NEW YORK STATE | Office of Victim Services

Claim Application and Instructions

How to Apply for Compensation

Who can apply for compensation?

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 and counseling expenses, loss of essential personal property, crime scene clean-up, and other losses that are the direct result of the crime.

How do I ask for compensation?

Send us your completed OVS application along with copies of documentation that OVS may request to determine your eligibility for compensation.

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 years or older, 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, safety, or welfare. This includes but is not limited to items like eyeglasses not covered by insurance, bedding, and clothing.

What if I move?

Mail or email 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 this claim form 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 online. You will need to create a my.ny.gov account to access the portal. For help submitting a claim online, please contact OVS at 800-247-8035 or email OVSInfo@ovs.ny.gov.

Do I have to fill out a HIPAA form?

Maybe. This form helps protect your private health information. If you are claiming medical or counseling expenses, you should fill out one HIPAA form for each service provider. You can photocopy a blank form to make extra copies.

What is restitution?

Restitution is money paid to a victim by the perpetrator of a crime for the losses or injuries incurred as a result of the crime. It must be ordered by the Court at the time of sentencing, and it is considered part of the sentence. Restitution is NOT for payment of damages for future losses, mental anguish, or "pain and suffering". For more information, please contact OVS at 800-247-8035 or visit the OVS website at https://ovs.ny.gov/legal-information.

Who can get restitution?

Anyone who has been the victim of a crime and suffered injuries, financial losses, or damages can seek restitution.

How do I ask for restitution?

You should contact the District Attorney's office and advise them of how severe your injuries are, your out-of-pocket losses, and the amount of damages you are requesting.

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

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

Application for Compensation
New York State Office of Victim Services

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 ☐Hispanic ☐American Indian/Alaskan Native ☐Asian Indian ☐Chinese ☐Japanese ☐Filipino ☐Korean ☐Vietnamese ☐Bangladeshi ☐Pakistan ☐Guamanian ☐Chamorro ☐Samoan ☐Native Hawaiian ☐Other ☐Multi-Race

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

Gender: ☐Male ☐Female ☐ X ☐Prefer Not to Answer

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:	**Was the victim injured** because of:		**The victim lost essential personal property** because of:	
☐Motor Vehicle (DUI/DWI) ☐Motor Vehicle (Other) ☐Terrorism ☐Arson ☐Human Trafficking ☐Other Homicide	☐Sexual Assault ☐Child Physical Abuse/Neglect ☐Child Sexual Abuse ☐Motor Vehicle (DUI/DWI) ☐Motor Vehicle (not DUI/DWI) ☐Child Pornography ☐Other (*Explain):* _____	☐Assault ☐Stalking ☐Kidnapping ☐Terrorism ☐Arson ☐Robbery ☐Human Trafficking	☐Burglary ☐Motor Vehicle (DUI/DWI) ☐Motor Vehicle (not DUI/DWI) ☐Human Trafficking ☐Robbery (no injury) ☐Other (*Explain):* _____	☐Arson ☐Criminal Mischief ☐Fraud/Financial Crime

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

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):*_____

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. Restitution:

Has the District Attorney (DA) asked the court to order restitution?	☐Yes	☐No	☐Unknown
Did the court order the suspect to pay restitution?	☐Yes (*Amount $ _____)*	☐No	☐Not Yet

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

NOTE – If you are eligible for compensation, 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. Visit https://ovs.ny.gov/legal-information for more information.

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

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.	$	3.	$
2.	$	4.	$

7. Check the boxes for other benefits or insurance you have that may help pay expenses related to this crime:

☐Private Health Insurance (through employer or self-pay)	☐Child Health Plus	☐SSDI/Disability	☐Home/Renter's Insurance
☐Secondary Health Insurance	☐Medicare	☐Worker's Comp	☐Auto Insurance
☐NYS Marketplace Health Insurance	☐Medicaid	☐Veteran's Benefits	☐None
☐NYS Essential Plan	☐Other:		

8. Is a private lawyer (not District Attorney) representing you? ☐Yes ☐No

If Yes:

_____ ( ) _____

Lawyer's Name Address Phone #

9. 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 #

10. 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 payments of an order of restitution. I authorize any funeral director, attorney, employer, police or other public authority, insurance company or any person who provided 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) listed on this application or any local government entity established in New York State to assist crime victims in order for the VAP or local government entity to assist the OVS in processing my claim, making its determination, and coordinating services. If I have listed a private lawyer on this application, I also authorize the OVS to share my information and records compiled for this claim with the lawyer 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 listed on this application, I authorize the OVS to share my information and records compiled for this claim with that person so they can assist me with this claim. I certify the information given on this application and any documentation provided in support of this application is true and complete. I understand that making a false statement on this application, or submitting any documentation provided in support of this application that is false, may be punishable as a criminal offense. I acknowledge that completing this application does not guarantee an award.

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 ☐Chinese ☐Arabic ☐Haitian Creole ☐Italian ☐Korean ☐Russian ☐Yiddish ☐Bengali ☐French ☐Urdu
Interpreter Needed: ☐ Yes ☐No	☐Other

To process your claim, please send OVS the following documents. Keep a copy for your records.

- All bills and receipts for expenses related to goods and services you described in sections 5 and 6 of this claim form.
- Your completed, signed claim form.
- One completed HIPAA form for each medical and mental health provider you saw for services related to this crime.
- Letters from any insurers or government agencies denying or authorizing payments related to goods and services you described in sections 5 and 6 of this claim form.

Remember: You must bill your insurance company or benefits plan **before** 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

Email your documents to: ovsintake@ovs.ny.gov

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 contact.**