For Office Use Only:

Claim No._____

Department of Labor and Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

Email: CrimeVictimsProgramM@Lni.wa.gov
Fax: 360-902-5333

Crime Victim's Application for Benefits – Homicide Claims

Visit our website at www.Lni.wa.gov/CrimeVictims

Homicide Victim Information

Victim's Name (First, Middle, Last)	Date of Crime	Date of Death
Social Security Number (Optional)	Homicide Victim's Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)

Marital Status

☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Separated

Spouse's or Partner's Name	Spouse's or Partner's Email Address
Spouse's or Partner's Mailing Address	
City State Zip Code	Spouse's or Partner's Telephone Number

Dependent Children

List the homicide victim's children, including any unborn children. If there are multiple children with different guardians, provide each guardian's contact information. If more space is needed, attach a separate sheet of paper.

	Name	Birth Date	Guardian Name
1.			
2.			
3.			
4.			

Address of Children's Legal Guardian		
City	State	Zip Code
Telephone Number of Children's Legal Guardian	Email of Children's Legal Guardian	

Other Information

What was the homicide victim's country of origin?

What was the victim's ethnicity?

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

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Person Applying for Benefits of the Homicide Victim

Name of Person Applying on Behalf of the Deceased Victim		
Preferred Language (if not English)	Relationship to Deceased Victim	
Mailing Address		
City	State	Zip Code
Telephone Number	Email Address	

How did you find out about the Crime Victim's Program? (Check the box that applies)

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

☐ Other: _____

What benefits are you applying for?

☐ Medical ☐ Dental ☐ Mental Health ☐ Wage Loss ☐ Burial Benefits ☐ Grief Counseling

Medical Treatment Related to the Crime Injury

If the homicide victim received medical treatment prior to death for the crime injury, please list the health care provider(s) below. Attach additional pages if needed.

Provider Name	Telephone Number	City

Crime Information

Date of Incident (mm/dd/yyyy)	Date Reported (mm/dd/yyyy)	Time ☐ AM ☐ PM	Date of Death (mm/dd/yyyy)
Crime Location Address			
City		State	Zip Code
Did the crime occur on the job? ☐ Yes ☐ No			
Name of Law Enforcement Agency (Check the box below for the type of agency)			
☐ Police ☐ Washington State Patrol ☐ Federal Bureau of Investigations ☐ Sheriff ☐ Tribal Police			
Officer's Name	Telephone Number	Report Number	

Type of Crime

☐ Murder ☐ Vehicular Assault

Brief Description of the Crime

Weapon Used	Area of the Body Injured	Offender's Name

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Attorney Information

Is there any attorney representing the estate of the homicide victim? ☐ Yes ☐ No

Attorney Name		
Email Address	Telephone Number	
Address		
City	State	Zip Code

Wage Information

Only the spouse, domestic partner, or minor children may be eligible for wage replacement benefits. For these benefits, the homicide victim must have been employed on the date of the crime.

Please fill out this section only if the homicide victim was employed or self-employed at the time of the crime and the spouse, domestic partner, or minor children are applying for wage loss benefits. We may contact the employer if necessary. If you have concerns about this, please call us.

Was the victim employed on the date of the crime? ☐ Yes ☐ No

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	
Rate of pay $ ☐ Hour ☐ Day ☐ Week ☐ Month		
Hours worked per day	Days worked per week	
Additional Earnings $	Additional Earning From ☐ Piecework ☐ Tips ☐ Commission ☐ Bonuses	
Annual Income Level (Select One) ☐ $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.

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 your insurance pays. Attach additional pages if needed.

Did the homicide victim have insurance? ☐ Yes ☐ No

If yes, list all available coverage including: health insurance, HCA/Medicaid, Medicare, Veterans, Social Security, DSHS/public assistance, workers' compensation, Indian health, vehicle insurance (victim and offender), life insurance, home owner's insurance, or renter's insurance. Attach additional pages if needed.

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

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

Funeral/Burial Expenses

To receive payment, send an itemized statement within 12 months of the homicide or the release of the remains.

Name of Funeral Home	Telephone Number	
Funeral Home's Address		
City	State	Zip Code

Notes

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Authorization to Release Confidential Information

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 the 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 other 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 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 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 government 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 CRF § 164.502(b)(2)(v).

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