Kansas Attorney General

Kris W. Kobach

Division of Crime Victims Compensation
120 SW 10th Avenue, 2nd Floor
Topeka, KS 66612-1597
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www.ag.ks.gov

APPLICATION FOR GRIEF THERAPY

(Must be filed within two years of the incident)

Questions regarding financial stress are required by Kansas Statute.

Persons receiving grief therapy **must be related to homicide victim in one of the following ways: spouse, child, sibling, parent, legal guardian, step-parent, or grandparent.*

Master Claim# _____ (for DCVC office use only)

Claim# _____ (for DCVC office use only)

Section A – NAME OF HOMICIDE VICTIM

1. Victim's Name:	2. Date of Birth:	3. Social Security Number:

Section B – NAME OF PERSON RECEIVING COUNSELING

1. Recipient of Grief Therapy:		2. Relationship to Homicide Victim:
3. Date of Birth:	4. Social Security Number:	☐ Spouse ☐ Legal Guardian ☐ Child ☐ Step-parent ☐ Sibling ☐ Grandparent ☐ Parent

Section C – APPLICANT INFORMATION

If applicant and recipient are the same, complete address and telephone portions only.
If someone other than the recipient is filing, complete the entire section.

1. Applicant's Name:			2. Relationship to Person named in *Section B*:
3. Street Address	4. City:	5. State:	6. Zip Code:

7. Applicant's Social Security No.:	8. Work Phone:	9. Home/Cell Phone:	10. Applicant's E-Mail:

Section D – GRIEF THERAPY INFORMATION (Maximum allowable is $1,500.00)

Please attach itemized statements or bills, receipts and insurance statements if they are available.

Name of Counselor / Organization	*Address*	*City, State*	*Zip*	*Phone Number*

Victim Name: _____, _____
Last First

Section E – CERTIFICATION OF FINANCIAL HARDSHIP *(Required by K.S.A. 74-7305(d)*

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

Section F – 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 in satisfaction as 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 G – 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 G – PROMISE TO REPAY

Pursuant to K.S.A. 74-7312, I promise to repay the Kansas Crime Victim Compensation Fund, through the Crime Victim 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.

_____ for _____

Applicant's Signature

If recipient is 12 years or older, they must sign on this line.

_____ _____

Applicant's Printed Name

Recipient's Date of Birth

_____ _____

Date

Last 4 Digits of Recipient's Social Security Number

Kansas Attorney General
Derek Schmidt

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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 (HIPPA). 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:

_____

_____

_____