CRIME VICTIM ASSISTANCE PROGRAM
Witness Application

The Crime Victim Assistance Program (CVAP) provides benefits to **Witnesses** of an injured or deceased victim of violent crime in accordance with the *Crime Victim Assistance Act* and its regulations.

The program may also provide benefits to **Victims of violent crime**, as well as **Immediate Family Members** of an injured or deceased victim of crime.

This application package consists of:

- **an instruction guide**
- **the application form required**
- **summary of benefits**

The instructions provided in this package follow the basic steps you will need to know to complete your application.

Before You Apply

WHO MAY USE THIS APPLICATION?

This application package is designed for a **Witness** of an injured or deceased victim of violent crime. Under the *Crime Victim Assistance Act,* a Witness is a person who may not necessarily be related to the victim, but has strong emotional attachments to the victim, and witnesses or comes upon the scene of a crime that caused a life-threatening injury to, or the death of, the victim.

If this definition does not apply to you, please see the application packages for **Immediate Family Members** or **Victims.**

THE CRIME VICTIM ASSISTANCE PROGRAM WILL *NOT* COVER

- injuries or loss sustained from motor vehicle accidents
- injuries or loss sustained at work, and which are covered by WorkSafeBC
- claims for pain and suffering
- lost or stolen personal property
- injuries sustained from an offence occurring outside of B.C. or prior to July 1, 1972

WHAT TYPES OF BENEFITS DOES THE CRIME VICTIM ASSISTANCE PROGRAM PROVIDE?

Benefits that may be available to Witnesses include:

- counselling
- prescription drug expenses
- transportation and related expenses
- crime scene cleaning

The Crime Victim Assistance Program will only provide benefits that are not covered by other programs (e.g., EI, ICBC, extended health coverage, personal insurance).

BRITISH COLUMBIA

INSTRUCTION GUIDE

FILLING OUT THE APPLICATION

The application package is available in PDF format at http://www.gov.bc.ca/crimevictimassistance. To download the appropriate viewer, visit http://get.adobe.com/reader.

Print versions of the application form are available from the Crime Victim Assistance Program or a local victim service program.

A local victim service program can help you complete this application. To locate a program near you, call VictimLink BC toll-free at **1-800-563-0808.**

BE COMPLETE AND ACCURATE

Complete all sections. If your application is incomplete, it may be returned to you and this will delay the processing of your application.

COMPLETING THE FORM

You must answer all the questions on this application form unless indicated otherwise.

1. Download and fill out the application form on a computer. You also have the option of saving your form and completing it later.
2. If you are completing the application form by hand, please use blue or black pen, and print clearly.
3. If you have completed this form on your computer, print all pages of your application form.
4. You must sign and date both the Authorization and Declaration in Sections 7 & 8. Applications without the required signatures will be returned to you.
5. Mail the original application and any attachments to:

   Crime Victim Assistance Program
   PO Box 5550, Stn Terminal
   Vancouver, BC V6B 1H1
6. If your address or telephone number changes after submitting this application, please inform the Crime Victim Assistance Program by calling **1-866-660-3888.**

For additional questions, please contact the Crime Victim Assistance Program at **604-660-3888** or toll-free in B.C. at **1-866-660-3888.**

For more information, see the Government of British Columbia website at http://www.gov.bc.ca/crimevictimassistance or query "cvap bc" using your internet search engine.

WITNESS APPLICATION FORM

Claim #_____

PIN # _____

SECTION 1 - WITNESSES INFORMATION (APPLICANT)

Applicant's Name (Last) (First) (Middle)		☐ Female ☐ Male
Other Names Used (e.g., nickname, maiden name, alias)		
Social Insurance Number	Birthdate Year Month Day	Occupation
Relationship to Victim		
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 - VICTIM INFORMATION

Victim'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		
Most Recent Mailing Address (Apt No, Street Number, Street Address, PO Box)		
City	Province	Postal Code
Primary Phone Number	Alternate Phone Number	E-mail

One-Year Time Limit
Applications to CVAP must be submitted within one year of the date of the incident. An explanation is required to determine if the time limit can be extended. The one year time limit does not apply if the applicant is a minor (under 19 years old).

Police Force/Police File Number
This information is needed by CVAP to access the police report about the incident.

Court File Number/Court Location
This information is needed by CVAP to access court records about the incident.

Claim # _____

PIN # _____

SECTION 3 - 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).

Location(s) of Crime:

City/Towns

Which police force is handling the investigation?

Police File Number:	Name of Investigating Officer (if known):

Name of the person who allegedly committed the crime (if known):

(Last) (First) (Middle)

Relationship of offender to victim (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
Is the victim deceased as a result of the crime? ☐ Yes ☐ No	If yes, date of death *(Month/Day/Year)*

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

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

Health Plan Coverage
CVAP will only pay expenses or provide benefits that are not already covered by your existing health plan.

Benefits available through CVAP
Please refer to the complete Summary of Benefits available to Witnesses included on the last page of this application package.

Original receipts are required for expenses not covered by your extended health or other insurance plan.

Claim # _____

PIN # _____

SECTION 4 - MEDICAL INFORMATION

This section provides information regarding any medical 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.
Do you have a family doctor who has been treating you as a result of the incident? ☐ Yes ☐ No	
If yes: Family Doctor's Name	Phone Number
Address (Apt No, Street Number, Street Address, PO Box)	
Please indicate any counsellor/therapist who has been treating you as a result of the incident.	
Name	Phone Number
Address (Apt No, Street Number, Street Address, PO Box)	

SECTION 5 - EXPENSES AND BENEFITS

This section provides information regarding any expenses or benefits you wish to claim. Please keep receipts for all expenses you are claiming. The program will require you to submit original receipts. For further information please see the Summary of Benefits available to Witnesses.

Please check all that apply:

- ☐ Counselling Services
- ☐ Transportation to obtain counselling
- ☐ Prescription drug expenses
- ☐ Crime scene cleaning (only if the victim is deceased as a result of the crime)

Claim # _____

PIN # _____

SECTION 6 - APPLICATION ON BEHALF OF WITNESS

DO NOT complete this section if you are a Victim Service Worker or other person who is helping the applicant 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 applicant.

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	
Are you an immediate family member? ☐ Yes ☐ No	*If yes:* What is your relationship to the applicant? (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 Witnesses 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)

Read this authorization before you sign
The information provided on your application to CVAP will only be used to assess your eligibility for benefits.

Applicant's Signature
If you are a parent, legal guardian or legal representative applying on behalf of the Witness, you may sign this authorization as the applicant.

Claim # _____

PIN # _____

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 #_____

PIN # _____

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

SUMMARY OF BENEFITS

The Crime Victim Assistance Program (CVAP) helps Victims, Immediate Family Members of victims, and Witnesses affected by violent crime. Benefits provided by CVAP offset financial loss and assist in recovery from injuries. This summary focuses on benefits available to Witnesses.

Benefits:	**For:**	**Examples:**
Counselling services or expenses	Witnesses who need counselling to recover from the psychological injury caused by witnessing the crime	• counselling sessions
Prescription drug expenses	Witnesses who need prescription drugs to recover from the psychological injury caused by witnessing the crime	• medications prescribed by a doctor
Transportation and related expenses, and transportation related childcare	Witnesses who have to travel some distance to obtain counselling services provided as crime victim assistance benefits	• transportation expenses such as bus fare, air fare, or mileage expenses • meals and accommodation • childcare while attending appointments
Crime scene cleaning	Witnesses who need specialized cleaning of their home or vehicle because the crime was committed there	• specialized cleaning and disinfecting of contaminated areas • replacement of contaminated flooring, wall covering, or other built-in features