State of Nevada
Victims of Crime Program

Application for Victim of Crime Compensation

VOCP Date Stamp and Claim #

Please complete Sections 1 through 11 to the best of your ability. ***Use a black or blue ballpoint pen****.* Please Print Neatly.

Section 1: Tell us about the Victim.

The victim is the person who was attacked, injured or killed during the crime.

First Name, Middle Initial, Last Name			
Mailing Address	City	State	Zip
Cell Phone or Home Phone	Work Phone	E-Mail	
Date of Birth	Age at time of crime	Last 4 Digits SSN	
☐ Male ☐ Female	**If victim is deceased, date of death:**		

Section 2: If you are applying for the victim, tell us about you.

An applicant is a person, other than the victim, who is completing the application where the victim is under the age of 18, mentally or physically incapable of completing the application, or deceased.

First Name, Middle Initial, Last Name			
Mailing Address	City	State	Zip
Cell Phone or Home Phone	Work Phone	E-Mail	
Relationship to victim:	Number of people requesting benefits	Last 4 Digits SSN	Date of Birth (applicant must be an adult)

Send Completed, Signed Applications to:

VOCP

500 E. Warm Springs Rd., Suite 100

Las Vegas, NV 89119

application@voc-net.com

Section 3: Tell us about the crime.

Please attach a copy of the police report prepared by the Law Enforcement Agency. *Claims submitted without a police report will be accepted and the VOCP will request a report. A decision will be made when the VOCP receives an official police report.*
Note: *Only Violent Crimes are eligible for VOCP assistance. No Theft or Property Crimes can be approved by the VOCP.*

Name of Law Enforcement Agency the crime was reported to:

Date of Crime:	**Date Crime was Reported:**	**Crime Report No:**

If Crime occurred more than two (2) years ago, please indicate why you did not apply to the VOCP until now:

- ☐ Unaware of the VOCP
- ☐ Physically/Mentally unable to apply
- ☐ Other, explain:

Type of Victimization related to Crime if applicable: (Do not choose more than one)

- ☐ Bullying
- ☐ Domestic & Family Violence
- ☐ Elder Abuse
- ☐ Hate Crime
- ☐ Mass Violence

Type of crime:

- ☐ Arson
- ☐ Assault
- ☐ Burglary
- ☐ Child Physical Abuse/Neglect
- ☐ Child Pornography
- ☐ Child Sexual Abuse*
- ☐ DUI/DWI
- ☐ Fraud/Financial Crimes
- ☐ Homicide
- ☐ Human Trafficking
- ☐ Kidnapping
- ☐ Other Vehicular Crimes
- ☐ Robbery
- ☐ Sexual Assault*
- ☐ Stalking
- ☐ Terrorism
- ☐ *Other:*

County where crime occurred:

- ☐ Clark
- ☐ Carson City
- ☐ Churchill
- ☐ Douglas
- ☐ Elko
- ☐ Eureka
- ☐ Esmeralda
- ☐ Humboldt
- ☐ Lyon
- ☐ Lincoln
- ☐ Lander
- ☐ Mineral
- ☐ Nye
- ☐ Pershing
- ☐ Storey
- ☐ Washoe
- ☐ White Pine

Sexual Assault Crimes Only:
Required by: NRS 217.290 and NRS 217.300

Did you submit an application to the County for sexual assault assistance?

- ☐ Yes If No: please explain:
- ☐ No

If Yes, have you received and/or exhausted those funds?

- ☐ Yes If No: please explain:
- ☐ No

Offender's Name and Address: (*if known*)

Where did the crime occur? (exact address, location, or nearest cross streets)

Describe how the crime occurred:

Describe victim's crime injuries:

Section 4: Tell us about your Crime Related Expenses

Please help us determine how we can help you. The VOCP has limited resources and we want to make sure the most important needs and financial issues are taken care of. Please ***check the crime related expenses you have incurred*** *or expect to incur because of the crime.* ***Attach your bills****, receipts, estimates, or other documents which support your request for payment.*
Expenses must be directly related to the crime and must have valid supporting documents to be paid by the VOCP.

- ☐ Medical Bills
- ☐ Ambulance Bills
- ☐ Medical/Hospital Bills
- ☐ Prescription Medication
- ☐ Vision/Glasses
- ☐ Chiropractic/Physical Therapy
- ☐ Loss of Earnings/Survivor Benefits
- ☐ Counseling/Mental Health
- ☐ Funeral and Burial expense
- ☐ Crime Scene Clean Up
- ☐ Child Care Expenses
- ☐ Relocation Expenses
- ☐ Home Security Repairs
- ☐ Home Health Care
- ☐ *Other:*

Section 5: Tell us about any Prior Disabilities or Medical Conditions

If you suffered from any disabilities, or were receiving medical treatment prior to the crime, please explain below:

Section 6: Tell us about any Prior Victim of Crime Claims.

Have you ever filed a Victims of Crime Claim in Nevada, or any other State?

- ☐ Yes
- ☐ No

If Yes: State where Claim Filed	Date filed	Type of Crime

Name of Victim, Applicant, or Claimant	Current Status: (Opened or Closed)

Section 7: Please provide Demographic and Statistical Information

This information is gathered for statistical reporting purposes only. ***This information does NOT affect eligibility in any way.***

Annual Income:

- ☐ $0 to $10,000
- ☐ $10,000 to $20,000
- ☐ $20,000 to $30,000
- ☐ $30,000 to $40,000
- ☐ $40,000 to $60,000
- ☐ $60,000 to $80,000
- ☐ $80,000 to $100,000
- ☐ Over $100,000

Employment at Time of Crime:

- ☐ Employed
- ☐ Self-Employed
- ☐ Unemployed
- ☐ Retired
- ☐ *Other:*

Primary Language:

- ☐ English
- ☐ Spanish
- ☐ Asian
- ☐ *Other*:

Were Alcohol or Drugs a factor in this crime, in any way?

- ☐ Yes
- ☐ No
- ☐ Unknown

Race:

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian and Other Pacific Islander
- ☐ White Non-Latino/Caucasian
- ☐ Some Other Race
- ☐ Multiple Races

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Domestic Partners
- ☐ Divorced
- ☐ Widowed

Education Level:

- ☐ Less than High School Graduate
- ☐ High School Graduate or GED
- ☐ Attended College
- ☐ Attended Graduate School/ University
- ☐ Have Advanced Degree

Section 8: How did you find out about the VOCP?

To help us evaluate and improve our services, please let us know how you heard of the VOCP. Please check one or two that apply.

- ☐ Law Enforcement
- ☐ District Attorney/Prosecutor
- ☐ Hospital/Clinic
- ☐ Medical/Dental Provider
- ☐ Children's Protective Services
- ☐ Mental Health Counselor
- ☐ Victim Advocate
- ☐ Victim Service Program (Safe Nest, Stop DUI, etc)
- ☐ Internet Search
- ☐ Newspaper/Media
- ☐ Friend/Family
- ☐ Other:

Section 9: Person helping the Applicant Complete this Application

Please complete the information below if you are helping the victim complete this application.

First Name	Last Name	Name of Company, Affiliation, or Relationship (Hospital, Dental Provider, Victim Program, etc):
Telephone	Email	

Section 10: If an Advocate or Attorney is helping you, tell us about them

Complete this section if an attorney or victim advocate is assisting the victim. An advocate or attorney is not required in order to apply.

First Name	Last Name	Office Telephone
Office Address	City, State, Zip:	
Victim Advocate Program or Law Firm Name:	Victim Advocate Email:	

☐ *Upon request, please provide the above advocate or attorney with copies of correspondence sent to the Applicant.*

Signature of Advocate or Attorney: (Required to receive documents)	Date:

Section 11: Tell us about the Victim's Insurance or Civil Suit Information

If you have any type of insurance or legal claim please enter the information in the space provided below. ***Use extra sheets if needed.***

Does the Victim/ Applicant have Life, Medical, Dental, or Vision Insurance? Please attach Insurance card.	If the crime involved an auto, does the Victim/ Applicant, or the Offender have Auto Insurance?	If the crime happened in Victim's home, or on Victim's property, is there Homeowners Insurance?	If the crime happened at the Victim/ Applicant's place of work, is there a Workers' Compensation
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Company Name:	**Phone Number:**	**Type and Policy Number:**

Has the victim/applicant filed, or will the victim/applicant file, a Civil Suit related to this crime?	Has the victim/applicant received or expect to receive any payment or settlement related to the crime?
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

State of Nevada
Victims of Crime Program

Authorization for Release of Information, Certification and Acknowledgements:

Victim Name:	Victim DOB:	VOCP Claim #:

I have filed an application with the Nevada Victims of Crime Compensation Program (VOCP). In order to assist the VOCP determine my eligibility I hereby consent to, and authorize the release of information to the VOCP. I hereby release and hold harmless anyone providing information to the VOCP from any liability for any such release.

Law Enforcement Reports: I hereby authorize any police, law enforcement agency, child protective agency, or Coroner's office to release any police, investigative, incident report, or coroner's report related to my application to the VOCP as required by: NRS 217.110 (2)(d), NRS 217.180, NRS 217.210 (1) and NRS 217.220 (1) and (2). I understand that all such reports will remain confidential as provided by State and Federal law and NRS 217.105.

Medical Information: I hereby authorize any hospital, medical clinic, physician, dentist, mental health provider, pharmacist, or any other medical provider to release any and all information including medical reports, histories, prognosis, treatment plans, billing information and any other information relating to my medical treatment for my crime related injuries or condition, to the VOCP as required by NRS 217.100. This information may be subject to re-disclosure and no longer protected by privacy rules. I have the right to revoke this authorization in writing at any time. *This Medical Authorization shall automatically expire without express revocation one year from the date below*. This release is in compliance with all HIPAA regulations. In order to continue to receive benefits past one year, an updated medical information release will be required.

VOCP Release of Information: I hereby authorize the VOCP to release information to police agencies, medical or other service providers, my advocate, attorney, or others concerning my application or claim only as necessary to administer the VOCP or my claim. No information will be released where prohibited by law. NRS 217.110 and 217.105.

Certificate of Financial Eligibility: I hereby certify that I do not have Savings or Investments exceeding the amount of my Annual Income, and that it would be a financial hardship if I were to receive no assistance from the VOCP. I hereby authorize any Insurer, Financial Institution, Government Agency, or any other person with information about me to release such information to the VOCP. NRS 217.220 (4).

My Promise to Repay the VOCP: I hereby acknowledge my legal obligation to repay the VOCP any money paid to me, or paid on my behalf, by the VOCP, ***if I receive any money, from any source, as a result of the crime.*** I hereby agree to notify the VOCP if I retain an Attorney to pursue a lawsuit or claim, or if I receive any court ordered restitution or other recovery including, but not limited to, insurance payments, settlements or other benefit payments. NRS 217.240.

Penalties for Providing False Information:

I understand that I may be imprisoned or fined for providing false or misleading, or intentionally incomplete information to the VOCP. I declare under Penalty of Perjury and pursuant to Nevada law that all the information I have provided is true, correct and complete to the best of my information and belief. NRS 217.270.

Print Full Name of Person Signing Application:	
Signature of Victim/Applicant (must be signed by an adult)	***Date:***

Send Completed, Signed Applications to:

VOCP
500 E. Warm Springs Rd., Ste 100
Las Vegas, NV 89119

Scan *and E-Mail to:* application@voc-net.com *Fax to: (702) 486-2825*