Application *for* Crime Victims' Compensation

South Carolina has a Crime Victims' Compensation Fund to help citizens with costs related to injuries received in a crime. To find out more, read this information sheet or call the State Office of Victim Assistance (SOVA) at 1.800.220.5370 or at 803.734.1900 in Columbia.

How much help can I get from SOVA's Crime Victims' Compensation Fund?

If you qualify, you can get help with the costs of medical care, counseling, lost wages/support, for yourself as a victim, or for a victim you are financially responsible for. You may also get repaid for what you spent on the funeral of a deceased victim. The law limits the amount of these payments. The most that can be paid on behalf of a victim for all expenses combined is $15,000. SOVA can pay for either 20 sessions or 180 days of counseling, whichever amount you use. For burials, the limit is $4,000.

How do I get financial help?

If you are a victim or claimant (person filing for a victim), you must show that:

- The crime happened in this state and was reported to law enforcement within 48 hours, if possible.
- You were not doing anything illegal at the time of the crime.
- You or your immediate family member have incurred, or will incur, medical, counseling, funeral bills and/or lost time from work because of injuries directly resulting from the crime.
- You submitted this application within 180 days from the date of the crime, if possible.
- Insurance and other payment sources will not cover the bills submitted.

What losses are not covered?

- Property damage or loss, to include crime scene cleanup
- Expenses related to going to court (lawyer, travel, etc.)
- "Pain and suffering"

Who can qualify for financial assistance?

Injured crime victims, immediate family members of crime victims, or someone who is paying bills or taking care of a crime victim may apply. There are some exceptions.

COMPLETING THE APPLICATION…

How can I get help with this application?

Law enforcement agencies, solicitors' offices and victim assistance groups in your area have victim advocates to help you with this form. If you are unable to reach one or don't know who to call, the Victim/Witness Assistance Program in the State Office of Victim Assistance (SOVA) will be glad to help you. Call us at 1.800.220.5370 between the hours of 8:30 am and 5:00 pm.

Do I have to fill out this whole packet of forms?

No. Only part of this packet is the application for compensation benefits. Supplemental forms are included for you to give to your counselor, doctor, or employer to complete as required.

If I want to apply now, what should I do?

Read the instructions on the back of this page and fill out the attached claim application. Also include copies of as much related information (i.e. copies of itemized receipts, bills, insurance statements) as you have. The more information we have now, the sooner your application can be processed. **You need to send the application within 180 days of the crime, so do not wait to collect all of your bills.** You can send more itemized bills later as you receive them.

SOVA ***will send you a letter when your application is received. If you have not received a letter after four weeks, please call your local victim advocate or*** **SOVA**. ***Keep in touch: If you move or if your phone number changes, please let us know!***

>> Section by section instructions are on the back of this sheet.

1205 Pendleton St., Brown Building Room 401, Columbia, SC 29201 ♦ Main Fax No.: 803.734.1708

HOW TO COMPLETE THE APPLICATION:

Save this information/instruction sheet for your files.

If you are...

- filing for ***yourself as an adult victim,*** then you are the "Victim," and the "Claimant."
- filing for a ***minor, or an incapacitated or incompetent victim,*** then you are the "Claimant," and the crime victim should be named as the "Victim" and the "Person Receiving Services."
- filing for the medical and/or burial bills ***for a deceased victim,*** then you are the "Claimant." The "Person Receiving Services" and the deceased crime victim should be named as the "Victim."
- filing for ***counseling for yourself because an immediate family member has been injured or killed,*** then you are the "Claimant" and the "Person Receiving Services." The injured or deceased family member is the "Victim."
- filing for ***counseling for a minor because his/her immediate family has been injured or killed,*** then you are the "Claimant," the minor is the "Person Receiving Services," and the injured or deceased family member is the "Victim."
- Please call your local victim advocate or our office for assistance in completing this form.

Print neatly and use a separate form for each applicant.

SECTION 1
"Person Receiving Services"

Print the name of the person who needs or is getting medical attention, counseling or other services because of the crime. The "Person Receiving Services" is the "Victim" and/or the "Claimant," and either an adult or child. **In homicide cases, the deceased Victim's name should appear here.**

SECTION 2
"Victim"

Print the name of the person injured at the crime scene. This should be the same person listed as the "Victim" on the law enforcement report. Complete the rest of this block with information about the victim.

SECTION 3
"Claimant"

Print the name of the **adult who is *assuming responsibility* for the crime-related bills.** This person is the "Claimant." If the "Person Receiving Services" is an adult responsible for his or her own bills, then also put his or her name here as the "Claimant." If the "Person Receiving Services" is under 18, incapacitated or incompetent, the financially responsible person (e.g. parent, guardian, spouse) should be named here. If the "Victim" died as a result of the crime, then the adult responsible for the deceased's medical and/or burial bills is the "Claimant."

SECTION 4
"Crime"

Be specific in describing injuries. Attach a copy of the incident report. If you don't have one, you can get one for free from the law enforcement agency that took the information about the crime. **The law enforcement incident report on the crime is necessary to determine eligibility and process the claim.**

SECTION 5
"Expense"

List the names of doctors, hospitals, and others who have provided services. If you already have itemized bills, please send copies with your applications. **If you have not received bills, do not wait on them.** You may send copies later as you receive them. SOVA can only pay for **counseling from a licensed counselor.** Your counselor must send SOVA a completed **Counselor's Report** relating the mental health treatment to the crime. This form is in the booklet marked "Supplemental Forms."

SECTION 6
"Insurance"

If you have insurance that may cover some of your crime-related bills, list your insurance information here.

SECTION 7
"Employment"

List your job information **if you have not been able to work for at least two weeks in a row because of crime-related injuries or to take care of someone with crime related injuries.** Your employer will need to complete the **Employer's Report**, giving us your average weekly wages and time missed from work. The doctor treating the "Victim" will need to complete the **Physician's Report,** telling us that the absence from work is medically necessary because of the crime. Both forms are included in the booklet marked "Supplemental Forms." For "Loss of Support," please call our office to see if you are eligible.

SECTION 8
"Civil Action"

If you hired a lawyer to settle an insurance claim or file a lawsuit related to this crime, complete this section.

SECTION 9
"Referral"

Print the name of the victim advocate or other professional who assisted you with this application.

SECTION 10
"Authorization"

Important: This application is a legal document which must be read and signed by the adult "Claimant."

SOVA Crime Victims' Compensation Application

Rev. 07/14

State Office of Victim Assistance . 1205 Pendleton St., Brown Building Room 401, Columbia, SC 29201 . 1.800.220.5370 or 803.734.1900

Use a separate form for each person filing a claim.

SECTION 1 *Person Receiving Services*

Victim or family member requesting assistance.

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. Full Legal Name of Individual Receiving Services/Benefits

Social Security # (last 5 digits) ☐-☐☐☐☐ **Date of Birth** **Sex:** ☐ Male ☐ Female

The person receiving services is the ☐ **Victim** *(as identified on the incident report upon which this claim is based)*

OR the Victim's ☐ Spouse ☐ Parent ☐ Sibling ☐ Child Other

Check services requested: ☐ Medical ☐ Counseling ☐ Lost Wages / Support ☐ Burial Other

Please call a local victim advocate or our office for help with completing this form.

SECTION 2 *Victim Information*

The Victim is the same person listed as a victim on the law enforcement incident report.

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. Name as it appears on the incident report

Social Security # (last 5 digits) ☐-☐☐☐☐ **Date of Birth**

Victim is: ☐ deceased ☐ incompetent ☐ under 18 ☐ disabled

Home Mailing Address (city,state, zip)

Home phone # **Other contact #(s)** *(i.e. work, cell, fax, e-mail)*

(For statistical purposes only and is optional) **Sex:** ☐ Female ☐ Male

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

SECTION 3 *Claimant Information*

Complete only if: The Claimant is the adult assuming responsibility for the crime-related bills and/or the adult that has physical custody of a minor.

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. **Full Legal Name**

Relationship to Victim Social Security # (last 5 digits) ☐-☐☐☐☐ **Date of Birth**

Home Mailing Address (city, state, zip)

Home phone # **Other contact #(s)** *(i.e. work, cell, fax, e-mail)*

SECTION 4 *Crime Information*

Attach a copy of the law enforcement incident report.

If law enforcement was not contacted, an incident report was not written within 48 hours of the crime, or if you are not filing this claim with SOVA within 180 days of the crime, please explain why:

Date of Crime **Date Reported** **Law Enforcement Agency**

Address of Crime **City/ County** **State**

Incident Report # **Name(s) of Offender(s)**

Was suspect arrested? ☐ Yes ☐ No Type of Crime and injury sustained:

Relationship of Offender(s) to Victim Warrant #(s) **Has the case gone to court?** ☐ Yes ☐ No

Please indicate the type of court: ☐ Magistrate ☐ Municipal ☐ General Sessions ☐ PTI

If yes, how much restitution was ordered ☐ None **or** Amount Ordered $ Amount Paid to Date $

SECTION 5 *Crime-Related Expense Information**

Attach copies of itemized bills (detailed bills, UB92 or HCFA 1500).

Name of Doctor/Hospital | **Services Provided from** (date) **to** (date) | **Phone#** | **Fax#**

Counselor | **Services Provided from** (date) **to** (date) | **Phone#** | **Fax#**

Funeral Home | **Services Provided from** (date) **to** (date) | **Phone#** | **Fax#**

SECTION 6 *Health Insurance / Benefits Information*

List insurance policies including Medicaid and Medicare.
Health insurance must be submitted to provider.

SECTION 7 *Lost Wages / Support Information**

If you have not been able to work for at least two weeks in a row, submit last two paystubs. If self-employed, submit prior year's tax return.

Employer's Name | **Phone #** | **Fax #** | **Employee's Name**

Name & Address of Company/Business
(list other employers on additional sheet)

If injured on the job, does your employer have Workers' Compensation? ☐ **Yes** ☐ **No**

Have you, or will you, file for Social Security disability (SSI)? ☐ **Yes** ☐ **No**

Is your household losing income/paychecks due to the crime? ☐ **Yes** ☐ **No**

Are you missing work to care for the victim? ☐ **Yes** ☐ **No**

SECTION 8 *Civil Action Information*

Have you hired a lawyer to settle with insurance or file a lawsuit? ☐ No

If yes, please provide: **Name of Lawyer**

Mailing Address | **Phone #**

SECTION 9 *Referral Source Information*

☐ *Solicitor* ☐ *LEVA* ☐ *Hospital/Dr.* ☐ *Counselor* ☐ *Other*

Name/Title of Professional Assisting with Application

Phone # | **Fax #** | **Agency/Office**

Mailing Address (P.O. Box or Street)

City and County | **State** | **Zip**

SECTION 10 *Legal Authorization & Signature*

This document is in compliance with the HIPAA guidelines.

I understand that I am responsible for all bills and the compensation program is designated to pay certain costs not covered by another source. Submitting this application does not entitle me to benefits. I authorize the State Office of Victim Assistance (SOVA) to request, obtain, and release any information or records to determine the eligibility of my claim or to obtain restitution for a period not to exceed the full processing of this application. I further understand that there is a potential for me to no longer be protected by the Privacy Rule, and that I have the right to revoke this authorization in writing at any point I so desire. I agree to repay SOVA if I receive money from another source, up to the amount paid on my behalf. This includes any payment I may receive from the offender, any insurance policy or settlements, judgments, or civil law suits. I authorize SOVA to request and obtain any information including settlement disbursements, negotiated medical bills, and all other records related to subrogation from myself or representatives acting on my behalf. I agree to notify SOVA of any changes, such as address or phone numbers, to maintain accuracy in the processing of this claim.

This information I have provided is true and correct to the best of my knowledge under penalty of law (§16-3-1280).

Original Signature of Victim/Claimant | **Date**

[Legal representative must sign if the Victim is under 18, legally declared incompetent or deceased.]

Print Name of Above Victim/Claimant

* See Supplemental Forms (**http://www.oepp.sc.gov/sova/apps.html**) to request counseling or Lost Wages/Support