Department of Public Safety – State of Hawaii
Crime Victim Compensation Commission

FORM #1

APPLICATION FORM

For Office Use Only – Case #:	Crime Victim Compensation Commission State of Hawaii, Department of Public Safety 1136 Union Mall, Room 600 Honolulu, Hawaii 96813 Telephone: (808) 587-1143 Fax (808) 587-1146 Website: http://www.hawaii.gov/cvcc
***TYPE** or **PRINT** in Black or Blue ink. Provide as much information as possible.*	

VICTIM INFORMATION

Name_____ Home Phone: _____
First Middle Last
Cell/Pager: _____
Mailing Address _____ Work Phone: _____
Street City State Zip

Date of Birth ___ ___/___ ___/___ ___ ___ ___ Social Security No. ___ ___ ___-___ ___-___ ___ ___ ___

PLEASE CHECK:

Sex ☐ Male ☐ Female **Disabled** ☐ Yes ☐ No

Marital Status ☐ Married ☐ Single **Were you visiting Hawaii at the time of the incident?** ☐ Yes ☐ No

Check the one you believe represents your ethnicity:

☐ Black ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Portuguese ☐ Hispanic ☐ Other
☐ Samoan ☐ Japanese ☐ Korean ☐ White ☐ Puerto Rican ☐ Native American

APPLICANT INFORMATION (Complete **only if** you are applying for a Victim who is a minor, deceased, or is incapacitated.)

Applicant's relationship to victim: _____ Home Phone: _____
Cell/Pager: _____
Work Phone: _____

Name_____
First Middle Last

Mailing Address _____
Street City State Zip

CRIME INFORMATION

Date of Crime _____ Type of Crime: (Assault, Sexual Assault, etc.) _____

Name of Suspect _____ Location of Crime _____
Last First Middle Street City Zip

Police Report No. _____

If incident was investigated by military police, provide the military police report no. and branch of service. _____

MEDICAL INFORMATION

Be sure to complete a Medical Authorization Form for each provider (doctor, hospital, or therapist) you saw due to the incident. In cases of death, provide the name of the mortuary or cemetery. Attach all bills, receipts, and insurance statements.

Name of Provider	Address	Service Date	Total Charges
1.			
2.			
3.			

Medical Insurance: Member #:

CONTINUED ON BACK

VICTIM EMPLOYMENT INFORMATION Complete only if claiming for Lost Wages

Did injury occur at work place? ☐ Yes ☐ No Did you miss work as a result of the injury? ☐ Yes ☐ No

Period of Absence: From _____ To _____
Month Day Year Month Day Year

Employer's Name_____ Phone No. _____

Mailing Address _____
Street City State Zip

Job Title: _____ Rate of Pay: _____

INSURANCE / LEGAL INFORMATION

Check all potential sources of full or partial payment of expenses:

☐ Medical Insurance ☐ Motor Vehicle Insurance ☐ Homeowner's Insurance ☐ Social Security Disability
☐ Welfare ☐ Medicare ☐ Medicaid ☐ Temporary Disability
☐ Worker's Compensation ☐ Other (Specify) _____

Have you filed or do you intend to file a civil law suit? ☐ Yes ☐ No

- If Yes, please complete the following:

Attorney's Name _____ Telephone No. _____

Mailing Address _____
Street City State Zip

HOW DID YOU FIND OUT ABOUT THE COMMISSION Please check:

☐ Hospital/Medical Personnel ☐ Sex Assault Counselor ☐ Police ☐ Newspaper ☐ Television
☐ Prosecutor's Victim Witness ☐ Domestic Violence Counselor ☐ Radio ☐ Other (Specify) _____

Name of Referring Victim Witness Advocate: _____

VICTIM CERTIFICATION & SIGNATURE

I certify that I have read this application and have provided information that is true and correct to the best of my knowledge. I understand that the law provides for penalties for false statements. I will repay the Commission should I receive moneys from civil suits, restitution, or insurance payments.

_____

Signature of Victim Date Signature of Applicant Date

STATEMENT OF POLICY: It is the policy of the Department of Public Safety, Crime Victim Compensation Commission, that no person shall on the grounds of race, color, religion, sex, national origin, age, or handicap, be excluded from participation in or subjected to discrimination when making their claim for compensation.

PLEASE CHECK BEFORE MAILING:

☐ Have you signed the *Application Form?*
☐ Have you provided us with your complete mailing address and telephone number(s)?
☐ Have you completed the information regarding the Police Report Number, Crime Date, and Type of Crime?
☐ Have you signed and submitted a *Medical Authorization Form* for each provider (doctor, hospital, clinic) that treated you?
☐ Have you submitted all of your medical bills, funeral bills, insurance statements and receipts?
☐ IF CLAIMING LOST WAGES, have you signed the *Employer Authorization Form* and submitted it to your employer?
  ☐ Have you submitted your pay stubs for the two periods prior to the incident and your medical disability certificate?
  ☐ If you are self-employed, have you submitted copies of your last two years' Federal and State tax returns?
☐ IF incident occurred in a MOTOR VEHICLE, have you contacted your motor vehicle insurance company?