State of Hawai'i
CRIME VICTIM COMPENSATION COMMISSION
1164 Bishop Street, Suite 1530
Honolulu, HI 96813
Telephone: (808) 587-1143 Fax: (808) 587-1146
Email: cvcc@hawaii.rr.com Website: http://dcr.hawaii.gov/cvcc

For Office Use Only

□ LEP □ Mass Violence

Case #:

APPLICATION FORM

PART 1: LANGUAGE ACCESS & SPECIAL SERVICES

Do you require language interpretation and /or translation? □ Yes □ No Preferred Language: _____

Do you require special assistance, auxiliary services and/or physical accommodation? □ Yes □ No Please specify: _____

PART 2: VICTIM INFORMATION (*Demographic information is optional.)

Legal Name (First, Middle Initial, Last)_____ Date of Birth: _ _ / _ _ _ / _ _ _ _

Social Security No.: xxx- xx- __ __ __ __ *Gender: □ Male □ Female * Marital Status: □ Single □ Married

*Race:

□ African American □ Chinese □ Filipino □ Hawaiian □ Hispanic □ Japanese □ Korean
□ Native American □ Portuguese □ Puerto Rican □ Samoan □ White □ Multiple Races □ Other _____

Mailing Address: _____ Apt No.:_____

City: _____ State: _____ Zip: _____

Contact Information: Home Phone: _____Cell Phone: _____Email:_____

PART 3: APPLICANT INFORMATION (Complete only if you are applying for the victim.)

Legal Name (First, Middle Initial, Last) _____ Is Victim Deceased? □ Yes □ No

Relation to Victim: □ Self □ Spouse □ Sibling □ Parent □ Other Relative □ Friend □ Other (Specify) _____

Mailing Address: _____ Apt No.:_____

City: _____ State: _____ Zip: _____

Contact Information: Home Phone: _____Cell Phone: _____Email:_____

PART 4: CRIME INFORMATION

Police Report Number: _____ Date of Crime: _____

Location of Crime: □ O'ahu □ Hawai'i Island □ Kaua'i □ Maui □ Moloka'i □ Lana'i □ Ni'ihau □ Other (Specify) _____

Did the crime occur on a military base? □ Yes □ No Branch of Service: _____Military Police Report No.:_____

PART 5: CRIME-RELATED EXPENSES (Check all that apply.)

□ Medical Services □ Mental Health Counseling □ Lost Wages
□ Dental Services □ Funeral and Burial □ Loss of Support

***Acknowledgement Award** - *You may be eligible for this one-time nominal monetary award given to recognize you as a victim of crime in Hawai'i. This award is not meant to quantify the emotional and/or physical impact of the crime.*

List any hospital, physician, counselor, funeral home or other person who attended, examined, or provided services to the crime victim or crime victim for whom you are the parent, legal guardian, or conservator and have the authority to act on his or her behalf.

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

PART 6: INSURANCE INFORMATION (Failure to provide this information may delay processing of the application.)

CONTINUED ON BACK

Does the victim have health insurance? □ Yes □ No Policy Number: _____

Name of Victim's Health Insurance Provider(s): (Check all that apply)

□ HMSA □ Kaiser Permanente □ Medicare □ MedQuest □ UHA □ UHC □ Other (Specify)_____

PART 7: VICTIM EMPLOYMENT INFORMATION

Are you requesting Lost Wages for work missed as a result of this incident? □ Yes □ No

Did the crime occur at work? □ Yes □ No Employment Status: □ Employed □ Self-Employed

PART 8: CIVIL SUIT INFORMATION

Do you intend to file a civil suit? □ Yes □ No □ Undecided

PART 9: REFERRED BY

How did you learn about the Commission? (Check all that apply)

□ Hospital/Medical Personnel □ Sexual Assault Counselor □ Police □ Newspaper □ Television

□ County Prosecutor - Victim Witness □ Domestic Violence Counselor □ Other (Specify): _____

Name of Advocate: _____

PART 10: CERTIFICATIONS

IMPORTANT – PLEASE READ CAREFULLY

Applicant/Victim Authorization for Release of Information

I authorize any hospital, physician, counselor, funeral home, or other person who attended, examined, or provided services to me—or to any minor child or incapacitated adult for whom I am the parent, legal guardian, or conservator—to release to the Crime Victim Compensation Commission or its representative any and all information regarding the incident that resulted in physical and/or emotional injuries or death, as well as information related to this application for victim compensation. A copy of this authorization shall be considered as effective and valid as the original. I understand that the Commission will request only the information necessary to determine my eligibility for benefits and/or to enable payment for services provided. I also understand that the Commission may share the information I provide with any hospital, physician, counselor, funeral home, or other service provider involved, as necessary to assist with processing, billing, or payment for services rendered.

Assignment of Recovery

I understand that if I, or the person I represent, receive money from any source related to the incident -- including payments from state or county agencies, insurance benefits, or workers' compensation -- the Commission is entitled by state law (HRS §351-63(b)) to recover the full amount it paid. I also acknowledge that my providers may be paid directly for any debts I owe.

I agree to notify the Commission if I file a lawsuit against any party responsible for the injury or death for which the Commission paid compensation. This includes directly liable parties, other liable or obligated third parties, and any insurance or governmental/private agency settlements. If I recover money through judgment or settlement, the Commission is entitled to the full amount it paid (HRS §351-63(b)).

If a court orders restitution to me or to the person I represent for expenses covered by the Commission, the Commission is entitled to reimbursement unless the court orders otherwise.

Declaration of Truthfulness

I certify that the information provided in this application is true to the best of my knowledge. I understand that knowingly making false statements to mislead the Commission will result in denial of my claim in its entirety (HRS §351-31(e)).

Victim's Signature: _____ Date _____

Applicant's Signature:_____ Date _____

SUBMIT THE ORIGINALLY SIGNED APPLICATION TO:

1164 Bishop Street, Suite 1530
Honolulu, HI 96813
Fax: (808) 587-1146
Email: cvcc@hawaii.rr.com

APPLICATIONS SUBMITTED FOR CHILD VICTIMS UNDER THE AGE OF 18 MUST BE COMPLETED AND SIGNED BY THE CHILD'S PARENT OR LEGAL GUARDIAN

It is the policy of the 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.

For Americans with Disabilities Act Accommodations,
please contact the Crime Victim Compensation Commission at (808) 587-1143.