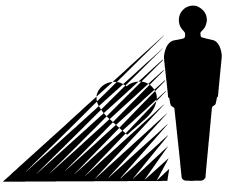
VICTIMS OF CRIME
FINANCIAL BENEFITS PROGRAM



10th Floor, 10365 - 97 Street
Edmonton, Alberta T5J 3W7
Phone: (780) 427-7217
Fax: (780) 422-4213

Case Number: *(for office use only)*

APPLICATION FOR FINANCIAL BENEFITS

Applications must be received within two years of the incident

Section 1. Victim's Personal Information (please print)

Name ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Last	First	Middle
Other names you use or have used (i.e. nickname, maiden name):		
Date of Birth (m/d/y):	Personal Health Care #:	
Complete Mailing Address		
Alternate Mailing Address		
Telephone numbers where we may contact you Home	Work	Cell/Messages
Email:		

Section 2. Applicant Information (Must be 18 or older)

Complete this part if you are applying on behalf of a victim (under 18 years of age or deceased or otherwise unable to apply on his/her own).

Name ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Last	First	Middle
Your relationship to the victim		Are you the victim's legal guardian?
Complete Mailing Address		
Telephone numbers where we may contact you Home	Work	Cell/Messages
Email:		

• **Continued on reverse**

VICTIMS OF CRIME
FINANCIAL BENEFITS PROGRAM

Section 3. Crime Information

Victim's Name	**Date of Birth** (m/d/y)

Date crime committed (m/d/y):	Time:	Offenders Name: (if known)
Location of crime:		
Police Service crime reported to:		Date Reported:
Police file No. (if known)	Type of offence (i.e. assault)	
Briefly describe what happened.		

The Director OR his/her designate has authority under section 13.1 of the Victims of Crime Act to collect the information necessary to determine eligibility for financial benefits. This includes, but is not limited to, information about other incidents and activities that may affect that determination. The following is the authorization of the person (victim) or his/her representative (applicant) to release the following information.

I hereby authorize:

(a) The police service, any other agency or government department (e.g. Medical Examiner) involved with the investigation, to provide the Director of the Victims of Crime Financial Benefits Program OR his/her designate with any information directly or indirectly related to the alleged crime(s) identified in this application,

(b) The Director of the Victims of Crime Financial Benefits Program OR his/her designate to have access to information regarding any related or unrelated federal offence convictions and associated sentences imposed on the victim,

(c) The Director of the Victims of Crime Financial Benefits Program OR his/her designate to release information, including relevant sections of the application, to police or other agencies as may be necessary to obtain the information requested under (a) or (b).

I understand that I may revoke any of the above authorizations at any time by advising the Director of the Victims of Crime Financial Benefits Program in writing. However, I understand that if the authorizations are revoked, or if I fail to provide the information requested by the Director, it may affect the ability of the Director to properly assess this application and this may result in a denial of benefits.

This authorization shall be valid for 2 years from the date of signature unless previously revoked in writing by the victim or the representative (applicant) signing this form.

Victim/Applicant's Signature

Date

The original or faxed authorization will be retained by the Victims of Crime Financial Benefits Program

• **Continued on next page**

VICTIMS OF CRIME
FINANCIAL BENEFITS PROGRAM

Section 4. Victim's Injuries (if applying for the death benefit, go to section 5)

Please describe the injuries (physical or psychological) received as a result of the crime.

Name of hospital(s) providing medical treatment for your injuries.

Hospital:		Hospital:	
City:	Date seen (m/d/y)	City:	Date seen (m/d/y)

Hospital:		Hospital:	
City:	Date seen (m/d/y)	City:	Date seen (m/d/y)

Names of doctors or other professionals providing treatment for your injuries.

Name			Telephone
Address	City	Province	Postal Code

☐ Family Physician ☐ Dentist ☐ Other ____________ Date(s) seen (m/d/y)
☐ Counsellor ☐ Specialist ____________

Name			Telephone
Address	City	Province	Postal Code

☐ Family Physician ☐ Dentist ☐ Other ____________ Date(s) seen (m/d/y)
☐ Counsellor ☐ Specialist ____________

Name			Telephone
Address	City	Province	Postal Code

☐ Family Physician ☐ Dentist ☐ Other ____________ Date(s) seen (m/d/y)
☐ Counsellor ☐ Specialist ____________

• **Continued on reverse**

VICTIMS OF CRIME
FINANCIAL BENEFITS PROGRAM

Authorization to Disclose Personal Health Information

Victim's Name	**Date of Birth** (m/d/y)

Name of hospital(s) providing medical treatment for your injuries.

The Director OR his/her designate has authority under section 13.1 of the *Victims of Crime Act* to collect the information necessary to determine eligibility for financial benefits and to determine the amounts of those benefits. The following authorization of the person (victim) or his/her representative (applicant) is provided for that purpose.

I hereby authorize:

(a) the **named medical hospitals/facilities** to disclose Emergency records, diagnostic imaging reports, operative reports, discharge summaries, consultant reports, and other treatment records as requested, which are directly or indirectly related to the incident identified in this application, to the Director of the Victims of Crime Financial Benefits Program OR his/her designate,

(b) **any health care provider** to disclose diagnostic, treatment and care information relating to the incident identified in this application, to the Director of the Victims of Crime Financial Benefits Program OR his/her designate,

(c) the Director of the Victims of Crime Financial Benefits Program OR his/her designate to release information, including relevant sections of the application as appropriate, to external health care agencies or treatment professionals for the purpose of making a determination on the application.

I understand that I may revoke any of the above authorizations at any time by advising the Director of the Victims of Crime Benefits Program in writing. However, I understand that if the authorizations are revoked, or I fail to provide the information requested by the Director, it may affect the ability of the Director to assess this application.

This authorization shall be valid for 2 years from the date of signature unless previously revoked in writing by the victim or the representative (applicant) signing this form.

Any photographic or facsimile copy shall be as valid as the original when presented to a health care facility or professional by the Director of the Victims of Crime Financial Benefits Program OR his/her designate.

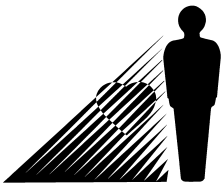
Victim/Applicant's Signature

Date

The original or faxed authorization will be retained by the Victims of Crime Financial Benefits Program

• Continued on next page

VICTIMS OF CRIME
FINANCIAL BENEFITS PROGRAM



Section 5. Death Benefit (if not applying for the death benefit, go to next page)

Please **complete the following questions** to assist us in determining the eligible recipients of the death benefit.

At the time of their death, what was the status of the victim? (check applicable box)

- ☐ married
- ☐ living common-law (adult interdependent partner) How long? _____
- ☐ separated
- ☐ divorced
- ☐ single

Please provide the name and address of **spouse/partner** (if applicable)

_____

_____

Please list the full names, addresses and birth dates of the victim's **children**.

Name	Address	Date of Birth (m/d/y)

If the victim did not have a spouse/partner or children, please list the names and addresses of the victims **parents and siblings.** Please indicate their relationship to the victim.

Name	Address	Relationship

• **Continued on reverse**

VICTIMS OF CRIME
FINANCIAL BENEFITS PROGRAM

Section 6. Acknowledgements

I understand:

1. the Director of the Victims of Crime Financial Benefits Program OR his/her designate will make a decision on my application based on information obtained from police services and health care providers,

2. the Director will request information only from the police services and/or health care providers considered necessary to reach a decision on my application. The Director may or may not contact all the parties identified or may contact other police services or health care providers not identified on my application.

3. refusing to reveal any information requested on this application or subsequently by the Director of the Victims of Crime Financial Benefits Program OR his/her designate may affect the decision on this application,

4. I may be subject to an independent medical examination as the Director of the Victims of Crime Financial Benefits Program OR his/her designate may require in assessing this application,

5. some of the information in this application may be subject to release to the prosecutor and the defense counsel or offender, if required by law (e.g. court order),

6. I have a right under the *Freedom of Information and Protection of Privacy Act* to examine and request a correction to my record, and request a review by the Information and Privacy Commissioner,

7. any request for access to my personal information obtained from other sources may be subject to the information protection legislation applicable to the information source.

I certify that I have completed this application to the best of my knowledge and that the information contained in the application is accurate to the best of my knowledge.

Victim/Applicant's Signature

Date

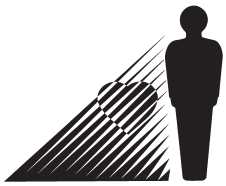
Did you remember to sign:

- **Section 3 Crime information**
- **Authorization to Disclose Health Information (back of Section 4)**
- **Section 6 Acknowledgements**

We cannot process your application unless these sections are signed.

• **Continued on next page**

VICTIMS OF CRIME
FINANCIAL BENEFITS PROGRAM



Additional Information

Please use this sheet if you require any additional space for any part of the application.