 7. Crime Information

This section must be completed and proof of crime (such as a law enforcement report or charging affidavit) must be attached. Failure to submit proof of crime will result in your application not being processed or your claim being denied.

NAME OF LAW ENFORCEMENT AGENCY	DATE OF CRIME	DATE REPORTED TO LAW ENFORCEMENT AGENCY

WAS THE CRIME REPORTED TO LAW ENFORCEMENT WITHIN 120 HOURS? ☐ YES ☐ NO

If no, please explain. (If no, failure to provide an acceptable explanation in this section will result in a denial of benefits.)

IS THE APPLICATION AND ACCEPTABLE DOCUMENTATION PROVING A COMPENSABLE CRIME OCCURRED BEING SUBMITTED WITHIN THREE YEARS FROM THE DATE OF CRIME?
☐ YES ☐ NO If no, please explain. (Please be advised that most benefits apply to treatment losses suffered within one year from the date of crime, with some exceptions for minor victims. If no, failure to provide an acceptable explanation in this section will result in a denial of benefits.)

TYPE OF CRIME AS SPECIFIED ON THE LAW ENFORCEMENT REPORT		LAW ENFORCEMENT REPORT NUMBER
NAME OF LAW ENFORCEMENT OFFICER	NAME OF OFFENDER (if known)	
NAME OF ASSISTANT STATE ATTORNEY HANDLING THE CASE (if applicable)		STATE ATTORNEY/ CLERK OF COURT CASE NUMBER (if applicable)

Section 8. Eligibility Requirements

Additional qualification criteria, deadlines, and exceptions not listed may apply.

Victim Compensation (VC): The victim must have suffered a physical injury or death as the result of a compensable crime; a psychiatric or psychological injury as a result of a forcible felony; or a mental injury as a result of child abuse as diagnosed by a psychologist or physician.

Property Loss (PL): The victim must have suffered a substantial diminution in their quality of life from the loss of tangible personal property as the result of a criminal or delinquent act. Property loss benefits cannot exceed the maximum payment amount determined by the Schedule of Benefits on any one claim, and a lifetime maximum of $1,000 on all claims.

Domestic Violence Relocation Assistance (DV): The victim must need immediate assistance to escape a domestic violence environment. The Relocation Certification Worksheet (BVC106) certified by a domestic violence center in the State of Florida is required and must be received within 30 days after the domestic violence crime occurred.

Relocation for Victims of Sexual Battery (RS): The victim must need to relocate due to a reasonable fear for his or her safety. The Relocation Certification Worksheet (BVC106) certified by a rape crisis center in the State of Florida is required and must be received within three years after the sexual battery crime occurred.

Human Trafficking Relocation Assistance (HT): The victim must have an urgent need to escape from an unsafe environment directly related to a sexual human trafficking offense. The Certification Worksheet (BVC106) certified by a domestic violence or rape crisis center in the State of Florida is required and must be received within 45 days of the crime or last identifiable threat communicated with the proper authorities.

Basic Eligibility Requirements: The victim must cooperate fully with law enforcement officials, State Attorney's Office, and the Attorney General's Office. The crime must be reported to the proper authority within 120 hours, unless there is good cause for delayed reporting. Applications must be received within three years, or within five years with good cause after the crime, the crime related death of the victim or intervenor, or after the date the death of the victim or intervenor is determined to be the result of a crime. Exceptions for filing time requirements apply to victims who are minors. The victim must not have engaged in an unlawful activity or contributed to the situation that brought about his or her own injury or death.

Criminal History Record Check: In order for compensation to be considered, the victim, and if applicable the applicant, must not have been confined or in custody in a county or municipal facility; a state or federal correctional facility; or a juvenile detention commitment, or assessment facility; adjudicated as a habitual felony offender, habitual violent offender, or violent career criminal; or adjudicated guilty of a forcible felony offense.

Notice of Payment Limitations: The Bureau of Victim Compensation may provide financial assistance to or on behalf of qualified crime victims, but only after all other sources of payment have been exhausted. Payments accepted by in-state providers on behalf of victims are considered payment-in-full per Florida Statute. Total victim compensation benefits cannot exceed the maximum payment amount determined by the Schedule of Benefits. Limits below the maximum may apply and can be reduced without prior notice to the award recipient based on the availability of funding.

Relocation Payment Limitations: A standard housing contract or a Notification of Residential Agreement (BVC110) is required at the time of application. Only short-term interim shelter, rental agreements, or long-term leases for a new location qualify. A victim whose relocation claim is determined eligible and payment is made must accept funds at the certifying domestic violence or rape crisis center within 30 days of payment issuance, and are required to submit and the department receive itemized documentation within 45 days from payment issuance, proving funds were used to satisfy the housing contract or agreement. Total relocation benefits cannot exceed the maximum payment amount determined by the Schedule of Benefits on any one claim and a lifetime maximum of $3,000 on all claims for that benefit type.

Acceptable Proof of Crime: The Bureau of Victim Compensation does not make an independent judgment on whether a compensable crime occurred, but instead relies on proof of crime from the proper authorities. Failure to provide acceptable documentation proving that a compensable crime occurred shall result in your application not being processed or your claim being denied. Acceptable documentation for proof that a compensable crime occurred shall include a law enforcement report; affidavit charging an individual with a crime filed by law enforcement; information charging an individual with a crime filed by a state attorney; indictment by a grand jury; written communication from any federal law enforcement agency; cybercrime investigator certification for purposes of s. 960.197, Fla. Stat.; or Law Enforcement Information Reporting Form (BVC430).

Complete Application Package: It is your responsibility to provide a complete application package which includes acceptable documentation proving that a crime occurred. If the department receives a report which is insufficient for proving that a compensable crime occurred, the application will be assigned a claim number and denied. Claim numbers assigned are not indicative of eligibility or denial. For assistance with collecting acceptable documentation, please contact your local law enforcement agency, the agency where the crime was reported, the referral source, or your local State Attorney's Office.

PLEASE READ CAREFULLY AND SIGN THE FOLLOWING CERTIFICATIONS

Section 9.

CONFIDENTIALITY: If you are the victim of a sexual battery, aggravated child abuse, aggravated stalking, harassment, aggravated battery, or domestic violence, you have the right to have information about your home address and telephone number, employment address and telephone number, and your personal assets, kept confidential for a period of five years. If you are the victim of any of these crimes, please mark one of the following statements. Your response will not affect the processing of your claim.

☐ I want the information to be confidential ☐ I do NOT want the information to be confidential

SERIOUS FINANCIAL HARDSHIP: I certify that I have a serious financial hardship because of crime-related expenses that cannot be paid by any other source.

PROPERTY LOSS CERTIFICATION: I certify that the property in question belonged to the victim; that this loss adversely affects the victim's quality of life; that there is no other source of reimbursement for this loss; and that replacement of the property would cause the victim a serious financial hardship.

RELEASE OF INFORMATION: I give permission to any hospital, doctor, dentist, mental health counselor, or other treatment provider, banking institution, social service agency, law enforcement agency, corrections agency, state attorney's office, insurance carrier, attorney or employer to provide information that is requested concerning any treatment rendered, employment, insurance, third-party payer, or law enforcement investigative information to the Bureau of Victim Compensation for use in processing my claim. I give permission to the Bureau to release information about the status of my claim to any treatment provider, law enforcement agency, or state attorney's office.

SOCIAL SECURITY NUMBER DISCLOSURE: The Bureau of Victim Compensation collects and uses Social Security numbers for the purpose of performing imperative duties and responsibilities which may include the following: searching criminal history records, identity management, billing and payments, benefit processing, and reporting to authorized state and federal government agencies. Failure to provide this optional information may delay the processing of your application or benefits. Federal and State laws require the Bureau to protect Social Security numbers from disclosure to unauthorized parties. Absent a waiver from you or your legal representative, Social Security numbers will be redacted, unless the agency receives a court order to turn over a non redacted file.

REPAYMENT REQUIREMENT: I understand that I must notify the Bureau of Victim Compensation before a civil settlement, restitution order, and/or any proceeds are obtained by any source. I acknowledge that the Bureau of Victim Compensation is the payor of last resort and that I must repay the Crimes Compensation Trust Fund if I receive compensation and also receive payment from another source as a result of the same criminal incident. Other sources include, but are not limited to, any payment from the offender, insurance policy, settlement, agreement, judgment, or an award in a third-party lawsuit. I also understand that if eligibility is rescinded or withdrawn, I must repay any amount received or paid on my behalf by the Crimes Compensation Trust Fund.

VICTIM: Must be signed and dated by the victim if filing as a competent adult.

Printed Name: _____

Signature: _____ Date: _____

Under penalty of perjury or fraud, the information I have provided is true and correct to the best of my knowledge.

APPLICANT: Applicant signature is required if filing as the parent, legal guardian, or individual authorized to administer a victim's estate.

Printed Name: _____

Signature: _____ Date: _____

Under penalty of perjury or fraud, the information I have provided is true and correct to the best of my knowledge.

NOTARIZATION REQUIREMENT: Persons submitting an application on behalf of an incompetent adult must submit proof of legal guardianship and have their signature witnessed by a Notary Public.

Sworn to and subscribed before me this _____ day of _____, 20 _____.

☐ Personally known to me. ☐ Identification produced.

Notary Public Signature: _____ Stamp/Seal: