犯罪受害者补偿申请(CRIME VICTIMS COMPENSATION APPLICATION)

伊利诺伊州
索赔法院

伊利诺伊州
总检察长

申请说明

- 谁应该填写申请表？申请必须由以下人员之一完成：1) 年满 18 岁、且符合《犯罪受害者补偿法案（Crime Victims Compensation Act）第 740 ILCS 45/2 项之申请人 资格、并在寻求报销其自身费用的人士；或 2) 如果受害者未满18岁或属于法定残疾人士，则受害者的父母或法定监护人应代表其填写申请表；或 3) 任何已支付或有义务支付受害者的费用（医疗/住院、葬礼/埋葬）的人士。申请书必须由申请人签署，如果受害者未满**18**岁或属于法定残疾，则由受害者的父母或法定监护人签署。

- 文件。为了处理您的索赔，我们需要您提供支持补偿请求的相关文件。如果有的话，请将您拥有的所有相关文件的副本与已填妥的申请表一起发送（例如，警方报告、全面保护令、民事禁止接触令、医院或医生账单）。如果您还没有准备好所有的文件，请着手收集所有其他文件的副本，以便我们与您联系时可以提供该文件。

- 警方报告。为了完成调查，我们将要求警方提供有关该事件的报告。如果您有警方报告编号，请将其包含在犯罪章节中。如果您没有报告编号，请提供尽可能多的有关该犯罪事件的信息。

- 请提供所有所需信息来完成申请。如果申请表上没有足够的空间，请附上额外的表格。在填写完成后，请检查您的申请，以确保已包含所有必需的信息。将填妥的申请表邮寄至：
  Office of the Illinois Attorney General
  Crime Victim Compensation Bureau
  115 South LaSalle Street
  Chicago, IL 60603

- 地址或电话号码的变更。在提交申请后，如果您的邮寄地址或电话号码发生了变化，您必须立即通知总检察长办公室。如果未能提供更新的联系信息，可能会导致索赔无法向索赔法院提出，或者索赔事宜被结案且不建议进行付款。

- 如果我们确定您有资格获得该计划的补偿，我们可能会要求您提供其他文件来支持您的补偿请求。所有必须填写的表格或总检察长要求的文件必须在 45 天内交回总检察长办公室，然后才能补偿任何费用。

- 在完成此申请时如果您需要帮助或需要服务推荐，请联系 伊利诺伊州总检察长办公室，其电话为 1-800-228-3368。有听力或语言障碍的人士可以使用7-1-1中继服务联系我们。

第 **1** 节。受害者和申请人信息

- 如果您是暴力犯罪的受伤受害者并且已年满 18 岁，请仅填写受害者信息。您是受害者，也是申请人，因此您无需在第1节第B部分填写您的联系信息，但您必须签署申请书。

- 如果您不是受伤的受害者，而是符合资格的申请人，并且正在寻求补偿自己的费用，您可以请求报销因犯罪事件所造成的自身损失。在这些情况下，您是一位合格的申请人。如果您是符合资格的申请人，且年满 18 岁，请在第1节第B部分的申请人信息栏中填写您的信息。填写第1节第A部分，其中包括受伤或死亡受害者的信息。您必须在申请书上签署。

- 如果您代表一位未成年人、残疾人或已故受害者申请（例如，您是未成年子女的父母或已故受害者的亲属），请在第1节第A部分填写受伤或死亡受害者的信息，并在第1节第B部分填写您的联系信息。如果您代表一位未成年人、残疾人或已故受害者填写申请，则应在申请表上签署。

- 如果您申请报销您为受害者支付的或有义务支付的费用，则您是一位合格的申请人。您必须填写第 **1** 节第 **A** 部分，其中包含遭受身体伤害的受害者的信息。您必须在第 **1** 节第 **B** 部分填写您自己的信息。您必须在申请书上签署。

- 需要您提供正确的信息，以便我们办公室在有其他疑问时与您联系和发送文件。如果您的联系信息不正确，您可能无法收到付款。

- 维权人士可与犯罪受害者进行合作并提供援助和转介。您并不需要一位律师来申请补偿。但是，如果您正在与一位律师合作，并且希望我们就您的索赔问题与您的辩护律师进行沟通，或者从您的辩护律师那里获取有关您案件的信息，请在第1节第C部分中列出相关信息。

- 如果您希望我们与另一位人士讨论您的索赔，请在第1节第C 部分提供该人士的姓名。如果处理您索赔的分析师无法联系到您，则可能不会建议支付您的索赔。通过其他方式获取有关索赔的信息以避免失去该计划的资格是有帮助的，但不是必要的。如果无法联系所列人员或该人员无法提供必要的信息，我们将与您联系以讨论相关索赔事宜。

- 如果您不是身体受伤者，但仍是申请补偿那些自付费用的合格申请人、受害人的配偶或父母，请在申请补偿自付费用时为自己填写一份单独的申请表。

第 **2** 节。犯罪和法庭信息

- 本部分收集有关犯罪事件以及因犯罪事件而导致的任何法庭诉讼 信息。并非所有部分都适用于您的情况；请提供尽可能多的信息。

- 如果知道的话，请注明警方报告编号。

- 针对每项罪行，请提交一份申请。

第 **3** 节。损失索赔

- 本节所收集的信息是关于您可能因犯罪事件而遭受哪些类型的可补偿损失。可补偿损失是指《犯罪受害者补偿法案》（Crime Victims Compensation Act）所涵盖的损失类型。

- 如果您有任何疑问或想了解更多有关可补偿费用之类型的信息，请拨打 1-800-228-3368，有听力或言语障碍的人士可以通过 7-1-1 中继服务联系我们。

第 **4** 节。医疗信息和福利

- 仅当您申请医疗、牙科或咨询费用时才填写此部分。

- 如果您是一位符合资格的申请人，并申请那些因对受害者实施的犯罪事件而产生的咨询费用，请以符合资格的申请人身份为自己单独填写一份申请表。

- 仅当这些咨询是由以下人员之一提供时，才会考虑支付咨询费用：执业临床心理学家、执业临床社会工作者、执业临床专业咨询师、执业专业咨询师或基督教科学行医者/护士。

第 **5** 节。就业信息

- 如果您正在申请补偿您的收入损失，请填写此部分。因犯罪事件后进行休假康复和出庭而损失的收入可获得报销。

- 如果您是父母、配偶或子女，申请补偿因照顾受伤的子女、配偶或父母而缺勤的收入损失，请填写单独的申请表，将您自己列为受害者。

第**6**节。葬礼/埋葬信息及死亡抚恤金

- 如果您代表已故受害者提出申请，请填写此部分。

- 失去支持是指在犯罪事件前，犯罪受害者正在工作，由于其死亡而不再能够提供经济支持或履行提供经济支持的法律义务，其亲人就会失去支持。

- 在提出任何建议之前，我们需要了解受害者所有受扶养人的信息。包括所有受抚养人的姓名、出生日期以及法定监护人的姓名和电话号码。

第 **7** 节。认证与授权

- 《代位求偿确认书》（Acknowledgement of Subrogation）表明您已阅读该部分内容，理解并同意在您从刑事案件中获得补偿或从民事诉讼中获得金钱的情况下，将您的追偿权利转让给我们。这意味着，如果您或代表您的任何供应商从犯罪受害者补偿计划收到补偿款，您同意，如果您从任何其他来源（例如从罪犯或民事诉讼）追回款项，您将偿还从犯罪受害者补偿计划收到的补偿款。

- 《信息披露》（Release of Information）授权伊利诺伊州总检察长办公室要求提供医疗、财务和其他必要信息来处理您的索赔。伊利诺伊州总检察长办公室将仅要求提供调查索赔所需的信息。

- 阅读《核证申请》（Certification of Application），其证明您在申请中提供的信息真实准确，如有伪证，愿受处罚。确保您在签署之前提供了最完整、最准确的可用信息。

- 该申请要求提供有关律师的信息。然而，您不需要一位律师来协助申请该计划。

*1964*年《民权法案》（*Civil Rights Act*）第六章（*42 U.S.C. 2000d et seq.*） 禁止在接受联邦财政援助的项目中基于种族、肤色或国籍进行歧视。对于以英语为第二语言的人士，若是联邦财政援助项目的申请人或受助人，将免费获得语言翻译和口译服务。在接受联邦财政援助的任何机构的项目中，若您认为自己受到歧视，您应该立即联系提供此类援助的联邦机构。

CRIME VICTIMS COMPENSATION APPLICATION

State of Illinois
Court of Claims

State of Illinois
Attorney General

COMPLETE ALL SECTIONS TO THE BEST OF YOUR ABILITY.
SEE INSTRUCTIONS FOR INFORMATION ON FILLING OUT THE APPLICATION.
Required fields are denoted with a red Asterisk "*".
If you need help, call the Attorney General's Office at **1-800-228-3368**, 7-1-1 relay service.

NOTICE:
Law enforcement reports or other documentation obtained by the Attorney General's office from an applicant, victim, or third party under the Crime Victims Compensation Act for the purposes of investigating an application for crime victim compensation, shall not be disclosed to the public or any individual or entity, not including the individual who supplied the report or documentation, by the Attorney General's office.Any records obtained by the Attorney General's office to process the application, including but not limited to applications, documents, and photographs, shall be exempt from disclosure by the Attorney General's office under the Freedom of Information Act.

Office Use Only

SECTION 1. VICTIM & APPLICANT INFORMATION

If the injured victim is a minor, or incapacitated adult, do you have legal guardianship?* ☐ YES ☐ NO
If the answer is YES, please provide documentation to show guardianship.

A. INJURED VICTIM / DECEASED VICTIM INFORMATION

Victim's Name:* _____Date of Birth:* _____ / _____ / _____
Street Address:* _____ Apt#: _____
City:* _____ State:* _____ Zip Code:* _____
E-mail Address:* _____
Cell Phone:* (____) _____ - _____ Alternate Phone: (____) _____ -_____
Work Phone: (____) _____ - _____
☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male
☐ Genderqueer/Gender Non-Conforming (GNC) ☐ Prefer Not to Answer ☐ Not Listed
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Civil Union Partner

The following information is used for statistical purposes only according to federal regulations. Providing this information is voluntary and will not affect your application. Victim's Race: ☐ White
☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian
Other Race _____
Victim's Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Do you have a disability? ☐ Yes ☐ No, If yes, nature of disability ☐ Physical ☐ Mental ☐ Developmental.

B. APPLICANT INFORMATION, if you are applying as an eligible applicant or on behalf of a minor injured victim or an incapacitated adult injured victim.

Applicant's Name:* _____ Date of Birth:* _____ / _____ / _____
Street Address:* _____ Apt#: _____
City:* _____ State:* _____ Zip Code:* _____
E-mail Address:* _____
Cell Phone:* (____) _____ - _____ Alternate Phone: (____) _____ -_____
Work Phone: (____) _____ - _____

☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Genderqueer/Gender Non-Conforming (GNC)
☐ Prefer Not to Answer ☐ Not Listed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Civil Union Partner

Relationship to the injured or deceased victim:_____

- Are you seeking compensation for your own expenses? ☐ Yes ☐ No
  If no, what expenses are you requesting compensation for?: _____

C. CONTACT INFORMATION

- Is English your preferred language? ☐ Yes ☐ No
  If no, language you are most comfortable speaking: _____
- Are you working with an advocate? ☐ Yes ☐ No If yes, please provide the following:
  Name:_____ Telephone: _____
  Organization: _____ E-mail Address: _____
- Do you consent to allow the Attorney General's Office to discuss your claim with your advocate or obtain documents required for your claim? ☐ Yes ☐ No
- Is there another person you would prefer us to contact to discuss your claim? ☐ Yes ☐ No
  Name: _____Telephone: _____
  Relationship to you: _____

SECTION 2 - CRIME AND COURT INFORMATION

A. CRIME INFORMATION

Police Report #: * _____

Date of Crime: * _____ / _____ / _____ Date Crime Reported: * _____ / _____ / _____

Street Address where crime occurred: * _____

City: * _____ County: * _____

Name of Agency/Police Department crime reported to: * _____

Briefly Describe crime: * _____

Briefly Describe injuries: * _____

Do you know the identity of the offender(s)? ☐ Yes ☐ No

- If yes, offender(s) name(s): _____
  Relationship, if any, between victim and offender(s): _____
- Was a sexual assault evidence collection kit performed at a hospital? ☐ Yes ☐ No

B. CRIMINAL CASE INFORMATION

- Was the offender arrested? ☐ Yes ☐ No ☐ Unknown
- Has the offender been charged in court? ☐ Yes ☐ No ☐ Unknown
- Were you required to testify for this case? ☐ Yes ☐ No ☐ Unknown
- What was the outcome of the criminal case? (Include criminal case number if any)

_____

_____

- Has restitution been ordered against the offender? ☐ Yes ☐ No, If yes, how much? $_____
- Has the offender been charged in a Human Trafficking Court Proceeding? ☐ Yes ☐ No ☐ Unknown
- Were you required to testify for the Human Trafficking court case? ☐ Yes ☐ No ☐ Unknown
- What was the outcome of the Human Trafficking court case? (Include criminal case number if any)

_____

_____

USE OF FORCE CLAIMS

- Does the Crime alleged involve law enforcement officer's use of force? ☐ Yes ☐ No
- If yes, have you participated in or intiatied one of the following: use of Force Legal Proceeding, filed a Use of Force complaint, filed a Use of Force civil lawsuit, received a Use of Force settlement, received a use of force civil suit verdict ☐ Yes ☐ No
- If yes, please explain and provide documentation for all complaints, proceedings or settlements

_____

_____

C. ORDER OF PROTECTION INFORMATION

Did you obtain a Plenary Domestic Violence Order of Protection, a Civil No-Contact Order, or a Stalking No Contact order? ☐ Yes ☐ No

If yes, please enter the number: OOP#_____ CNCO#_____

What is the date the Domestic Violence Order of Protection, Civil No-Contact Order, or a Stalking No Contact order was issued? _____

When does the Order of Protection expire? _____

D. SUPPLEMENTAL DOCUMENTATION PROVIDED BY THE APPLICANT

Are you providing supplemental forms of documentation with this application about the alleged crime, injuries sustained or any information relevant to your request for compensation?

☐ Yes ☐ No

If yes, please provide the date you received the supplemental forms of documentation along with the type of documentation provided. _____

_____

_____

E. CIVIL CASE INFORMATION

- Has a civil lawsuit been filed against anyone in relation to this incident? ☐ Yes ☐ No
  Name of lawyer handling your civil suit: _____ ARDC No.: _____
  Telephone: (____) _____ - _____ E-mail Address: _____

SECTION 3 - LOSSES CLAIMED

☐ Medical/Hospital	☐ Dental	☐ Transportation	☐ Accessibility Costs
☐ Crime Scene Cleanup	☐ Counseling**	☐ Relocation Costs	☐ Temporary Lodging
☐ Tattoo Removal*	☐ Loss of Earnings	☐ Tuition	☐ Replacement Service Loss
☐ Locks	☐ Windows	☐ Clothing	☐ Bedding
☐ Prosthetic Appliances	☐ Eyeglasses/Contacts	☐ Hearing Aids	☐ Replacement Costs
☐ Loss of Support	☐ Towing and Storage	☐ Funeral/Burial	☐ Loss of Future Earnings
☐ Legal Fees	☐ Doors	☐ Funeral/Cremation	☐ Dependent Replacement Service Loss
		☐ Headstone	

- * Available for victims of Human Trafficking only
- ** Counseling expenses must be provided by a psychiatrist, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, or a Christian Science practitioner / nurse.

SECTION 4 - MEDICAL INFORMATION & BENEFITS

Please submit copies of itemized bills. All bills must be submitted to other sources of recovery available to the victim.

Medical Provider	City	Provider Phone No.	Date(s) of Services	Amount of Bill

Insurance and Other Collateral sources? ☐ Yes ☐ No

Insurance and other collateral source information. The Crime Victims Compensation Program offers reimbursement after all other sources of payment have been exhausted.

Please enter Policy and ID# information in the corresponding field.

Medical Card	Medicare	Medical Insurance
Union Insurance	**Vision/Dental Insurance, etc.**	**Worker's Compensation**
Veterans Administration	**SSI or SSDI**	**Auto Insurance**
Proceeds of Personal Injury or Other Litigation	**Hospital Uninsured Patient Discount**	**Other Insurance**

SECTION 5 - EMPLOYMENT INFORMATION

- In order to qualify for loss of earnings the victim must have been actively employed at the time of the crime.
- Are you applying for loss of earnings due to the crime? ☐ Yes ☐ No
  Please list all employment history during the six (6) months before the crime:

Name of Employer	Employer's Address	Employer's Phone No.	Victim's Net Monthly Wages (Take Home Pay)

Did you receive sick, vacation, personal time, or disability benefits from work after the crime? ☐ Yes ☐ No

Type of Benefits	Amount
Sick	$
Vacation	$
Personal	$
Disability	$
Other	$
Death Benefit From City of Chicago Fund	$
Life, health accident, vehicle towing, or liability insurance	$
Unemployment Payments	$
Veterans or Social Security Burial Benefits	$
Worker's Compensation or Dram Shop	$
Federal Medicare or State Public Aid Program	$

SECTION 6 - FUNERAL/BURIAL INFORMATION & DEATH BENEFITS

A. FUNERAL AND BURIAL

Name of Funeral Home

Funeral Home Phone Number

Total Amount of Funeral Bill

$

Name of Person(s) who have paid	Relationship to Victim	Amounts
		$
		$
		$
		$
		$

Have you received funds through the City of Chicago Emergency Supplemental Victims Fund (ESVF) for funeral and burial expenses? ☐ Yes ☐ No

If yes, how much money did you receive for funeral and burial expenses?

CEMETERY INFORMATION

Name of Cemetery

Cemetery Phone Number	Total Amount of Cemetery Bill
	$

Name of Person(s) who have paid	Relationship to Victim	Amounts
		$
		$
		$
		$
		$

Total Amount of Funeral/Cemetery Expenses

B. LIFE INSURANCE AND DEATH BENEFITS

- Did the victim have a life insurance policy? ☐ Yes ☐ No

Name of Insurance Company	Name of Beneficiary	Beneficiary's Phone No.	Amount Paid

C. LOSS OF SUPPORT TO DEPENDENTS

- Was the victim employed during the six (6) months before the crime? ☐ Yes ☐ No

Name of Dependent	Relationship to Victim	Date of Birth	Name/Phone Number of Legal Guardian

SECTION 7 - CERTIFICATION AND AUTHORIZATION

Acknowledgement and Subrogation: As required by the subrogation provision of the Illinois Crime Victims Compensation Act, 740 ILCS 45/17, I will contact and repay the Crime Victims Compensation Program if I receive any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private agency to cover expenses for which I receive payment from the Compensation Program. I understand that I will be responsible for repaying the Compensation Program any amount for which it is later determined that I was not eligible.

Release of Information: I hereby authorize any hospital, physician, health care provider, mental health provider, funeral director, or other person who rendered related services; any employer of the victim or applicant; any law enforcement or governmental agency; any insurance company; or any other individual company, agency or organization having relevant knowledge, to furnish any and all information in their possession with respect to the incident that is the basis for this claim to the Crime Victims Compensation Bureau of the Illinois Attorney General's Office. This information is to be used in any way necessary related to my claim for an award of compensation from the Illinois Crime Victims Compensation Program.

I understand that medical records may contain information regarding care of psychiatric/psychological conditions, drug or alcohol abuse, HIV test results, AIDS, and AIDS-related conditions.

I understand that at any time I may revoke this authorization from the Illinois Attorney General's Office, except to the extent that action has been taken in reliance on this authorization. This authorization will expire in 3 years from the date the victim/applicant signed or when this claim is resolved.

This authorization complies with the requirements of 45 C.F.R. § 164.508, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule. A photocopy or facsimile copy of this authorization shall have the same effect as the original.

Certification of Application: I hereby certify, subject to the penalties of perjury, that all of the information that I have provided in this application is true, accurate, and complete to the best of my knowledge. I understand that if I willfully provide any information that is false, incomplete, or misleading, I may be denied benefits and/or I may be prosecuted for crimes punishable by imprisonment, a fine, or both.

_____ _____

Applicant's Signature **Date Signed**

Are you being represented by counsel for this Crime Victims Compensation Claim? ☐ Yes ☐ No

Name of Lawyer: _____ ARDC No: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: (_____) _____-_____ E-mail Address: _____

740 ILCS 45/12 prohibits the charging of fees for presenting this form to the Court of Claims.

Please return completed application and all subsequent information to:

Office of the Illinois Attorney General
Crime Victims Services Bureau
115 South LaSalle Street
Chicago, IL 60603

Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq., prohibits discrimination on the basis of race, color, or national origin in programs receiving federal financial assistance. Persons who speak English as a second language who are applicants or recipients to programs receiving federal financial assistance, will be afforded language translation and interpretation services at no charge to the applicant or recipient. If you believe you have been discriminated against in a program of any institution which receives Federal financial assistance, you should immediately contact the Federal agency providing such assistance.