NEW YORK STATE | Office of Victim Services

Claim Application and Instructions

How to Apply for Compensation

Who can apply for compensation?

Innocent victims of crime, certain relatives, dependents, legal guardians and eligible Good Samaritans can apply to the Office of Victim Services (OVS) for compensation of out-of-pocket expenses not covered by insurance or other resources.

What kind of expenses can I get compensated for?

OVS offers compensation related to personal injury, death and loss of essential personal property.

The specific expenses OVS may cover include:

- Medical, pharmacy and counseling expenses
- Loss of Essential Personal Property *(up to $500, including $100 for cash)*
- Burial or Funeral Expenses *(up to $6,000)*
- Lost Wages or Lost Support *(up to $30,000) (Parents or guardians of hospitalized minor children may be eligible for this benefit.)*
- Transportation (court/medical)
- Occupational/Vocational Rehabilitation
- Security Devices and DV Shelter Costs
- Crime scene clean-up *(up to $2,500)*
- Good Samaritan property losses *(up to $5,000)*
- Moving expenses *(up to $2,500)*

How do I ask for compensation?

Send us your completed OVS application along with copies of:

- Police reports
- Medical bills
- Correspondence with insurance companies or benefits plan saying if they will cover your loss
- Insurance cards
- Receipts for essential personal property
- Death certificate and funeral contract
- Victim's birth certificate
- Proof of age (driver's license, birth certificate etc.)
- Legal guardianship papers

What if I don't have some of the papers OVS needs?

Send your application in right away. You can send the other documents later.

What if my property was lost, damaged or destroyed because of the crime?

If you are under 18, 60 or over, disabled or were injured, you may apply for benefits to replace your *essential* personal property or cash that was not covered by any other resource.

Essential means necessary for your health and welfare, like eyeglasses and clothes.

What if I move?

Send OVS a signed letter right away. Tell us your new address and phone number. Also let us know if your email address changes.

Who can sign the claim?

Generally, the victim must sign the claim. However, if the victim is under 18, or is physically or mentally incapable of signing, then the legal guardian (the person receiving the benefits) must fill out section 2 of the claim and sign the claim.

If the victim died, the person asking for benefits must fill out section 2 of the claim and sign the claim.

Is there another way to apply?

Yes. Visit ovs.ny.gov to access the secure Victim Service Portal (VSP) and file an application on line.

Do I have to fill out the attached HIPPA form?

Yes. Fill out one HIPAA form for **each** service provider. You can photocopy a blank form to make extra copies.

80 S. Swan Street
Albany, NY 12210-8002
(518) 457-8727

55 Hanson Place
Brooklyn, NY 11217-1523
(718) 923-4325

ovs.ny.gov **800-247-8035**

Court Ordered Restitution Information

What is restitution?
Restitution is compensation paid to a victim by the perpetrator of a criminal offense for the losses or injuries incurred as a result of the criminal offense. It must be ordered by the Court at the time of sentencing, and is considered part of the sentence.

Restitution is **NOT** for payment of damages for future losses, mental anguish or "pain and suffering."

When the District Attorney's (DA) office advises the Court that you have requested restitution or when the victim impact statement contained in the probation investigation report (pre-sentence, pre-plea or pre-disposition report) indicates that the victim seeks restitution, the Court must order restitution unless the interests of justice dictate otherwise. When the judge does not order restitution, the judge must clearly state his/her reasons on the record.

What can I request as restitution?
You can ask for any expense you incur as a result of the criminal offense – even for items the OVS may not be able to reimburse. Restitution may include, but is not limited to, reimbursement for medical bills, counseling expenses, loss of earnings, funeral expenses, insurance deductibles and the replacement of stolen or damaged property.

Who is entitled to restitution?
Anyone who has been the victim of a criminal offense and has suffered injuries, economic losses or damages can seek restitution. Many times, victims who deserve restitution do not request it. This can occur because victims are not aware that they are entitled to restitution, or do not know what steps to take to go about receiving the restitution they deserve.

How do I ask for restitution?
You should contact the DA's office and advise them of the extent of your injury, your out-of-pocket losses and the amount of damages you are requesting.

It is your responsibility to give the police, DA and, upon request, the local probation department copies of the bills and other documents showing the extent of your injuries, your out-of-pocket losses and the amount of damages you want considered by the Court. Your claim for restitution will be included in any probation investigation report (pre-sentence, pre-plea or pre-disposition report). Be sure to:

- Keep accurate records such as original receipts of any expenses you have as a direct result of the criminal offense.
- Give copies of these receipts to the police, DA and local probation department.

You need to clearly explain your need for restitution as soon as possible to the DA, the victim/witness advocate, and the probation department. Plea agreements can occur within days of the actual criminal offense. If this information is not provided before the plea agreement and sentencing, you may have to pursue the perpetrator in Civil Court.

The DA is under an obligation to petition the Court to order restitution on your behalf.

In all felony criminal cases, many misdemeanor criminal cases and all juvenile delinquency and persons in need of supervision (PINS) cases, a pre-sentence or predisposition investigation report is required. The local probation department will contact you about the issue of restitution as it pertains to your case.

How is restitution determined?
The amount of restitution is based on proof of your out-of-pocket losses incurred as a result of the criminal offense. The perpetrator has a right to object to the amount of restitution. The Court may hold a hearing on the issue of restitution where the Court may consider the perpetrator's ability to pay. The DA's office may contact you and ask you to testify at the restitution hearing. If you have a concern about appearing personally in Court, you should explore alternatives with the DA assigned to your case.

If the OVS has paid your bills, the Court may order that restitution payments be made to the OVS for those paid items. It is important that you advise the DA's Office that you filed a claim with the OVS.

If you filed a claim with the OVS, it is important that you advise the OVS if the Court orders the perpetrator to pay restitution.

Read *How to Apply for Compensation* before filling out this form.

Application for Compensation

New York State Office of Victim Services

Please print. Answer all questions. *It is a crime to file a false claim!*

Victim Assistance Program Use Only		
OVS VAP ID#	Program Name/Phone	Advocate Name/Email

1 Tell us about the victim.

Last Name	First Name	MI	Social Security # ☐Check here if you do not have one. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date of Birth

Mailing Address:

Street *Apt. # (or P.O. Box)* *City* *County* *State (or Foreign Country)* *Zip Code*

Race/Ethnicity: ☐White ☐Black ☐Asian ☐Hispanic ☐American Indian/Alaskan Native ☐Pacific Islander/Native Hawaiian ☐Other ☐Multi-Race

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Lives with partner

Gender: ☐ Male ☐ Female **Was the victim disabled at the time of the crime?** ☐Yes ☐No ☐Unknown

How did you first hear about the Office of Victim Services?

☐Police ☐Hospital ☐District Attorney ☐Victim Assistance Program ☐Radio/TV ☐Brochure/Poster ☐Internet ☐Other

2 If you are *not* the victim, and you are signing this claim, you are the claimant. Tell us about you. (See "Who can sign the claim?" on the instructions page.)

Last Name	First Name	MI	Social Security # ☐Check here if you do not have one. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Date of Birth

Mailing Address:

Street *Apt. # (or P.O. Box)* *City* *County* *State (or Foreign Country)* *Zip Code*

What is your relationship to the victim? (*Check **only** one.*)

☐ Parent ☐ Spouse ☐ Child ☐ Legal Guardian ☐ Attorney ☐ Other *(Explain)*: _____

3 Tell us about the crime. *(Check **only** one.)*

The victim died because of:

☐ Motor Vehicle (DUI/DWI)
☐ Motor Vehicle (Other)
☐ Terrorism
☐ Arson
☐ Human Trafficking
☐ Other Homicide: _____

The victim was injured because of:

☐ Assault
☐ Sexual Assault
☐ Child Physical Abuse/Neglect
☐ Child Sexual Abuse
☐ Motor Vehicle (DUI/DWI)
☐ Motor Vehicle *(not DUI/DWI)*
☐ Child Pornography
☐ Other *(Explain)*: _____
☐ Stalking
☐ Kidnapping
☐ Terrorism
☐ Arson
☐ Robbery
☐ Human Trafficking

The victim lost essential personal property because of:

☐ Burglary
☐ Motor Vehicle (DUI/DWI)
☐ Motor Vehicle *(not DUI/DWI)*
☐ Human Trafficking
☐ Robbery (No injury)
☐ Other *(Explain)*: _____
☐ Arson
☐ Criminal Mischief
☐ Fraud/Financial Crime

Where did the crime happen? (*Check **only** one.)* ☐ Work ☐ Owned residence ☐ Apt. Bldg. ☐ Public Street

☐Subway/Bus ☐Parking Lot ☐Restaurant/Bar ☐School/School grounds ☐Shopping Mall ☐ Other *(Explain)*: _____

Was this a crime related to domestic violence?..... ☐ Yes ☐ No ☐ Unknown

Was this a crime related to bullying?..... ☐ Yes ☐ No ☐ Unknown

Was this a crime related to elder abuse/neglect?..... ☐ Yes ☐ No ☐ Unknown

Was this a hate crime?..... ☐ Yes ☐ No ☐ Unknown

Was the victim driving a livery cab when the crime happened?..... ☐ Yes ☐ No ☐ Unknown

Was the victim's property lost or damaged while trying to prevent or stop a crime against someone else or while helping the authorities stop the crime? .... ☐ Yes ☐ No

Crime Report #: _____ **Police or criminal justice agency reported to**: _____

County where crime happened: _____ Date of crime: _____ Date crime was reported: _____

If more than 7 days between the date of crime and date the crime was reported, explain why: _____

If more than 1 year between the date of crime and the date you are filing this claim, explain why: _____

Describe the crime in your own words: _____

4 Tell us about the suspect. Suspect's name *(if you know):* _____

Has the suspect been arrested for this crime? ☐ Yes ☐ No
Has the suspect been prosecuted for this crime? ☐ Yes ☐ No ☐ Not Yet
Does the suspect live in the same house as the victim OR is the suspect a member of the victim's family? ☐ Yes ☐ No
Has the court issued an order of protection in this case? ☐ Yes ☐ No *(If Yes, attach a copy.)*
Has the DA asked the court to order restitution? ☐ Yes ☐ No ☐ Not Yet
Did the court order the suspect to pay restitution? ☐ Yes *(Amount $ _____)* ☐ No ☐ Not Yet

NOTE - If you are eligible for compensation, the OVS may be able to reimburse for the expenses listed below. These items should also be requested as part of court ordered restitution. Applicants are encouraged to share this information with prosecutors if there is a criminal case. See the Court Ordered Restitution Information page for important information about restitution.

5 Tell us about your expenses related to this crime. *(Check all that apply.)*

☐ Medical/Ambulance
☐ Crime Scene Cleanup
☐ Security Device/System
☐ Counseling
☐ Other *(Explain):* _____
☐ Loss of Support (Death Claim Only)
☐ Vocational/Rehabilitation
☐ Funeral/Burial
☐ Lost Wages
☐ DV Shelter
☐ Moving/Storage
☐ Essential Personal Property
Personal Transportation
☐ Medical/Counseling
☐ Court

6 List any essential personal property, like cash, eyeglasses, or clothing that needs to be replaced because of this crime. *(If none, skip to 7.)*

Describe what was lost/damaged:	Cost	Describe what was lost/damaged:	Cost
1. _____	$ _____	4. _____	$ _____
2. _____	$ _____	5. _____	$ _____
3. _____	$ _____	6. _____	$ _____

Homeowner/Renter Insurance Company	Policy or ID #	Deductible $
Auto/Other Insurance Company	Policy or ID #	Deductible $

— If there were no injuries and you are only asking for essential personal property benefits, skip to 15. —

7 Tell us about the victim's or the parent's employment and insurance for Lost Wages.
If you do not want us to contact your employer, you cannot ask to be reimbursed for Lost Wages. (*Skip to 8.)*

Was the victim/parent of hospitalized minor victim employed when the crime happened? ☐ Yes ☐ No *(If No, skip to 8.)*
Did the victim/parent of hospitalized minor victim miss work because of the crime? ☐ Yes ☐ No
Was the victim/parent self-employed? ☐ Yes ☐ No *(If Yes, attach copies of last year's federal tax return and all schedules.)*

Employer's Name, Address, and Phone #:
_____ ( ) _____
Employer Street City State Zip Code Phone #

Other Employer's Name, Address, and Phone #:
_____ ( ) _____
Employer Street City State Zip Code Phone #

Name, Address, and Phone # of doctor who certified victim could not go to work:
_____ ( ) _____
Doctor Street City State Zip Code Phone #

Tell us about any insurance company that will cover the victim's lost time at work. *(If none, write "None" below and skip to 8.)*

	Policy or ID # or "None"		Policy or ID # or "None"
1. Unemployment Insurance		5. Workers' Compensation	
2. Disability Insurance		6. Other insurance	
3. Pension Plan		7. Social Security Benefits (ssn required)	SSN __ __ __ - __ __ - __ __ __ __
4. Other insurance		8. SSI Benefits (ssn required)	SSN __ __ __ - __ __ - __ __ __ __

8 If the victim died, fill out below if you have any burial expenses. *(If not, skip to 9.)*
Also, attach a copy of the funeral home contract, other bills for burial expenses, and a photocopy of the Death Certificate, if you have them.

Name of Funeral Home: _____ Phone #: ( ) _____

Address: _____
Street City State Zip Code

9 If the victim was injured or died because of this crime, fill out below.

Describe the victim's injuries, briefly: _____

_____

Did the victim receive any medical treatment? ☐ Yes ☐ No *(If **No**, skip to section10.)*

Tell us about the health professionals who treated the victim for injuries related to this crime:

	Full Name	Complete Address	Phone #
First Hospital			(____)
Other Hospital			(____)
First Doctor *(not in hospital)*			(____)
Other Doctor			(____)
First Dentist			(____)
Victim's Counselor			(____)

10 Tell us about the victim's dependents or others who depended on the victim for support. *(If none, skip to 11.)*

Dependent	Name	Social Security # __ __ __ - __ __ - __ __ __ __	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? ☐ Yes ☐ No
Other Dependent	Name	Social Security # __ __ __ - __ __ - __ __ __ __	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? ☐ Yes ☐ No
Other Dependent	Name	Social Security # __ __ __ - __ __ - __ __ __ __	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? ☐ Yes ☐ No

If more than 3 dependents, attach a separate sheet and check here: ☐

11 Did anyone besides the victim receive counseling because of this crime? *(If no, skip to 12.)*

Who received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			
Who else received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			

If more than 2 people received counseling because of this crime, check here and attach a separate sheet to describe. ☐

12 List any insurance covering the victim or the victim's dependents. *If no insurance, write **"None"** below. If you have applied but are not covered yet, write "Pending" under Policy or ID #.*

	Policy or ID #	*Name of person(s) covered by this insurance:*
Primary Insurance Company		
Major Medical Insurance Company		
Other Insurance *(Union, Dental, Vision, etc.)*		
Medicare		
Medicaid		
Workers' Compensation		
Auto Insurance		
Other insurance		

13 If the victim died, tell us about any life insurance and death benefits.
(If the victim did not die, or does not have any life insurance or death benefits, skip to 14.)

	Company Name	Address	Phone #	Policy or ID #
Life Insurance			( )	
Pension Plan			( )	
Other Insurance/Plan			( )	
Medicaid			( )	
Workers' Compensation			( )	

If any other insurance or death benefits, list here: _____

Do any of these policies cover the victim's burial expenses? ☐ Yes ☐ No

Has anyone applied for the Social Security Death Benefit? ☐ Yes ☐ No

14 Tell us about your financial situation. You MUST fill out ALL sections below. If none, enter zero (0).

How many dependents do you have? _____

What is your total annual income (from ALL sources)? If you are not sure, estimate: $ _____

List ALL your assets and ALL your debts below. If you are not sure, estimate. Attach additional pages, if needed.

Your Assets – If none, enter zero (0).		**Your Debts** – How much do you owe now?	
Savings, stocks, bonds	$		**If none, enter zero (0).**
Real Property (house, etc.)	$	Mortgage	$
Proceeds from life insurance	$	Loans	$

15 Is a private lawyer (not DA) representing you? ☐ Yes ☐ No

If Yes:

_____ ( )
Lawyer's Name Address Phone #

16 Authorization to speak with representative:

If you would like to give permission to a family member, friend or other person to speak to OVS regarding your claim, enter here.

_____ ( )
Name of Person Address Phone #

17 Victim/Claimant's Authorization:

I ACKNOWLEDGE that accepting an award from the Office of Victim Services (OVS) creates a lien in favor of the State of New York on any recovery relating to the crime upon which this claim is based, including any judgment, settlement or order of restitution. I further authorize any funeral director, attorney, employer, police or other public authority, insurance company or any person who rendered services to the above, or having knowledge of the same, to furnish the OVS or its representatives the following information: Workers' Compensation records, information relating to the crime or any injuries or death suffered as the result of the crime, and information relating to this claim. If an award is made, I authorize the OVS to make payments directly to the provider of services. I also authorize the OVS to share my information and records compiled for this claim with the local Victim Assistance Program (VAP) in order for the VAP to assist the OVS in processing my claim and making its determination. If a private lawyer has been indicated above, I also authorize the OVS to share my information and records compiled for this claim with the lawyer in order for him/her to act as my representative. I understand a separate Notice of Appearance from my lawyer will be needed in addition to this authorization. If a family member, friend or other person is indicated above, I authorize the OVS to share my information and records compiled for this claim with that person in order that they assist me with this claim.

A photocopy of this authorization shall be deemed as effective as the original.

▶ _____ ( )
Claimant's Signature Date Daytime Phone #

Email: _____

Language you prefer to speak: ☐ English ☐ Spanish ☐ Simplified Chinese ☐ Traditional Chinese ☐ Haitian Creole ☐ Italian ☐ Korean ☐ Russian ☐ Other _____

Interpreter Needed: ☐ Yes ☐ No

To process your claim, mail us the following documents. ***(Keep a copy for your records.)***

- All bills and receipts for services listed on this form
- Your completed, signed claim form
- One completed HIPAA form for **each service provider** listed on this form (You can photocopy the HIPAA form.)
- Letters from any insurers denying or authorizing payment for the services listed on this form.

Remember: You must bill your insurance company or benefits plan **before** the OVS can pay.

Mail your documents to: New York State Office of Victim Services
AE Smith Building
80 S. Swan Street
Albany, NY 12210-8002

HIPAA

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA
[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number XXX-XX-__ __ __ __
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
NYS OFFICE OF VICTIM SERVICES – AE SMITH BLDG., 80 S. SWAN ST., ALBANY, NY 12210-8002

9(a). Specific information to be released:
- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____
  _____

Include: (*Indicate by Initialing*)
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information
(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
NEW YORK STATE OFFICE OF VICTIM SERVICES
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
At request of the individual for purposes of establishing eligibility for New York State Office of Victim Services benefits.	***This authorization will expire upon the termination of the individual's eligibility for Office of Victim Services benefits.***
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**