



**WISCONSIN**

# CRIME VICTIM COMPENSATION PROGRAM APPLICATION INFORMATION

An application may be filed by, or on behalf of, a person who was injured or died as a result of the crime. The Program may help with certain expenses such as medical or mental health bills or other losses directly related to the crime and covered by the Program. **Personal property losses including cash, or “pain and suffering” claims cannot be reimbursed by the Program.**

## WHAT TO DO

- Please print clearly in ink. Separate applications must be completed for each injured victim.
- Enclose copies of crime-related medical bills received so far and send any other bills as they are received. The Program requires that the bills be itemized. It is the applicant’s responsibility to document the losses. **If there is insurance, Medical Assistance or other coverage sources for costs of medical or mental health expenses, a provider from within the provider group or that the network will reimburse, must be used. If those sources are not used first, the Program may not be able to consider reimbursement of those costs.**
- Send the completed application to the Crime Victim Compensation Program as soon as possible. Do **not** wait until court is over or until treatment is completed.
- The application must be signed by the injured victim or by the parent or guardian if the victim is under 18 years of age. If the victim is deceased, the application may be signed by a family member or by the administrator of the victim’s estate.
- Provide all information requested by the District Attorney’s Office to them in a timely manner. The Crime Victim Compensation Program Application does not need to be sent there.
- Return the completed application to the address listed on the bottom of this page. The applicant will receive a letter from the Crime Victim Compensation Program acknowledging the receipt of the application. Call the Program if a letter is not received after two weeks of submitting the application. Notify the Program of any changes in address or phone number. If you have any questions, please call (608) 264-9497 or 1-800-446-6564 (Toll-free). **Keep this information sheet for your records.**

## REMEMBER

- The crime must be **reported to law enforcement within 5 days of the date of the crime** and the victim must cooperate in the investigation and prosecution of any known suspects. **The application must be filed within 1 year of the date of the crime.** There are very limited circumstances in which this requirement may be waived. If the crime was not reported within 5-days or the claim was not filed within 1 year, attach a written statement explaining the reason for the delay. Victims who were a minor at the time of the crime may file within one year after turning eighteen.
- Any money received from other sources such as restitution, lawsuits, insurance settlement, etc. **must be repaid** to the Crime Victim Compensation Program for crime related expenses paid by the Program.

**Wisconsin Department of Justice**  
**Crime Victim Compensation Program**  
**Post Office Box 7951**  
**Madison, WI 53707-7951**  
**(608) 264-9497 or 1-800-446-6564 (Toll-free)**

*All information will be verified by the Crime Victim Compensation Program. Section 949.17 of the Wisconsin Statutes provides penalties for persons who submit fraudulent applications.*

	WISCONSIN	<h1 style="margin: 0;">CRIME VICTIM COMPENSATION APPLICATION</h1> <p style="margin: 0;">Post Office Box 7951 Madison, WI 53707-7951 (608) 264-9497 or 1-800-446-6564 (Toll-free) WI Statutes Chapter 949</p>	<p>CLAIM NO: _____</p> <p>DATE RECEIVED: _____</p> <p style="text-align: right; font-size: 0.8em;">(For Office Use Only)</p>
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**PLEASE BE SURE TO SIGN THE APPLICATION ON THE LAST PAGE  
THE APPLICATION MUST BE FILED WITHIN 1 YEAR OF THE DATE OF THE CRIME**

**SECTION 1: VICTIM INFORMATION**

1. Victim's First Name		Victim's Last Name		2. <input type="checkbox"/> Female	3. Date of Birth	
				<input type="checkbox"/> Male	/ /	
4. Social Security Number		5. Mailing Address				
6. City		7. State	8. Zip Code		9. County	
10. Home Telephone ( )		11. Cell Phone ( )		12. Work Telephone ( )		
13. Is the victim represented by an attorney due to this crime:			14. Name of Attorney			
In filing this application? <input type="checkbox"/> Yes <input type="checkbox"/> No			Street Address			
In a civil lawsuit? <input type="checkbox"/> Yes <input type="checkbox"/> No			City		State	Zip Code
In an insurance action? <input type="checkbox"/> Yes <input type="checkbox"/> No						

**15. The following information is used for statistical purposes only and is needed to comply with federal regulations**

A. Handicapped Before Crime: <input type="checkbox"/> Yes <input type="checkbox"/> No After Crime: <input type="checkbox"/> Yes <input type="checkbox"/> No	B. Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Other
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C. How did you learn about the Compensation Program? (Check all that apply)

<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Attorney	<input type="checkbox"/> Probation or Parole	<input type="checkbox"/> Friend	<input type="checkbox"/> Poster or Brochure
<input type="checkbox"/> District Attorney	<input type="checkbox"/> Sexual Assault Program	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Relative	<input type="checkbox"/> Public Service Announcement
<input type="checkbox"/> Victim/Witness Program	<input type="checkbox"/> Domestic Abuse Program	<input type="checkbox"/> Funeral Director	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other

**SECTION 2: PERSON FILLING OUT THE APPLICATION IF VICTIM IS A MINOR, HAS A GUARDIAN, OR IF VICTIM IS DECEASED**

1. Person's Name		2. Relationship to Victim			
3. Mailing Address		4. City	5. State	6. Zip Code	
7. Home Telephone ( )		8. Cell Phone ( )		9. Work Telephone ( )	

**SECTION 3: CRIME INFORMATION**

1. Type of Crime (Check all that apply)

<input type="checkbox"/> Homicide	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Hit and Run of Pedestrian	<input type="checkbox"/> Drunk Driving / DUI
<input type="checkbox"/> Attempted Homicide	<input type="checkbox"/> Child Physical Abuse	<input type="checkbox"/> Sexual Assault	<input type="checkbox"/> Other _____
<input type="checkbox"/> Assault/Battery	<input type="checkbox"/> Child Sexual Abuse	<input type="checkbox"/> Robbery	

2. Location of Crime: Street Address \_\_\_\_\_ 3. City \_\_\_\_\_ 4. State \_\_\_\_\_ 5. County \_\_\_\_\_

6. Date of Crime / / 7. Date Crime Reported / / 8. Law Enforcement Agency to which crime was reported \_\_\_\_\_ Officer's Name \_\_\_\_\_

9. Offender(s) Names(s): \_\_\_\_\_

10. Did victim know offender(s)?  Yes  No If yes, in what way? \_\_\_\_\_

Description of crime (optional): \_\_\_\_\_

**SECTION 4: MEDICAL/MENTAL HEALTH EXPENSE INFORMATION**

1. Name and address of medical facility where victim was first treated: \_\_\_\_\_ 2. Date of Treatment: / /

3. Mental Health Treatment received, or to be received?  Yes  No  Unknown

**SECTION 5: MISCELLANEOUS EXPENSES**

Homemaker Services \$ \_\_\_\_\_ Documented Crime Scene Cleanup \$ \_\_\_\_\_

Securing a Crime Scene \$ \_\_\_\_\_ Property held as evidence and damaged by Crime Lab testing \$ \_\_\_\_\_

Clothing/bedding held as evidence and the reasonable replacement value of each:

\_\_\_\_\_ \$ \_\_\_\_\_ \_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_ \_\_\_\_\_ \$ \_\_\_\_\_

**SECTION 6: INSURANCE AND BENEFIT INFORMATION**

1. Was there insurance or other source of payment to cover expenses at the time of the crime?  Yes  No

2. Check all that apply:

<input type="checkbox"/> Employers/Union Group	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Medical Assistance/Title 19	<input type="checkbox"/> Homeowners Insurance
<input type="checkbox"/> Veterans' Benefits	<input type="checkbox"/> County Welfare/GAMP	<input type="checkbox"/> Victim/Spouse/Parent Insurance	<input type="checkbox"/> Badger Care
<input type="checkbox"/> Lawsuit	<input type="checkbox"/> Disability	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other (describe) _____

**SECTION 7: CRIMES INVOLVING MOTOR VEHICLES**

Did the victim have auto insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of company: _____
Did the driver have auto insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of company: _____
Did the offender have auto insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of company: _____

**SECTION 8: EMPLOYMENT INFORMATION**

Complete the section **ONLY** if the victim was employed at the time of injury.

1. Did victim miss time from work immediately following the crime?  Yes  No  Unknown

2. Is the victim self-employed?  Yes  No

3. Dates absent from work due to crime related injuries: From \_\_\_\_\_ To \_\_\_\_\_

4. Name of Employer \_\_\_\_\_ 5. Employer Telephone ( ) \_\_\_\_\_

6. Employer Mailing Address \_\_\_\_\_ 7. City \_\_\_\_\_ 8. State \_\_\_\_\_ 9. Zip Code \_\_\_\_\_

## FOR CRIME RESULTING IN DEATH

### SECTION 9: FUNERAL/BURIAL EXPENSES

1. Funeral Home Name		2. Mailing Address	
3. City	4. State	5. Zip Code	6. Telephone (     )
7. Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown      Amount: \$ _____      Beneficiary _____			

### SECTION 10: DEPENDENTS FINANCIALLY SUPPORTED BY VICTIM AT TIME OF DEATH

First Name	Last Name	Date of Birth Month / Day / Year	Relationship to Victim
		/   /	
		/   /	
		/   /	

NOTE: If a claim is approved, the Program may be able to assist certain family/household members of the deceased victim with losses due to emotional/physical reactions to the death. More information can be obtained by calling the Crime Victim Compensation Program office.

### AGREEMENT

- My signature below means that I certify that information on this application is true and correct.
- I agree that payments for bills may be paid directly to whom the payment is owed.
- I understand that the Crime Victim Compensation Program reimburses for costs not covered by any other source.
- I agree to notify the Crime Victim Compensation Program if a lawsuit is filed.
- I agree to repay the Crime Victim Compensation Program for all payments made if I receive money from any other source.
- I agree to refund the Crime Victim Compensation Program for all money paid by the Program if this claim is determined to be false or fraudulent.

### AUTHORIZATION

I authorize and request any person having information needed by the Crime Victim Compensation Program to process my claim to release that information to the Wisconsin Department of Justice. That includes, but is not limited to, all past law enforcement records concerning me; private and governmental physicians and hospitals; local, state and federal law enforcement and prosecutors office and federal court personnel; any employer; and any private company or governmental agency that is providing or may provide medical or monetary benefits. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I authorize the Crime Victim Compensation Program to release copies of crime-related medical bills and wage information to the Office of the District Attorney for determination and documentation of restitution. I certify that I understand and agree to the above statements.

\_\_\_\_\_  
Signature of Victim or Person filing Claim

\_\_\_\_\_  
Date

### RETURN COMPLETED APPLICATION TO:

**Wisconsin Department of Justice  
Crime Victim Compensation Program  
Post Office Box 7951  
Madison, WI 53707-7951  
FAX (608) 264-6368**

**FOR ASSISTANCE CALL: In Madison (608) 264-9497  
Toll Free 1-800-446-6564**