Application

for Crime Victim Compensation

South Carolina has a Crime Victim Compensation Fund to help citizens with costs related to injuries received as a result of the crime. To find out more, read the instructions below or call the Department of Crime Victim Compensation (DCVC) at 1.800.220.5370 (Victims Only) or 803.734.1900 in Columbia, South Carolina or contact your local Victim Advocate.

Assistance from the Department of Crime Victim Compensation

If you qualify for services, DCVC may consider the costs of medical care, counseling, lost wages/support, for you as the victim, or for a victim you are financially responsible for. You may also be reimbursed for money you spent on the funeral/burial of a deceased victim. The law limits the amount of these payments so call DCVC for information. The most that can be paid on behalf of a victim for all expenses combined is $15,000. DCVC can pay for either up to 40 counseling sessions or 180 days of counseling sessions, whichever is greater.

DCVC Eligibility Criteria

If you are a victim or claimant (person filing for a victim), please note that:

- Crime must occur in South Carolina
- Victim must sustain direct injury – (Physical or Psychological)
- South Carolina law requires DCVC to consider contributory or illegal behavior when making eligibility determinations
- Victim must cooperate with DCVC and Law Enforcement
- Crime must be reported within 48 hours (May be Waived)
- Claims must be filed within 180 days (May be Waived)
- Claim must be filed within 4 years of the incident
- **DCVC is considered the payer of last resort.**

What losses are not covered?

- **Property damage or loss**
- **Crime scene cleanup**
- **Expenses related to going to court (lawyer, travel, etc.)**
- **"Pain and suffering"**

Who can qualify for financial assistance?

Injured crime victims, immediate family members of crime victims, or someone who is paying bills or taking care of a crime victim may apply. There are some exceptions so call DCVC for information.

How can I get help with this application?

Law enforcement agencies, solicitors' offices and victim assistance organizations in your area have victim advocates to help you with this application. If unable to reach an agency or don't know who to call, the Department of Crime Victim Compensation (DCVC) is available to assist you. Please call DCVC at 1.800.220.5370 (Victims Only) or 803.734.1900 between 8:30 am and 5:00 pm.

Do I have to fill out this entire packet?

No. Only part of this packet is the application for compensation benefits. Supplemental forms are included for you to give to your counselor, doctor, or employer to complete if applicable.

If I want to apply now, what should I do?

Read the instructions and fill out the attached application. Also include as much related information (i.e. itemized receipts, bills, insurance statements, and incident report) as possible. **You must submit the application within 180 days of the crime, so do not wait to collect all of your bills.** You can send additional itemized bills later as you receive them. You will be notified as your claim is processed through the system.

If you have not received a letter after four weeks, please call DCVC or your local victim advocate.
If you move, or if your phone number changes, please let DCVC know immediately.

For assistance with claims for anonymous reporting, contact DCVC for details.

DCVC

South Carolina Attorney General's Office
Department of Crime Victim Compensation

HOW TO COMPLETE THE APPLICATION: ***Save this information/instruction sheet for your files.***

If you are. . .

- Filing for ***yourself as an adult victim,*** then you are the "Victim", and the "Claimant".
- Filing for a ***minor, or an incapacitated or incompetent victim,*** then you are the "Claimant", and the crime victim should be named as the "Victim" and the "Person Receiving Services".
- Filing for the medical and/or funeral/burial bills ***for a deceased victim,*** then you are the "Claimant". The "Person Receiving Services" and the deceased crime victim should be named as the "Victim".
- Filing for ***counseling for yourself because an immediate family member has been injured or killed,*** then you are the "Claimant" and the "Person Receiving Services". The injured or deceased family member is the "Victim".
- Filing for ***counseling for a minor because his/her immediate family has been injured or killed,*** then you are the "Claimant". The minor is the "Person Receiving Services", and the injured or deceased family member is the "Victim".

Please call your local victim advocate or DCVC for assistance in completing this application.
(Supplemental forms can be found online or in the application packet)

Print neatly and use a separate application for each applicant.

SECTION 1 "Person Receiving Services"
Print the name of the person who is getting medical attention, counseling or other services as a result of the crime. The "Person Receiving Services" is the "Victim" and/or the "Claimant," or the immediate family member of the person injured or killed. **In homicide cases, the deceased Victim's name should appear here.**

SECTION 2 "Victim"
The crime victim is the person who was injured, threatened with injury or is deceased as a result of the crime. This will be the same person listed as the "Victim" on the law enforcement incident report.

SECTION 3 "Claimant"
If the "Person Receiving Services" is an adult responsible for his/her own bills, please list his/her name as the "Claimant". If the "Person Receiving Services" is under 18, incapacitated or incompetent, the financially responsible person (e.g. parent, guardian, spouse) should be named in this section. If the "Victim" is deceased as a result of the crime, then the adult legally responsible for the medical and/or funeral/burial bills and expenses is the "Claimant".

SECTION 4 "Crime"
Be specific in describing injuries. Attach a copy of the incident report. If you don't have one, you can obtain a free copy from the law enforcement agency that you reported the crime to. **The law enforcement incident report is required to determine eligibility and process the claim.**

SECTION 5 "Expense"
List the names of doctors, hospitals, and others that have provided services. If you already have itemized bills, please send copies with your application(s). **You must send the application within 180 days of the crime, so do not wait to collect all of your bills.**

SECTION 6 "Insurance"
If you have insurance that may cover some of your crime-related bills, list your insurance information in this section.

SECTION 7 "Employment"
List your job information **if you have not been able to work for at least two weeks in a row because of crime-related injuries or to take care of someone with crime related injuries.** Your employer will be required to complete the **Employer's Report**; the doctor treating the "Victim" will be required to complete the **Physician's Report.**

SECTION 8 "Civil Action"
Complete if you have hired a lawyer to settle an insurance claim or file a lawsuit related to this crime.

SECTION 9 "Referral"
Provide the information of the victim advocate or other professional who assisted you with this application.

SECTION 10 "Authorization"
Important: This application is a legal document which must be read and signed by the adult "Claimant" (must be 18 or older). Person(s) representing an agency cannot sign the application on behalf of the victim.

DCVC: Crime Victims' Compensation Application

Rev. 08/21

Department of Crime Victim Compensation, Edgar A. Brown Bldg., 1205 Pendleton St., Rm. 401, Columbia, SC 29201 . 1.800.220.5370 or 803.734.1900

Use a separate application for each person. Incomplete or unsigned applications will not be accepted.

SECTION 1 *Person Receiving Services*

Victim or family member requesting assistance.

Check one: ☐ Mr. ☐ Mrs. ☐ Ms.

Full Legal Name of Individual Receiving Services/Benefits

Social Security # (last 5 digits) ☐ - ☐☐☐☐

Date of Birth

Sex: ☐ Male ☐ Female

The Person Receiving Services is the ☐ Victim *(as identified on the incident report upon which this claim is based)*

OR the Victim's ☐ Spouse ☐ Parent ☐ Sibling ☐ Child Other

Check services requested: ☐ Medical ☐ Counseling ☐ Lost Wages / Support ☐ Burial Other

Please call a local victim advocate or DCVC if you need help with completing this form.

SECTION 2 *Victim Information*

The Victim is the same person listed as a victim on the law enforcement incident report.

Check one: ☐ Mr. ☐ Mrs. ■ Ms.

Name as it appears on the incident report

Social Security # (last 5 digits) ☐ - ☐☐☐☐

Date of Birth

Victim is: ☐ Deceased ☐ Incompetent ☐ Under 18 ☐ Disabled

Home Mailing Address (City, State, Zip)

E-Mail Address

Contact #(s) *(i.e. work, cell, fax)*

(For statistical purposes only and is optional) Sex: ☐ Female ☐ Male

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Native American ☐ Asian or Pacific Islander Other

SECTION 3 *Claimant Information*

Complete only if: The Claimant is the adult assuming responsibility for the crime-related bills and/or the adult that has physical custody of a minor.

Check one: ☐ Mr. ☐ Mrs. ☐ Ms.

Full Legal Name

Relationship to Victim

Social Security # (last 5 digits) ☐ - ☐☐☐☐

Date of Birth

Home Mailing Address (City, State, Zip)

E-Mail Address

Contact #(s) *(i.e. work, cell, fax*

SECTION 4 *Crime Information*

Complete this section in its entirety and attach a copy of the law enforcement incident report.

If law enforcement was not contacted, an incident report was not written within 48 hours of the crime, or if you are not filing this claim with DCVC within 180 days of the crime, please explain why:

Date of Crime

Date Reported

Law Enforcement Agency

Address of Crime

City

State

Incident Report #

Name(s) of Offender(s)

Was suspect arrested? ☐ Yes ☐ No

Type of Crime and Injury Sustained:

Relationship of Offender(s) to Victim

Warrant #(s)

Has the case gone to court? ☐ Yes ☐ No

Please indicate the type of court: ☐ Magistrate ☐ Municipal ☐ General Sessions ☐ PTI ☐ Family Court

How much restitution was ordered: ☐ None $ Amount Ordered $ Amount Paid to Date

SECTION 5 Crime *Related Expense Information**

Attach copies of itemized bills (detailed bills, UB92 or HCFA 1500).

Name of Doctor/Hospital	Services Provided from (date) to (date)	Phone #	Fax#
Counselor	Services Provided from (date) to (date)	Phone #	Fax#
Funeral Home	Services Provided from (date) to (date)	Phone #	Fax#

SECTION 6 Health *Insurance / Benefits Information*

Does the victim have public/private Health Insurance? ☐ Yes ☐ No

Please provide Health Insurance / Medicaid / Medicare Information below. Health insurance must be submitted to provider.

Private Insurance: Policy Name _____ Policy Number _____

Medicaid: Policy Number _____

Medicare: Policy Number _____

SECTION 7 Lost *Wages / Support Information**

If you have missed at least two consecutive weeks, you may be able to qualify for compensation for your lost wages. If you were employed, you must submit your last two pay stubs, the Employer's Report and the Physician's Disability Report. If you were self- employed, you must submit your most recent Tax Return Transcripts from the IRS, the Self-Employment Verification Form, and the Physician's Disability Report.
See Supplemental Forms at (http://dcvc.scag.gov) to request Lost Wages/Support.

Employer's Information _____ Phone # _____

If injured on the job, does your employer have Workers' Compensation? ☐ Yes ☐ No

Have you, or will you, file for Social Security disability (SSI)? ☐ Yes ☐ No

Are you missing work to care for the victim? ☐ Yes ☐ No

SECTION 8 Civil Action Information

Have you hired a lawyer to settle with insurance or file a lawsuit? ☐ Yes ☐ No

If yes, please provide: Name of Lawyer _____

Mailing Address _____ Phone # _____

SECTION 9 Referral Source Information

☐ **Solicitor** ☐ **LEVA** ☐ **Hospital/Dr.** ☐ **Counselor** **Other** _____

Name/Title of Professional Assisting with Application _____

Phone # _____ Fax # _____ Agency/Office _____

Mailing Address _____

County _____ Referral's Email Address _____

SECTION 10 *Legal Authorization & Signature*

This document is in compliance with the HIPAA guidelines.

I understand that I am responsible for all bills and the compensation program is designated to pay certain costs not covered by another source. Submitting this application does not entitle me to benefits. I authorize the Department of Crime Victim Compensation (DCVC) to request, obtain, and release any information or records to determine the eligibility of my claim or to obtain restitution for a period not to exceed the full processing of this application. I further understand that there is a potential for me to no longer be protected by the Privacy Rule, and that I have the right to revoke this authorization in writing at any point I so desire. I agree to repay DCVC if I receive money from another source, up to the amount paid on my behalf. This includes any payment I may receive from the offender, any insurance policy or settlements, judgments, or civil law suits. I authorize DCVC to request and obtain any information including settlement disbursements, negotiated medical bills, and all other records related to subrogation from myself or representatives acting on my behalf.
I agree to notify DCVC of any changes, such as address or phone numbers, to maintain accuracy in the processing of this claim. Incomplete or unsigned applications will not be accepted.

This information I have provided is true and correct to the best of my knowledge under penalty of law (§16-3-1280).

Original Signature of Victim/Claimant _____ **Date** _____

[Legal representative must sign if the Victim is under 18, legally declared incompetent or deceased]

Print Name of Above Victim/Claimant _____

*** See Supplemental Forms (http://dcvc.scag.gov) to request counseling or Lost Wages/Support**