



Kansas Attorney General

Kris W. Kobach

Division of Crime Victims Compensation

120 SW 10th Avenue, 2nd Floor

Topeka, KS 66612-1597

PHONE: (785) 296-2359 • FAX: (785) 296-0652

www.ag.ks.gov

APPLICATION FOR CRIME VICTIM COMPENSATION

Must be filed within two years of the incident, except pursuant to K.S.A. 74-7305.

Cases of child sexual assault are based on the date the crime was reported to law enforcement.

It is the claimant's responsibility to establish proof that the claim was filed timely pursuant to K.S.A. 74-7305.

All information provided is confidential, pursuant to K.S.A. 74-7308.

Please check the type(s) of crime victim compensation for which you are applying:

- Medical Counseling Loss of wages Funeral Crime scene cleanup Clothing/Bedding Moving

Section A – Victim Information *(Person who was injured or killed during the crime.)*

Name of victim (first, middle, last)		Date of birth	SSN or Government ID Number	
Address (include Apt #, Lot #, PO Box, etc.)		City	State	ZIP
Safe daytime phone number	Other safe phone number	Email address		

Preferred language: English Spanish Other _____

The following information is optional and will be used for statistical purposes only and is requested to comply with Federal Civil Right Act under Section 1403(e) of the Victims of Crimes Act of 1984.

Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White Non-Latino or Caucasian <input type="checkbox"/> Biracial or Multiracial <input type="checkbox"/> Other _____	How did you find out about this program? <input type="checkbox"/> Police or Police Advocate <input type="checkbox"/> Victim Assistance Program <input type="checkbox"/> Hospital <input type="checkbox"/> Prosecutor or Prosecutor's Advocate <input type="checkbox"/> Counselor or Therapist <input type="checkbox"/> Media/News <input type="checkbox"/> Poster/Brochure <input type="checkbox"/> Other _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Special Needs: <input type="checkbox"/> Disability <input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____
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Section B – Applicant Information *(Complete this section if the victim is a minor, incapacitated or deceased.)*

Person applying is the victim. *(Proceed to section C)*

Person applying is not the victim Applicant's relationship to the victim: _____

Name of applicant (first, middle, last)		Date of birth	SSN or Government ID Number	
Address (include Apt #, Lot #, PO Box, etc.)		City	State	ZIP
Safe daytime phone number	Other safe phone number	Email address		

Section C – Contact Person *(Complete this section you would like to give permission for this office to contact someone other than you about your claim if we can't reach you.)*

Name of contact person		How do you know them?	
Address (include Apt #, Lot #, PO Box, etc.)		City	State
			ZIP
Safe daytime phone number	Other safe phone number	Email address	

Section D – Attorney Representation *(Complete this section if you are represented by a private attorney in a civil lawsuit or insurance action as a result of the incident.)*

Attorney's name		Name of law firm	
Address (include Apt #, Lot #, PO Box, etc.)		City	State
			ZIP
Phone number	Fax number	Email address	

Section E – Information about the crime *(This section must be completed.)***Type of crime** *(Please check one):*

- | | | |
|--|--|--|
| <input type="checkbox"/> Arson | <input type="checkbox"/> Fraud/Financial Crime | <input type="checkbox"/> Robbery |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Homicide/Murder | <input type="checkbox"/> Sexual Assault (Adult) |
| <input type="checkbox"/> Burglary | <input type="checkbox"/> Child Abuse Homicide | <input type="checkbox"/> Sexual Assault (Child) |
| <input type="checkbox"/> Child Physical Abuse | <input type="checkbox"/> Domestic Abuse Homicide | <input type="checkbox"/> Stalking |
| <input type="checkbox"/> Child Pornography | <input type="checkbox"/> DUI Homicide | <input type="checkbox"/> Terrorism |
| <input type="checkbox"/> Domestic Abuse | <input type="checkbox"/> Vehicular Homicide | <input type="checkbox"/> Vehicular crime (Other than homicide) |
| <input type="checkbox"/> DUI | <input type="checkbox"/> Human Trafficking | <input type="checkbox"/> Child witnessed a crime (please specify): |
| <input type="checkbox"/> Electronic Solicitation | <input type="checkbox"/> Kidnapping | _____ |

Date of crime	Date crime reported	Name of law enforcement agency reported to
Police report number	Name of investigating officer/detective	

Brief description of the crime:**Location of the crime:**

Address (include Apt #, Lot #, etc.)	City	County	ZIP
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Name(s) of suspect(s): _____

Did the Victim know the suspect(s)? Yes No **If yes, in what way?** _____Has an arrest been made(s)? Yes No UnknownCourt case number: _____ District Court Municipal Court

Section F – Funeral/burial expenses *(Complete this section if you are seeking funeral benefits for a deceased victim and attach copies of bills. Maximum benefit is \$7,500.)*

Note: Applications for grief therapy for family members of deceased victims are also available. Please visit our website or contact our office for details.

Name of funeral home			
Street address	City	State	ZIP
Phone number	\$	\$	
	Total amount paid	Total amount still due	

Have funeral and burial expenses been paid? Yes No If yes, by whom? _____

Will applicant receive funeral payment, death benefits or other help with the costs of the funeral? Yes No

If yes, please explain:

Section G – Loss of support *(For death claims only. Maximum benefit is \$400 per week.)*

Was the victim employed or paying child support when they were killed? Yes No

If yes, please attach copies of a marriage certificate, birth certificate(s) and/or child support order(s).

Section H – Medical Information *(List all medical expenses incurred as a result of this incident, including hospital and doctor charges, ambulance fees, x-rays, prescriptions and dental. Please attach itemized statements or bills, receipts and insurance statements if they are available.)*

Name of medical provider	Address	City	State	ZIP code	Phone number

Briefly describe the victim's injuries:

Section I – Counseling Information *(Please attach itemized statements or bills, receipts and insurance statements if they are available.)*

Name of counselor/organization	Address	City	State	ZIP code	Person receiving counseling and relationship to victim
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Section J – Financial Information *(Required by K.S.A. 74-7305.)*

Number of dependents: _____ Net income per year: \$ _____

Resources (savings, checking): _____ Total monthly living expenses: \$ _____

Special needs of applicant and dependents: _____

Section K – Insurance/Collateral Sources *(This section must be completed.)*

Please check all available sources that could be applied to your claim

- | | | |
|--|---|--|
| <input type="checkbox"/> Health/Life Insurance | <input type="checkbox"/> Social Security | <input type="checkbox"/> Other Sources |
| <input type="checkbox"/> Automobile Insurance | <input type="checkbox"/> Veterans Administration Benefits | <input type="checkbox"/> I do not have insurance or other financial resources. |
| <input type="checkbox"/> Burial Insurance | <input type="checkbox"/> Armed Services (CHAMPUS) | |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Workers Compensation | |
| <input type="checkbox"/> Medicare | | |

List insurance information below.

Name/type of source	Name and address of source	Policy/claim number
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Section L – Wage Loss *(Applicants for wage loss must attach a copy of their most recent Federal Income Tax Return and/or pay stubs. Compensation may be awarded at a maximum rate of \$400 per week for unreimbursed wage loss.)*

 Was the victim employed at the time of the crime? Yes No

If you answered yes to both of these questions, please complete section L.

 Did the victim miss work and pay because of the crime? Yes No

Name of employer		Phone number	
Employer's mailing address		City	State ZIP

 Did the victim use any vacation, sick leave or PTO? Yes No

 Did the victim receive short- or long-term disability pay? Yes No

Please check all available sources that could be applied to your claim

- | | | |
|--|--|---|
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Unemployment Compensation | <input type="checkbox"/> Other Sources, including crowdfunding websites like GoFundMe |
| <input type="checkbox"/> Public Assistance | <input type="checkbox"/> Workers Compensation | |

Name of doctor or therapist who can verify length of disability to work		Phone number	
Doctor's street address		City	State ZIP

Section M – Certification of Financial Hardship *(Required by K.S.A. 74-7305(d).)*

I (Applicant) affirm the customary level of health, safety and education for self and dependents cannot be maintained without undue hardship as a result of the incident upon which this claim is based.

Section N – Assignment of Benefits

- 1) **Medical care expenses** – I hereby assign any compensation awarded for unpaid medical care to the applicable medical care provider. This assignment is conditional that such provider agrees to accept a direct payment from the Kansas State Treasurer to pay 80% of allowable charges as satisfaction of payment in full. I authorize the Kansas State Treasurer to pay 80% of such allowable unpaid medical charges to the appropriate medical care provider.
- 2) **Non-medical care expenses** – I hereby assign any compensation awarded for unpaid non-medical care charges to the applicable provider. I authorize the Kansas State Treasurer to pay any such allowable unpaid non-medical charges directly to the provider.

Section O – Certification of Claim

I hereby certify, subject to the penalty of fine or imprisonment, that all losses claimed herein are a direct result of the crime and that the information contained in this application for an award is true and correct to the best of my knowledge and belief.

Section P – Promise to Repay

Pursuant to K.S.A. 74-7312, I promise to repay the Kansas Crime Victims Compensation Fund, through the Crime Victims Compensation Board if I receive payments from the offender (restitution or civil action), insurance, settlements or any other government or private agency resulting from this incident.

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I authorize and request any person having information with respect to the incident leading to the victim's personal injury or death necessary to the administration of this claim, *including all past law enforcement records, medical diagnosis, medical records, medical examination information, and medical claim information*, to release that information to the Crime Victims Compensation Board, or its representative. This release includes but is not limited to, private and governmental physicians and hospitals; local, state and federal law enforcement and prosecutors' offices; local, state and federal court personnel, any employer; any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I hereby agree and certify that no person shall incur any legal liability by releasing any information pursuant to this authorization. A photocopy of this authorization is effective and valid as the original. All information obtained by the Board will remain confidential pursuant to K.S.A. 74-7308 and amendments thereto. This Release of Confidential Information will remain in effect until terminated by me in writing.

Applicant's Signature	<i>for</i>	<i>(If victim is 12 years or older, they must sign this line.)</i>
Applicant's Printed Name		Victim's Date of Birth
Date Signed		Last 4 Digits of Victim's Social Security Number



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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize all health care providers to disclose my protected health information to the Kansas Crime Victims Compensation Board (“Board”), its employees, and agents, for purposes of processing my claim for crime victims compensation. This authorization includes my entire medical record, to the extent requested by the Board.

I understand that after this information is disclosed, it may not be protected by federal law and may be subject to redisclosure. However, all records and information given to the Board shall remain confidential in accordance with K.S.A. 74-7308(e).

The Board is not a covered entity under the Health Insurance Portability and Accountability Act (HIPAA). This authorization is voluntary, but I understand that refusal to sign this authorization may impact my eligibility for crime victims compensation if the Board is unable to obtain information necessary to process my claim.

This authorization will expire when the Board has completed processing my claim for compensation.

I understand that I am entitled to receive a copy of this authorization.

I understand that I have the right to revoke this authorization at any time by notifying the Board in writing at 120 SW 10th Ave, 2nd Floor, Topeka, KS 66612-1597. I understand that any use or disclosure made prior to a revocation will not be affected by the revocation.

Signature of Individual

Date

If a Personal Representative executes this form, that Representative warrants that he/she has authority to sign the form on the basis of:

Office of the Kansas Attorney General • Division of Crime Victims Compensation

APPLICATION FOR CRIME VICTIMS COMPENSATION AND ELIGIBILITY REQUIREMENTS

(You may wish to keep this page for your information. Not required to be submitted with your application.)

If you have been an innocent victim of a violent crime and have suffered financial losses that are not covered by insurance or any other source, the Kansas Crime Victims Compensation Fund may be of assistance to you. The State of Kansas is committed to helping victims who meet the eligibility requirements of the Kansas Crime Victims Compensation Act. While no amount of financial aid can erase the trauma of crime, it is the goal of this program to ease the aftermath of crime for the victim whenever possible.

Eligibility Requirements:

1. Applications must be filed within two years of the incident with certain exceptions for sexual assault cases. In some circumstances, compensation for mental health counseling may be awarded to victims of sexual assault or child witnesses of certain crimes if a claim is filed beyond the two-year period. Cases of child sexual assault are based on the date the crime was reported to law enforcement. It is the claimant's responsibility to establish proof that the claim was filed timely pursuant to K.S.A. 74-7305.
2. Victim suffered bodily injury (including mental disorder or death) as a victim of a violent crime.
3. The incident occurred in Kansas, or outside the United States to a Kansas resident.
4. The incident was reported to law enforcement officials within 72 hours, or would have been reported within that time except for a valid reason.
5. The claimant (and/or victim) fully cooperated with law enforcement officials during their investigation and prosecution.
6. The victim was not an accomplice to and did not commit a crime in connection with this incident (e.g. gang activity, drug dealing.) Victim must not have provoked or caused the injury or death.

Requirements 4, 5, and 6 do not apply to a victim of human trafficking who was 18 years old or younger at the time of the crime.

KANSAS STATUTE AUTHORIZES THE BOARD TO REDUCE OR DENY CLAIMS THAT INVOLVE THE VICTIM'S CONTRIBUTORY MISCONDUCT OR PARTICIPATION IN UNLAWFUL ACTIVITIES.

Eligible and Ineligible Expenses:

- ◆ Medical expenses not covered by other sources are eligible expenses.
- ◆ Reasonable costs for replacement of clothing and bedding seized as evidence are compensable.
- ◆ Victims or claimants who are required to testify in sexually violent predator cases may be eligible for compensation for mental health counseling.
- ◆ Crime scene cleanup expenses may include replacement of materials that were removed because such materials were biohazardous or were damaged as part of evidence collection.
- ◆ Other property loss, property damage and pain and suffering are ineligible expenses.

Award Maximums:

- ◆ Overall maximum award of \$25,000.00.
- ◆ Funeral expense maximum of \$7,500.00.
- ◆ Grief therapy for family members of homicide victims is available.
Call for separate grief therapy application. (Maximum award is \$1,500.00.)*
- ◆ Outpatient mental health counseling maximum of \$5,000.00.*
- ◆ Inpatient mental health care maximum of \$10,000.00.*
- ◆ Lost wages/loss of support maximum of \$400.00 per week.
- ◆ Crime scene clean-up maximum of \$2,500.00.

**Additional compensation may be awarded based on extenuating circumstances.*

HOW TO FILE YOUR APPLICATION FOR COMPENSATION

Read all instructions for each section before completing this application. Please provide all information requested. Applications which are not completed and signed will be returned, thus delaying a decision on your claim. Please include copies of your medical bills and other expenses. Once your completed application is received and all requests for additional documents and information have been received and reviewed, you will be notified in writing of the Board's decision. You have the right to appeal that decision if you disagree.

The complete application/investigation process may take approximately 3 months.

If you have any questions while completing the application, please call our office at (785) 296-2359.