For MOVA use only:
VC#

Application for Victim Compensation

Please print legibly and fill out both sides.

Acknowledgement and Information Release

I understand that the Victim Compensation Fund is a fund of last resort. I agree to inform the Massachusetts Office for Victim Assistance (MOVA) of any funds I receive from any source for losses for which I have requested compensation, and agree to promptly reimburse the Commonwealth for any such funds awarded to me or on my behalf. If an award is made, I authorize MOVA to make payments directly to the provider of services if I fail to respond within 3 months of the date on the Notice of Award.

I give permission to any hospital, medical facility, doctor, mental health provider, insurance company, employer, person or agency, including state and federal agencies, to give information to MOVA, including medical records and test results which may include drug and alcohol screens, HIV screening and AIDS related information. I understand that the information will be used to determine my claim for victim compensation benefits. I do not authorize the use or release of this information to any person or entity for any other purpose without my express written consent, except where such use or release is provided for by court order or otherwise provided for by law. A photocopy of this signed release is as valid as the original. This authorization shall expire upon final determination of all requirements under M.G.L. c. 258C and 940 CMR 14.00.

I certify, under the pains and penalties of perjury, that all information and supporting documentation contained in this application is true and accurate to the best of my knowledge and belief.

If you are unable to provide an electronic signature, please print and sign below with a wet-ink signature before submitting your application by email, fax, or mail.

Applicant signature: _____ **Date**: _____

Parent or guardian if victim is a minor.

Prepared by _____ on behalf of _____

I. Victim Information

Victim's name: _____ Gender: _____
First *Middle Initial* *Last*

Mailing address: _____ Home phone: _____

City/State: _____ Zip: _____ Cell phone: _____

Email address: _____

Date of birth: _____ Age at time of incident: _____ SSN: ___ ___ ____

II. Applicant Information *If victim is applicant, write "same." If under 18, applicate is parent/guardian. If homicide victim, applicate is individual incurring expenses.*

Applicant's name: _____ Gender: _____
First *Middle Initial* *Last*

Mailing address: _____ Home phone: _____

City/State: _____ Zip: _____ Cell phone: _____

Email address: _____

Date of birth: _____ Relationship to victim: _____ SSN: ___ ___ ____

If filing on behalf of minor dependent(s) of homicide victim, relationship to minor dependent(s): _____

Has the victim, or applicant on behalf of the victim, filed for crime victim compensation before? ☐ Yes ☐ No

If yes, please list the month and year when filed. ____/____

III. Crime Information *Type of crime:*

- ☐ Arson
- ☐ Assault
- ☐ Burglary
- ☐ Child Physical Abuse/Neglect
- ☐ Child Pornography
- ☐ Child Sexual Abuse
- ☐ DUI/DWI
- ☐ Homicide
- ☐ Human Trafficking
- ☐ Kidnapping
- ☐ Other Vehicular Crimes
- ☐ Robbery
- ☐ Sexual assault
- ☐ Stalking
- ☐ Terrorism
- ☐ Other: _____

Location of crime: _____ City/State: _____

Date of Crime: Date crime was reported:

Name of police department: _____ Investigating officer: _____

Name(s) of person(s) who committed crime (if known): _____

If you have been assisted by a victim advocate in the court/district attorney's office, provide the name and telephone number of advocate: _____

IV. Victimization Information *Indicate whether one (1) or more of the following is related to the selected crime type(s):*

☐ Bullying ☐ Domestic and Family Violence ☐ Elder Abuse/Neglect ☐ Hate Crime ☐ Mass Violence

V. Expenses *Check types of expenses for which you seek compensation.*

- ☐ Medical services*
- ☐ Medical supplies/pharmacy*
- ☐ Dental services*
- ☐ Replacement homemaker services*
- ☐ Ancillary funeral/burial expenses*
- ☐ Replacement bedding/clothing*
- ☐ Lost wages (***for victim only***)
- ☐ Loss of financial support (***for dependents of homicide victims***)
- ☐ Funeral/burial* †
- ☐ Crime scene cleanup*
- ☐ Forensic Sexual Assault Exam associated expenses*
- ☐ Counseling for victim*
- ☐ Counseling for family members of homicide victim*
- ☐ Counseling for children who witness violence against a family member*
- ☐ Security Measures*
- ☐ Counseling for non-offending parents of a child victim*

**Attach copies of bills and/or receipts.*

†Name of funeral home: _____

Address: _____ Phone: (___) _____

VI. Lost Income *Complete if seeking lost wages or loss of support.*

Victim's employer: _____ Contact person: _____

Mailing address: _____ Phone: _____

City/State: _____ Zip: _____

If victim has or will return to work, estimated period of disability: _____

If requesting financial support for dependent(s) of a homicide victim, provide the following information:

Name(s) of dependent(s)	Date of birth	SSN	Relationship to victim
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____

VII. Other Sources of Financial Assistance *Check all potential sources of full or partial payment of expenses.*

☐ Health insurance ☐ Hospital-based "free care" ☐ Workers' compensation
☐ Life/accident insurance ☐ Unemployment benefits ☐ Restitution
☐ Automobile insurance ☐ Disability benefits ☐ Public benefits (welfare, Medicare, Medicaid, SSDI)
☐ Other (*specify*): _____

Name of applicable insurance companies: _____

Address: _____ Phone: _____ Policy No.: _____

Are you represented by an attorney? Yes: _____ No: _____ Not sure: _____

If yes, attorney's name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

VIII. Optional Information *For statistical purposes only.*

Race/ethnicity of victim:

☐ American Indian/ Alaska Native ☐ Hispanic/Latino ☐ Some Other Race
☐ Asian ☐ Native Hawaiian and Other Pacific Islander ☐ Multiple Races
☐ Black/African-American ☐ White Non-Latino/Caucasian ☐ I decline to answer this question

Who referred you to Victim Compensation? _____

Return completed application to:

Massachusetts Office for Victim Assistance
One Ashburton Place, Suite 1310
Boston, MA 02108

Phone: (617) 586-1340 Fax: (617) 742-6262
Email: VCCorrespondence@state.ma.us