



New York State Office of Victim Services

Claim Application and Instructions

1 Columbia Circle, Suite 200
Albany, NY 12203-6383
(518) 457-8727

55 Hanson Place, Room 1000
Brooklyn, NY 11217-1523
(718) 923-4325

65 Court Street, Room 308
Buffalo, NY 14202-3406
(716) 847-7992

How to Apply for Compensation

Who can apply for compensation?

Innocent victims of crime, certain relatives, dependents and the guardian can apply to OVS (Office of Victim Services) for compensation of out-of-pocket expenses not covered by insurance or other resources.

What kinds of expenses can I get compensated for?

OVS offers compensation related to personal injury, death and loss of essential personal property.

The specific expenses OVS may cover include:

- Medical, pharmacy and counseling expenses
- Loss of Essential Personal Property (*up to \$500, including \$100 for cash*)
- Burial or Funeral Expenses (*up to \$6,000*)
- Lost Wages or Lost Support (*up to \$30,000*) (*Parents or guardians of hospitalized minor children may be eligible for this benefit.*)
- Transportation (court/medical)
- Occupational/Vocational Rehabilitation
- Security and Shelter
- Crime scene clean-up (*up to \$2,500*)
- Good Samaritan property losses (*up to \$5,000*)

How do I ask for compensation?

Send us your completed OVS application along with copies of:

- Police reports
- Medical bills
- Correspondence with insurance companies or benefits plan saying if they will cover your loss
- Insurance cards
- Receipts for essential personal property
- Death certificate and funeral contract
- Victim's birth certificate

What if I don't have some of the papers OVS needs?

Send your application in right away. You can send the other documents later.

What if there is not enough room on the application form?

You can attach as many pages as you need to the application form.

Do I need a lawyer to file a claim to OVS?

No. But, if you hire a lawyer to help you with this claim and it is awarded, you can ask OVS to reimburse up to \$1,000 of the legal fees.

What if my property was lost, damaged or destroyed because of the crime?

If you are under 18, 60 or over, disabled or were injured, you may apply for benefits to replace your *essential* personal property or cash that was not covered by any other resource.

Essential means necessary for your health and welfare, like eyeglasses and clothes.

What if I move?

Write to OVS right away. Tell us your new address and phone number. Also let us know if your email address changes.

What if I have questions or need help filing a claim?

We can help you find a victim assistance program near you. Call us at: **1-800-247-8035**

Or visit our website: www.ovs.ny.gov

It's best to fill out the form completely, or it may take longer to process your claim.

Who can sign the claim?

Generally, the victim must sign the claim. However, if the victim is under 18, or is physically or mentally incapable of signing, then the legal guardian (the person receiving the benefits) must fill out section 2 of the claim and sign the claim.

If the victim died, the person asking for benefits must fill out section 2 of the claim and sign the claim.

Do I have to fill out the attached HIPAA form?

Yes. Fill out one HIPAA form for **each** service provider. You can photocopy a blank form to make extra copies.

New York State
Office of Victim Services
1 Columbia Circle, Suite 200
Albany, NY 12203-6383
Tel: 1-800-247-8035
TTY: 1-888-289-9747
www.ovs.ny.gov



Read
How to Apply for
Compensation before
filling out this form.

Application for Compensation

New York State Office of Victim Services



Please print. Answer all questions. *It is a crime to file a false claim!*

Victim Assistance Program Use Only		
OVS VAP ID#	Program Name/Phone	Advocate Name/Email

1 Tell us about the victim.

Last Name	First Name	MI	Social Security # <input type="checkbox"/> Check here if you do not have one. ____ - ____ - ____	Date of Birth	
Mailing Address:					
<i>Street</i>	<i>Apt. # (or P.O. Box)</i>	<i>City</i>	<i>County</i>	<i>State (or Foreign Country)</i>	<i>Zip Code</i>
Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other <input type="checkbox"/> Unknown					
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Lives with partner					
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Was the victim disabled at the time of the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
How did you first hear about the Victim Services Program?					
<input type="checkbox"/> Police <input type="checkbox"/> Hospital <input type="checkbox"/> District Attorney <input type="checkbox"/> Victim Assistance Program <input type="checkbox"/> Radio/TV <input type="checkbox"/> Brochure/Poster <input type="checkbox"/> Internet <input type="checkbox"/> Other					

2 If you are *not* the victim, and are signing this claim, tell us about you. (See "Who can sign the claim?" on the instructions page.)

Last Name	First Name	MI	Social Security # <input type="checkbox"/> Check here if you do not have one. ____ - ____ - ____	Date of Birth	
Mailing Address:					
<i>Street</i>	<i>Apt. # (or P.O. Box)</i>	<i>City</i>	<i>County</i>	<i>State (or Foreign Country)</i>	<i>Zip Code</i>

What is your relationship to the victim? (Check **only one**.)

Parent Spouse Child Guardian Attorney Other (Explain): _____

3 Tell us about the crime. (Check **only one**.)

The victim died because of: <input type="checkbox"/> Motor Vehicle (DWI) <input type="checkbox"/> Motor Vehicle (Other) <input type="checkbox"/> Terrorism <input type="checkbox"/> Arson <input type="checkbox"/> Human Trafficking <input type="checkbox"/> Other Homicide: _____	The victim was injured because of: <input type="checkbox"/> Assault <input type="checkbox"/> Stalking <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Kidnapping <input type="checkbox"/> Child Physical Abuse <input type="checkbox"/> Terrorism <input type="checkbox"/> Child Sexual Abuse <input type="checkbox"/> Arson <input type="checkbox"/> Motor Vehicle (DWI) <input type="checkbox"/> Robbery <input type="checkbox"/> Motor Vehicle (<i>not</i> DWI) <input type="checkbox"/> Human Trafficking <input type="checkbox"/> Other (Explain): _____	The victim lost essential personal property because of: <input type="checkbox"/> Burglary/Robbery <input type="checkbox"/> Arson <input type="checkbox"/> Motor Vehicle (DWI) <input type="checkbox"/> Motor Vehicle (<i>not</i> DWI) <input type="checkbox"/> Human Trafficking <input type="checkbox"/> Other (Explain): _____
--	---	---

Where did the crime happen? (Check **only one**.) Work Owned residence Apt. Bldg. Public Street
 Subway/Bus Parking Lot Restaurant/Bar School/School grounds Shopping Mall Other (Explain): _____

Was this a domestic violence crime? Yes No Unknown

Was the victim driving a livery cab when the crime happened? Yes No Unknown

Was the victim's property lost or damaged while trying to prevent or stop a crime against someone else or while helping the authorities stop the crime? Yes No

Crime Report #: _____ **Police or criminal justice agency reported to:** _____

County where crime happened: _____ Date of crime: _____ Date crime was reported: _____

If more than 7 days between the date of crime and date the crime was reported, explain why: _____

If more than 1 year between the date of crime and the date you are filing this claim, explain why: _____

Describe the crime in your own words: _____

4 Tell us about the suspect. Suspect's name (if you know): _____

- Has the suspect been arrested for this crime? Yes No
 Has the suspect been prosecuted for this crime? Yes No Pending
 Does the suspect live in the same house as the victim
 OR is the suspect a member of the victim's family? Yes No
 Has the court issued an order of protection in this case?.. Yes No (If Yes, attach a copy.)
 Did the court order the suspect to pay restitution? Yes (Amount \$ _____) No Pending

5 Tell us about your expenses related to this crime. (Check all that apply.)

- Medical Medical transportation Funeral/Burial Court Transportation
 Crime Scene Cleanup Loss of Support Lost Wages DV Shelter or Moving
 Security Device/System Vocational/Rehabilitation Counseling Essential Personal Property
 Other (Explain): _____

6 List any essential personal property, like cash, eyeglasses, or clothing that needs to be replaced because of this crime. (If none, skip to 7.)

Describe what was lost/damaged:	Cost	Describe what was lost/damaged:	Cost
1. _____	\$ _____	4. _____	\$ _____
2. _____	\$ _____	5. _____	\$ _____
3. _____	\$ _____	6. _____	\$ _____

Homeowner/Renter Insurance Company	Policy or ID #	Deductible \$
Auto/Other Insurance Company	Policy or ID #	Deductible \$

— If there were no injuries and you are only asking for essential personal property benefits, skip to 15. —

7 If the victim was injured or died because of this crime, fill out below.

Describe the victim's injuries, briefly: _____

Did the victim receive any medical treatment? Yes No (If **No**, skip to section 8.)

Tell us about the health professionals who treated the victim for injuries related to this crime:

	Name	Address	Phone #
First Hospital	_____	_____	(____) _____
Other Hospital	_____	_____	(____) _____
First Doctor (not in hospital)	_____	_____	(____) _____
Other Doctor	_____	_____	(____) _____
First Dentist	_____	_____	(____) _____
Victim's Counselor	_____	_____	(____) _____

8 Tell us about the victim's dependents or others who depended on the victim for support. (If none, skip to 9.)

Dependent	Name	Social Security # ____-____-____	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Dependent	Name	Social Security # ____-____-____	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Dependent	Name	Social Security # ____-____-____	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No

If more than 3 dependents, attach a separate sheet and check here:

9 Did anyone besides the victim receive counseling because of this crime? (If no, skip to 10.)

Who received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			
Who else received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			

If more than 2 people received counseling because of this crime, check here and attach a separate sheet to describe.

10 List any insurance covering the victim or the victim's dependents. If no insurance, write "None" below. If you have applied but are not covered yet, write "Pending" under Policy or ID #.

Primary Insurance Company	Policy or ID #	Name of person(s) covered by this insurance:
Major Medical Insurance Company	Policy or ID #	Name of person(s) covered by this insurance:
Other Insurance (Union, Dental, Vision, etc.)	Policy or ID #	Name of person(s) covered by this insurance:
Medicare	Policy or ID #	Name of person(s) covered by this insurance:
Medicaid	Policy or ID #	Name of person(s) covered by this insurance:
Workers' Compensation	Policy or ID #	Name of person(s) covered by this insurance:
Auto Insurance	Policy or ID #	Name of person(s) covered by this insurance:
Other insurance	Policy or ID #	Name of person(s) covered by this insurance:

11 Tell us about the victim's or the parent's employment and insurance for Lost Wages.

If you do not want us to contact your employer, you cannot ask to be reimbursed for Lost Wages. (Skip to 12.)

Was the victim/parent employed when the crime happened? Yes No (If No, skip to 12.)

Did the victim/parent miss work because of the crime? Yes No

Was the victim/parent self-employed? Yes No (If Yes, attach copies of last year's federal tax return and all schedules.)

Employer's Name, Address, and Phone #:

 Employer Street City State Zip Code Phone # ()

Other Employer's Name, Address, and Phone #:

 Employer Street City State Zip Code Phone # ()

Name, Address, and Phone # of doctor who certified victim could not go to work:

 Doctor Street City State Zip Code Phone # ()

Tell us about any insurance company that will cover the victim's lost time at work. (If none, write "None" below and skip to 12.)

1. Unemployment Insurance	Policy or ID # or "None"	5. Social Security Benefits	SSN - - - - -
2. Disability Insurance	Policy or ID # or "None"	6. SSI Benefits	SSN - - - - -
3. Pension Plan	Policy or ID # or "None"	7. Workers' Compensation	Policy or ID # or "None"
4. Other insurance	Policy or ID # or "None"	8. Other insurance	Policy or ID # or "None"

12 If the victim died, fill out below if you have any burial expenses. (If not, skip to 14.)

Also, attach a copy of the funeral home contract, other bills for burial expenses, and a photocopy of the Death Certificate, if you have them.

Name of Funeral Home: _____ Phone #: ()

Address: _____
 Street City State Zip Code

13 If the victim died, tell us about any life insurance and death benefits.

(If the victim did not die, or does not have any life insurance or death benefits, skip to 14.)

	Company Name	Address	Phone #	Policy or ID #
Life Insurance	_____	_____	(____)	_____
Pension Plan	_____	_____	(____)	_____
Other Insurance/Plan	_____	_____	(____)	_____
Medicaid	_____	_____	(____)	_____
Workers' Compensation	_____	_____	(____)	_____

If any other insurance or death benefits, list here: _____

Do any of these policies cover the victim's burial expenses? Yes No

Has anyone applied for the Social Security Death Benefit? Yes No

14 Tell us about your financial situation. You must fill out ALL sections below. If none, enter zero (0).

How many dependents do you have? _____

What is your total annual income (from ALL sources)? If you are not sure, estimate: \$ _____

List ALL your assets and ALL your debts below. If you are not sure, estimate.

Your Assets – If none, enter zero (0).		Your Debts – How much do you owe now?	
Savings, stocks, bonds	\$ _____		If none, enter zero (0).
Real Property (house, etc.)	\$ _____	Mortgage	\$ _____
Proceeds from life insurance	\$ _____	Loans	\$ _____
Other	\$ _____	Other	\$ _____

15 Is a private lawyer helping with this claim or representing you in a civil suit? Yes No

If Yes: _____ (____)

Lawyer's Name	Address	Phone #
---------------	---------	---------

16 Claimant's Authorization:

If you would like to give permission to a family member, friend or other person to speak to OVS regarding your claim, enter here.

_____ (____)

Name of Person	Address	Phone #
----------------	---------	---------

I ACKNOWLEDGE that accepting an award from the Office of Victim Services (OVS) creates a lien in favor of the State of New York on any recovery relating to the crime upon which this claim is based, including any judgment, settlement or order of restitution. I further authorize any funeral director, attorney, employer, police or other public authority, insurance company or any person who rendered services to the above, or having knowledge of the same, to furnish the OVS or its representatives the following information: Worker's Compensation records, information relating to the crime or any injuries or death suffered as the result of the crime, and information relating to this claim. If an award is made, I authorize the OVS to make payments directly to the provider of services. I also authorize the OVS to share my information and records compiled for this claim with the local Victim Assistance Program (VAP) in order for the VAP to assist the OVS in processing my claim and making its determination. If a private lawyer has been indicated above, I also authorize the OVS to share my information and records compiled for this claim with the lawyer in order for him/her to act as my representative. I understand a separate Notice of Appearance from my lawyer will be needed in addition to this authorization. If a family member, friend or other person is indicated above, I authorize the Office of Victim Services to share my information and records compiled for this claim with that person in order that they assist me with this claim.

A photocopy of this authorization shall be deemed as effective as the original.

_____ (____)

Claimant's Signature	Date	Daytime Phone #
----------------------	------	-----------------

Email: _____ Language you prefer to speak: English Spanish Other _____

To process your claim, mail us the following documents. (Keep a copy for your records.)

- All bills and receipts for services listed on this form
- Your completed, signed claim form
- One completed HIPAA form for each service provider listed on this form (You can photocopy the HIPAA form.)
- Letters from any insurers denying or authorizing payment for the services listed on this form.

Remember: You must bill your insurance company or benefits plan before the OVS can pay.

Mail your documents to:

New York State Office of Victim Services
1 Columbia Circle, Suite 200
Albany, NY 12203-6383



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent: NYS OFFICE OF VICTIM SERVICES – 1 COLUMBIA CIRCLE, SUITE 200, ALBANY, NY 12203-6383

9(a). Specific information to be released:	
<input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____	
<input type="checkbox"/> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.	
<input type="checkbox"/> Other: _____	Include: <i>(Indicate by Initialing)</i>
	_____ Alcohol/Drug Treatment
	_____ Mental Health Information
	_____ HIV-Related Information
Authorization to Discuss Health Information	
(b) <input type="checkbox"/> By initialing here _____ I authorize _____	
Initials	Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:	
NEW YORK STATE OFFICE OF VICTIM SERVICES	
(Attorney/Firm Name or Governmental Agency Name)	

10. Reason for release of information: <i>At request of the individual for purposes of establishing eligibility for New York State Office of Victim Services benefits.</i>	11. Date or event on which this authorization will expire: <i>This authorization will expire upon the termination of the individual's eligibility for Office of Victim Services benefits.</i>
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**