# 犯罪受害者補償申請
# (CRIME VICTIMS COMPENSATION APPLICATION)

伊利諾州
索賠法院

伊利諾州
總檢察長

## 申請說明

- 誰應該填寫申請表？ 申請必須由以下人員之一完成：1) 年滿 18 歲、且符合《犯罪受害者補償法案》（Crime Victims Compensation Act）第740 ILCS 45/2 項之申請人 資格、並在尋求報銷其自身費用的人士；或 2）如果受害者未滿18歲或屬於法定殘障人士，則受害者的父母或法定監護人應代表其填寫申請表；或 3）任何已支付或有義務支付受害者的費用（醫療/住院、葬禮/埋葬）的人士。申請書必須由申請人簽署，如果受害者未滿18歲或屬於法定殘障，則由受害者的父母或法定監護人簽署。

- 文件。為了處理您的索賠，我們需要您提供支持補償請求的相關文件。如果有的話，請將您擁有的所有相關文件的副本與已填妥的申請表一起發送（例如，警方報告、全面保護令、民事禁止接觸令、醫院或醫生賬單）。如果您還沒有準備好所有的文件，請著手收集所有其他文件的副本，以便我們與您聯繫時可以提供該文件。

- 警方報告。為了完成調查，我們將要求警方提供有關該事件的報告。如果您有警方報告編號，請將其包含在犯罪章節中。如果您沒有報告編號，請提供儘可能多的有關該犯罪事件的資訊。

- 請提供所有所需資訊來完成申請。如果申請表上沒有足夠的空間，請附上額外的表格。在填寫完成後，請檢查您的申請，以確保已包含所有必需的資訊。將填妥的申請表郵寄至：
  Office of the Illinois Attorney General
  Crime Victim Compensation Bureau
  115 South LaSalle Street
  Chicago, IL 60603

- 地址或電話號碼的變更。 在提交申請後，如果您的郵寄地址或電話號碼發生了變化，您必須立即通知總檢察長辦公室。如果未能提供更新的聯繫資訊，可能會導致索賠無法向索賠法院提出，或者索賠事宜被結案且不建議進行付款。

- 如果我們確定您有資格獲得該計劃的補償， 我們可能會要求您提供其他文件來支持您的補償請求。所有必須填寫的表格或總檢察長要求的文件必須在 45 天內交回總檢察長辦公室，然後才能補償任何費用。

- 在完成此申請時如果您需要幫助 或需要服務推薦，請聯繫 伊利諾州總檢察長辦公室，其電話為1-800-228-3368。有聽力或語言障礙的人士可以使用7-1-1轉接服務聯繫我們。

第 1 節。受害者和申請人資訊

- 如果您是暴力犯罪的受傷受害者並且已年滿 18 歲，請 僅 填寫受害者資訊。您是受害者，也是申請人，因此您無需在第1節第B部分填寫您的聯繫資訊，但您必須簽署申請書。
- 如果您不是受傷的受害者，而是符合資格的申請人，並且正在尋求補償自己的費用，您可以請求報銷因犯罪事件所造成的自身損失。在這些情況下，您是一位合格的申請人。如果您是符合資格的申請人，且年滿 18 歲，請在第1節第B部分的申請人資訊欄中填寫您的資訊。填寫第1節第A部分，其中包括受傷或死亡受害者的資訊。您必須在申請書上簽署。
- 如果您代表一位未成年人、殘障人或已故受害者申請（例如，您是未成年子女的父母或已故受害者的親屬），請在第1節第A部分填寫受傷或死亡受害者的資訊，並在第1節第B部分填寫您的聯繫資訊。如果您代表一位未成年人、殘障人或已故受害者填寫申請，則應在申請表上簽署。
- 如果您申請報銷您為受害者支付的或有義務支付的費用，則您是一位合格的申請人。您必須填寫第 1 節第 A 部分，其中包含遭受身體傷害的受害者的資訊。您必須在第 1 節第 B 部分填寫您自己的資訊。您必須在申請書上簽署。
- 需要您提供正確的資訊，以便我們辦公室在有其他疑問時與您聯繫和發送文件。如果您的聯繫資訊不正確，您可能無法收到付款。
- 維權人士可與犯罪受害者進行合作並提供援助和轉介。您並不需要一位律師來申請補償。但是，如果您正在與一位律師合作，並且希望我們就您的索賠問題與您的辯護律師進行溝通，或者從您的辯護律師那裡獲取有關您案件的資訊，請在第1節第C部分中列出相關資訊。
- 如果您希望我們與另一位人士討論您的索賠，請在第1節第C 部分提供該人士的姓名。如果處理您索賠的分析師無法聯繫到您，則可能不會建議支付您的索賠。通過其他方式獲取有關索賠的資訊以避免失去該計劃的資格是有幫助的，但不是必要的。如果無法聯繫所列人員或該人員無法提供必要的資訊，我們將與您聯繫以討論相關索賠事宜。
- 如果您不是身體受傷者，但仍是申請補償那些自付費用的合格申請人、受害人的配偶或父母，請在申請補償自付費用時為自己填寫一份單獨的申請表。

第 2 節。犯罪和法庭資訊

- 本部分收集有關犯罪事件以及因犯罪事件而導致的任何法庭訴訟 資訊。並非所有部分都適用於您的情況；請提供儘可能多的資訊。
- 如果知道的話，請註明警方報告編號。
- 針對每項罪行，請提交一份申請。

第 3 節。損失索賠

- 本節所收集的資訊是關於您可能因犯罪事件而遭受哪些類型的可補償損失。可補償損失是指《犯罪受害者補償法案》（Crime Victims Compensation Act）所涵蓋的損失類型。

- 如果您有任何疑問或想瞭解更多有關可補償費用之類型的資訊，請撥打1-800-228-3368，有聽力或言語障礙的人士可以通過7-1-1轉接服務聯繫我們。

第 4 節。醫療資訊和福利

- 僅當您申請醫療、牙科或諮詢費用時才填寫此部分。
- 如果您是一位符合資格的申請人，並申請那些因對受害者實施的犯罪事件而產生的諮詢費用，請以符合資格的申請人身份為自己單獨填寫一份申請表。
- 僅當這些諮詢是由以下人員之一提供時，才會考慮支付諮詢費用：執業臨床心理學家、執業臨床社會工作者、執業臨床專業諮詢師、執業專業諮詢師或基督教科學行醫者/護士。

第 5 節。就業資訊

- 如果您正在申請補償您的收入損失，請填寫此部分。因犯罪事件後進行休假康復和出庭而損失的收入可獲得報銷。
- 如果您是父母、配偶或子女，申請補償因照顧受傷的子女、配偶或父母而缺勤的收入損失，請填寫單獨的申請表，將您自己列為受害者。

第6節。葬禮/埋葬資訊及死亡撫卹金

- 如果您代表已故受害者提出申請，請填寫此部分。
- 失去支持是指在犯罪事件前，犯罪受害者正在工作，由於其死亡而不再能夠提供經濟支持或履行提供經濟支持的法律義務，其親人就會失去支持。
- 在提出任何建議之前，我們需要瞭解受害者所有受扶養人的資訊。包括所有受撫養人的姓名、出生日期以及法定監護人的姓名和電話號碼。

第 7 節。認證與授權

- 《代位求償確認書》（Acknowledgement of Subrogation）表明您已閱讀該部分內容，理解並同意在您從刑事案件中獲得補償或從民事訴訟中獲得金錢的情況下，將您的追償權利轉讓給我們。這意味著，如果您或代表您的任何供應商從犯罪受害者補償計劃收到補償款，您同意，如果您從任何其他來源（例如從罪犯或民事訴訟）追回款項，您將償還從犯罪受害者補償計劃收到的補償款。
- 《資訊披露》（Release of Information）授權伊利諾州總檢察長辦公室要求提供醫療、財務和其他必要資訊來處理您的索賠。伊利諾州總檢察長辦公室將僅要求提供調查索賠所需的資訊。
- 閱讀《核證申請》（Certification of Application），其證明您在申請中提供的資訊真實準確，如有偽證，願受處罰。確保您在簽署之前提供了最完整、最準確的可用資訊。
- 該申請要求提供有關律師的資訊。然而，您不需要一位律師來協助申請該計劃。

1964年《民權法案》（Civil Rights Act）第六章（42 U.S.C. 2000d et seq.） 禁止在接受聯邦財政援助的項目中基於種族、膚色或國籍進行歧視。對於以英語為第二語言的人士，若是聯邦財政援助項目的申請人或受助人，將免費獲得語言翻譯和口譯服務。在接受聯邦財政援助的任何機構的項目中，若您認為自己受到歧視，您應該立即聯繫提供此類援助的聯邦機構。

# 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.*