For Office Use Only:

Claim No._____

Washington State Department of Labor & Industries

Crime Victim's Application for Benefits — Injury Claims

Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

Email: CrimeVictimsProgramM@Lni.wa.gov
Fax: 360-902-5333
Visit our website at www.Lni.wa.gov/CrimeVictims for information

Victim Information

Preferred Language (If not English)	Email Address
Name (First, Middle, Last)	
Social Security Number (Optional)	Telephone Number
Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female
Mailing Address	
City	State Zip Code

If the victim is a minor, provide the full name of the parent or guardian applying on the victim's behalf.

Name	Relationship

Who has permission to call CVCP on your behalf?

Name	Relationship
Telephone Number	Email Address

Other Information

How did you find out about the CVCP? Check the box that applies.

☐ Police/Law Enforcement ☐ Prosecutor's Office ☐ Victim Assistance Program Advocate
☐ Victim Witness Service ☐ Hospital ☐ Health Care Provider
☐ Other:

What is your marital status? Check the box that applies.

☐ Married ☐ Single ☐ Domestic Partner ☐ Divorced ☐ Separated

What is your country of origin?

What is your ethnicity? Check the box that applies.

☐ African American ☐ Asian ☐ Caucasian
☐ Hispanic ☐ Native American ☐ Pacific Islander
☐ Other:

Do you have a disability? ☐ No ☐ Yes	Was the disability caused by the crime? ☐ No ☐ Yes

Is the disability:

☐ Physical ☐ Mental ☐ Both

What benefits are you applying for?

☐ Medical ☐ Dental ☐ Mental Health ☐ Wage Loss

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Crime Information

NOTE: The crime must be reported to a police agency

Date of Incident (mm/dd/yyyy)	Date Reported (mm/dd/yyyy)	Time Incident Occurred ☐ AM ☐ PM

Crime Location Address

City	State	Zip Code

Did the crime occur on the job?
☐ No ☐ Yes

What law enforcement agency did you report the crime to?

Check the box that applies:
☐ Police ☐ Washington State Patrol ☐ Federal Bureau of Investigations ☐ Sheriff ☐ Tribal Police

Officer's Name	Telephone Number	Report Number

Type of Crime

☐ Assault	☐ Civil Commitment	☐ DUI	☐ Failure to Secure Load
☐ Sexual Assault	☐ Domestic Violence	☐ Vehicular Assault	☐ Robbery/Burglary

Brief Description of the Crime

Weapon Used	Area of Body Injured	Offender's Name

Was the offender living with you when the incident occurred?
☐ No ☐ Yes

If you were involved in a civil commitment proceeding of a sexually violent predator, when were you contacted about the proceedings?

Date	Who Contacted You	Telephone Number

Have you filed or do you intent to file a civil suit?
☐ No ☐ Yes ☐ Unsure

Attorney Information

Do you have an attorney representing you?
☐ No ☐ Yes

If you have an attorney representing you, check the box that applies:

☐ Attorney is representing me for a personal injury claim (auto-insurance) or lawsuit

☐ Attorney is representing me for both the crime victim claim and a personal injury claim (auto-insurance) or lawsuit

NOTE: *If the attorney represents you on your crime victim claim, all department correspondence will go to your attorney.*

Attorney Name

Email Address	Telephone Number

Address

City	State	Zip Code

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Wage Information

For wage loss benefits, you must have been employed on the date of the injury or employed in the six months before the injury.

Please fill out this section only if you were employed or self-employed at the time of the crime or employed in the six months before the date of the crime and are applying for wage loss benefits. We may contact your employer if necessary. If you have concerns about this, please call us.

Were your employed on the date of the crime?
☐ No ☐ Yes

Were you employed in the six months before the crime?
☐ No ☐ Yes

If yes and you are requesting wage replacement benefits, provide the following employer information

Employer Name	Contact Name
Employer Address	
City	State Zip Code
Telephone Number	Date Last Worked
Have You Returned to Work? ☐ No ☐ Yes	If yes, date you returned to work
Rate of Pay $ ☐ Hour ☐ Day ☐ Week ☐ Month	
Hours Worked Per Day	Days Worker Per Week
Additional Earning $	Additional Earning From ☐ Piecework ☐ Tips ☐ Commission ☐ Bonuses
Did you use sick/vacation leave or disability benefits? ☐ No ☐ Yes	
Annual Income Level. Check the box that applies to you ☐ $0 — $20,000 ☐ $20,001 — $50,000 ☐ $50,001 — $75,000 ☐ $75,001 — $100,000 ☐ $100,000 or more	

Insurance Information

Providing this information will ensure proper payment of medical expenses.

Note: You are required to use any available private or public insurance you have first. The Crime Victims Compensation Program is the last payer of benefits. If you have private or public insurance, your provider must bill your insurer first. Please provide accurate information about any insurance you have to ensure bills are paid correctly.

Do you have insurance? If yes, provide the information requested below.
☐ No ☐ Yes

The Crime Victims Compensation Program is the payer of last resort. Providers should bill your primary insurance first. Please list all available coverage to include: health insurance, dental insurance, vision insurance, HCA/Medicaid, Veteran, Social Security, DSHS/public assistance, workers' compensation, Indian Health, automobile insurance (victim and offender), motorcycle insurance, life insurance, home insurance, renter's insurance. CVCP can only pay benefits after you insurance pays. Attach additional pages if needed.

Insurance Company Name	
Telephone Number	Policy Holder Name
Provide one of the following: Policyholder ID, Group No., or SSN	Date of Eligibility
Insurance Company Name	
Telephone Number	Policy Holder Name
Provide one of the following: Policyholder ID, Group No., or SSN	Date of Eligibility

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Provider Information

If you have already seen a medical or other provider, or are completing this form in a medical office or hospital, please ask the medical professional seeing you to complete the section below.

Provider Name	Provider's L&I Provider Number	
Facility Name	Telephone Number	
Address		
City	State	Zip Code
Date Patient First Treated for Crime Injury		
Diagnosis Codes		
Description of Injury		
Will the patient lose time from work due to their injuries? ☐ No ☐ Yes		
Wage Loss Certified From:	To:	

Provider's Signature _____ Date _____

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Authorization to Release Confidential Information

NOTE: The victim or legal guardian must sign this form to be valid

I hereby authorize any hospital, physician, funeral director, or other person who provided services; any employer of the victim; any law enforcement agency or other government agency, including state and federal services; any and all insurance companies or any other agency having knowledge necessary for this determination of eligibility of this claim for benefits to furnish to the Crime Victims Compensation Program or its representatives any and all information, including but not limited to documents generated by themselves and others, specifically pertaining to this claim. Other information may be required to determine whether conditions are related to the crime. I understand this may include results of HIV and other sexually transmitted disease testing, alcohol, drug, and psychiatric treatment.

I understand that if I receive any recovery of my losses through court-imposed restitution or civil lawsuit against the offender, any insurance settlement, or moneys from any government or private agency, I shall reimburse the State of Washington Crime Victims Compensation Program for any compensation paid out under this claim.

By signing below, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

If the victim is a minor, parent or legal guardian, please sign. If you are the legal guardian, please send the Crime Victims Compensation Program a copy of the guardianship documentation.

Print Name	Signature	Date

Note to Medical Providers:

RCW 7.68.145: Release of information in performance of official duties.

Notwithstanding any other provision of law, all law enforcement, criminal justice, or other governmental agencies, or hospital; any physician or other practitioner of the healing arts; or any other organization or person having possession or control of any investigative or other information pertaining to any alleged criminal act or victim concerning which a claim for benefits has been filed under this chapter, shall, upon request, make available to and allow the reproduction of any such information by the section of the department administering this chapter or other public employees in their performance of their official duties under this chapter.

Your disclosure of this information is allowed under the Health Insurance Portability and Accounting Act (HIPAA). This disclosure is required by Washington State law. You may disclose health information under HIPAA without an authorization if that disclosure is required by law, 45 CRF § 164.512(a). Also, since your disclosure is required by law it is not subject to HIPAA's minimum necessary standard, 45 CFR § 164.502(b)(2)(v).