VICTIM APPLICATION FORM

Claim #_____

PIN # _____

SECTION 1 - VICTIM INFORMATION (APPLICANT)

Applicant's Name (Last) (First) (Middle)		☐ Female ☐ Male
Other Names Used (e.g., nickname, maiden name, alias) (Last) (First)		Date of Name Change Year Month Day
Social Insurance Number	Birthdate Year Month Day	Occupation
Marital Status ☐ Married ☐ Common Law ☐ Widowed ☐ Divorced ☐ Separated ☐ Single		
Mailing Address (Apt No, Street Number, Street Address, PO Box)		
City	Province	Postal Code
Primary Phone Number	Alternate Phone Number	E-mail
Alternate Mailing Address (e.g., the address of a family member) in case mail sent to the address above is returned to us.		
City	Province	Postal Code

SECTION 2 - CRIME INFORMATION

Please indicate the type of crime that occurred (e.g., home invasion, assault). Type of Crime:	If the crime occurred over a period of time, please provide the approximate dates (e.g., Sept 2001 – Dec 2002). Date of Crime:
Is this application being filed within one year of the date of the crime? ☐ Yes ☐ No *If no:* Briefly explain why you did not apply sooner (see reverse for explanation).	
Please provide the city/town in B.C. where the crime took place. If the crime occurred over a period of time in more than one location, please provide the names of all locations. Location(s) of Crime:	

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SECTION 2 CON'T - CRIME INFORMATION

Was a report made to police? ☐ Yes ☐ No	*If no:* Please identify who the report was made to (doctor, social worker, counsellor, other).
To which police force was the report made?	Date report was made to police Year | Month | Day
Police File Number:	Name of Investigating Officer (if known):
Name of the person who allegedly committed the crime (if known): (Last) (First) (Middle)	
Relationship to the alleged offender (if any):	Has the alleged offender been charged? ☐ Yes ☐ No ☐ Unknown
Court File Number (if known):	Court Location:
Have you sued the alleged offender(s)? ☐ Yes ☐ No ☐ *If yes:* File # Court Location	Do you intend to sue the alleged offender? ☐ Yes ☐ No ☐ Undecided

Briefly describe how the incident occurred, in your own words. Please complete this section even if you have filed a police report.

Please specify any injuries, physical or psychological, you sustained as a result of the crime (e.g., bruised leg, broken wrist, sleeplessness).

If you have additional information, please attach a separate sheet.

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SECTION 3 - MEDICAL/DENTAL INFORMATION

This section provides information regarding any medical or dental treatment you received as a result of the crime.

Do you have medical services coverage (e.g., a BC Services Card or BC Care Card)? ☐ Yes ☐ No	*If yes:* Provide your personal health number.
Do you have other health coverage? (e.g., Blue Cross) ☐ Yes ☐ No	*If yes:* Provide your extended health plan number and provider.
Did you go to a hospital to be treated for injuries resulting from the incident? ☐ Yes ☐ No	
If yes: Name of Hospital	Date of Treatment Year Month Day
Do you have a family doctor who has been treating you for injuries resulting from the incident? ☐ Yes ☐ No	
If yes: Family Doctor's Name	Phone Number
Address (Apt No, Street Number, Street Address, PO Box)	

Please fill out the following about any other doctors, specialists, or counsellors who have been treating you for injuries resulting from the incident.

☐ ***Specialist*** ☐ ***Counsellor/Psychologist*** ☐ ***Dentist*** ☐ ***Other*** _____	
Name	Phone Number
Address (Apt No, Street Number, Street Address, PO Box)	
☐ ***Specialist*** ☐ ***Counsellor/Psychologist*** ☐ ***Dentist*** ☐ ***Other*** _____	
Name	Phone Number
Address (Apt No, Street Number, Street Address, PO Box)	
☐ ***Specialist*** ☐ ***Counsellor/Psychologist*** ☐ ***Dentist*** ☐ ***Other*** _____	
Name	Phone Number
Address (Apt No, Street Number, Street Address, PO Box)	

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SECTION 4 - EXPENSE AND LOSS INFORMATION

This section provides information regarding any expenses or losses you are claiming as a result of the crime.
Please keep receipts for all expenses you are claiming. The program will require you to submit **original receipts**.

Please check all that apply:

- ☐ Medical expenses
- ☐ Dental expenses
- ☐ Prescription drug expenses
- ☐ Counselling
- ☐ Lost employment income (reimbursed at minimum wage)
- ☐ Repair or replacement costs of damaged or destroyed personal property that you were wearing at the time of the incident (e.g., eyeglasses, clothing)
- ☐ Protective measures (e.g., moving expenses, security devices)
- ☐ Disability benefits, services or equipment
- ☐ Crime scene cleaning
- ☐ Other (please specify): _____

If you have received or will receive benefits as a result of the crime, check all that apply:

- ☐ Disability Plan Benefits
- ☐ Employment Insurance Benefits
- ☐ Income Assistance
- ☐ Canada Pension Plan
- ☐ Aboriginal Affairs and Northern Development Canada
- ☐ Benefits you have received as a result of civil action
- ☐ Other (please specify): _____

SECTION 5 - EMPLOYMENT INCOME

This section provides information regarding employment information. Complete this section if you are requesting benefits for lost employment income.

Were you employed when the crime occurred? ☐ Yes ☐ No ☐ Self-employed	Were you at work at the time of the incident?
If yes: Have you applied for Workers' Compensation Benefits? ☐ Yes ☐ No	What is your Workers' Compensation Benefits claim number?
As a result of any crime-related injuries: Did you miss work? ☐ Yes ☐ No Did you lose wages? ☐ Yes ☐ No	
If yes: Provide days of work missed From: To:	
Name of Company/Organization	Phone Number
Address (Apt No, Street Number, Street Address, PO Box)	
If you are requesting benefits for lost wages, may we contact your employer? ☐ Yes ☐ No	
Name of Contact Person	

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SECTION 6 - APPLICATION ON BEHALF OF VICTIM

DO NOT complete this section if you are a Victim Service Worker or other person who is helping the victim to complete the application form. Complete this section if you are a parent, legal guardian, or legal representative signing this application form on behalf of the victim.

Person completing the application (Last) (First) (Middle)		
Mailing Address (Apt No, Street Number, Street Address, PO Box)		
City	Province	Postal Code
Phone Number	E-mail (Optional)	
Are you an immediate family member? ☐ Yes ☐ No	*If yes:* What is your relationship to the victim? (e.g., mother)	
Are you a legal representative? ☐ Yes ☐ No	*If yes:* What is your authority? (e.g., Public Guardian and Trustee)	
Note: *If you are not the natural or adoptive parent of the applicant, please attach a copy of any court order or other document that is proof of guardianship/trusteeship.*		

SECTION 7 - DECLARATION

Your application will be returned if this section is not signed and dated.

Information supplied on this form is necessary to determine your eligibility for benefits, and is collected under the authority of Section 6 of the *Crime Victim Assistance Act*. Any information collected will be used only for the purposes of adjudicating your claim for benefits.

By signing this section you declare that the information you have provided on this application is true and correct. It is an offence to provide false or misleading information on this application and may lead to prosecution. If it is discovered at a later time that false or misleading information has been provided on this application form, you may be required to repay to CVAP any benefits received.

I, _____, (*please print*) submit this application in support of a claim for benefits available to Victims under the *Crime Victim Assistance Act*, and declare the information provided in this application for benefits is true and correct.

Applicant's Signature _____ Date _____
(Month/Day/Year)

*** Your application will be returned if this section is not signed and dated.**

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SECTION 8 - AUTHORIZATION

This section authorizes the Crime Victim Assistance Program to contact the persons and organizations listed so that we may process your claim for benefits. Your application will be returned if this section is not signed and dated. You may be required to submit other authorizations that are needed to process your claim. If you have any questions about the collection and use of the information gathered by the Crime Victim Assistance Program, please contact the program at (604) 660-3888 or toll free in B.C. at 1-866-660-3888.

I, _____ , (*please print*) hereby authorize:

1. The doctor, dentist, optometrist, chiropractor, or other health care professional who treated my injuries (physical and/or psychological) to give the Crime Victim Assistance Program, on request, medical or other reports regarding my injuries, treatment or other information relevant to this application;

2. The police or other law enforcement authorities to give the Crime Victim Assistance Program, on request, a copy of police reports, statements, incident reports or other information relevant to this application;

3. The Workers' Compensation Board of BC or other authority from which the victim received or will receive or will be eligible to receive payments from provincial, federal or other jurisdictions funds to give the Crime Victim Assistance Program, on request, information relevant to this application;

4. My employer(s) or similar authority to give the Crime Victim Assistance Program, on request, information as to my employment, earnings, benefits or other information relevant to this application;

5. Any accident, disability, sickness, life insurance/assurance company or private pension scheme or extended health benefits scheme from which payments or services were received or will be received to give the Crime Victim Assistance Program, on request, information relevant to this application;

6. Human Resources and Skills Development Canada or Aboriginal Affairs and Northern Development Canada or any other authority from which payments were received or will be received to give the Crime Victim Assistance Program, on request, information relevant to this application;

7. The Canada Employment Insurance Commission or the Canada Pension Plan or similar employment insurance and pension plans from other jurisdictions, to give the Crime Victim Assistance Program, on request, information as to benefits received or to be received relevant to this application; and,

8. Canada Revenue Agency or other similar agency in any other jurisdiction, to give the Crime Victim Assistance Program, upon request, information as to my employment income.

I understand that the Crime Victim Assistance Program may notify the above authorities that I have submitted an application for benefits pursuant to the *Crime Victim Assistance Act.*

Applicant's Signature _____ Date _____

(Month/Day/Year)

Claim # _____

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SECTION 9 - OPTIONAL AUTHORIZATION

CVAP staff requires your written permission to discuss the information in your file with other persons. Please complete this section if you want to allow program staff to discuss your file with another person, such as a family member or victim service worker.

This is the authorization (written permission) to discuss your file with another person.

I, _____, (*please print*) hereby authorize the Crime Victim Assistance Program staff to discuss my claim with _____

Name of authorized person you allow program staff to talk to (print clearly)

Authorized Person's Phone Number	Authorized person's relationship to you (applicant)

Applicant's Signature _____ Date _____

(month/day/year)

Agency Name and Address