SLAVERY CRIMES VICTIMS REPARATIONS APPLICATION FORM

Date Received: (Office Use Only)	Complete and submit to :	Claim Number: / Claims Specialist: (Office Use Only)

SECTION 1. VICTIM INFORMATION	Name of person injured or killed or having prejudice as the result of the slavery crime. Complete a separate application for each victim		
Victim's Name (last, first, m.i.)		Date of Birth (MM/DD/YY)	Social Security Number None ❒
Gender ❒ Male ❒ Female	What is the language preference of the victim and/or claimant? ❒ English ❒ Spanish ❒ Other_____		Is Victim Deceased? ❒ No ❒ Yes
Address	City	State	Zip Code
Phone	Email Address		

SECTION 2. CLAIMANT INFORMATION	Complete **only** if the person(s) submitting the application is not the victim. This section must be completed by a parent, guardian or relative if the victim is a minor, deceased or incapacitated.

Claimant 1			
Claimant's Name (last, first, m.i.)		Date of Birth (MM/DD/YY)	Social Security Number None ❒
Gender ❒ Male ❒ Female	Relationship to Victim ❒ Parent ❒ Spouse/Partner ❒ Former Spouse/Partner ❒ Child ❒ Sibling ❒ Grandparent ❒ Other _____		
Address	City	State	Zip Code
Phone	Email Address		
Which kinship proof with the victim is provided by the claimant ? ❒ family record book ❒ Other _____		Which identity proof is provided by the claimant ? ❒ Passport ❒ Other _____	
Is the claimant also suffering an injury because of the crimes committed ? ❒ No ❒ Yes	If so, the claimant can fulfill its own application form.		
If the identity of the claimant was disclosed to the defense or the Prosecutor of the Justice Dept, would the claimant have to worry about its safety, welfare, dignity or privacy ? ❒ No ❒ Yes ❒ Why ? _____			
If the identity of the claimant was disclosed to the defense or the Prosecutor of the Justice Dept, would any other person have to worry about its safety, welfare, dignity or privacy ? ❒ No ❒ Yes ❒ Why ? _____			
❒ Who ? (last, first, m.i.)		Date of Birth (MM/DD/YY)	Social Security Number None ❒

SECTION 3. REFERRAL SOURCE	How did you learn of the reparations program?		
❒ Community	❒ Hospital	❒ Sexual Assault Program	❒ Website
❒ Domestic Abuse Program	❒ Police	❒ Social Services, Cleric or School	❒ Other_____
❒ Funeral Home	❒ Probation	❒ Victim Assistance Program	

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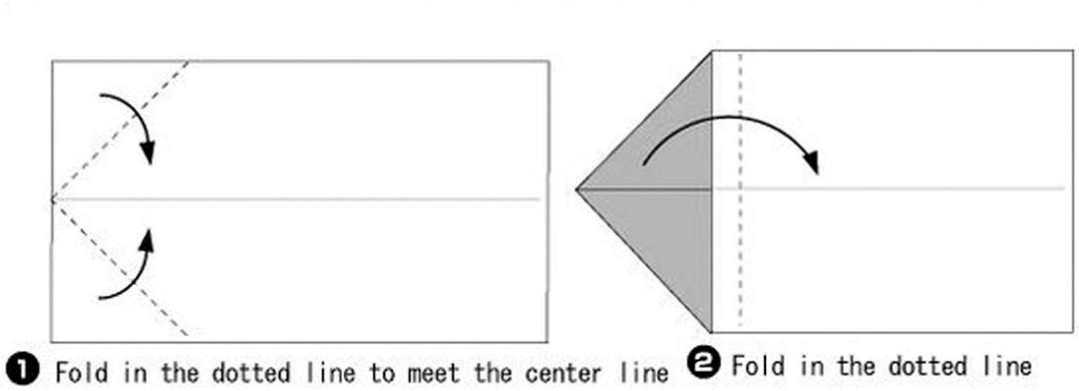
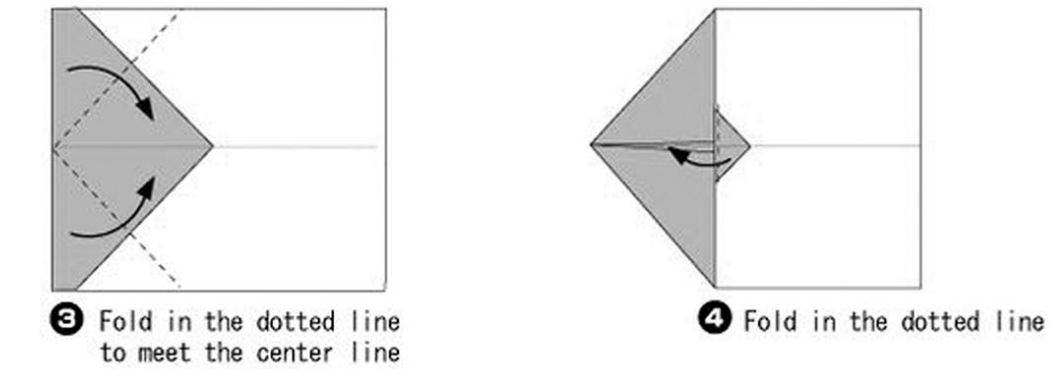
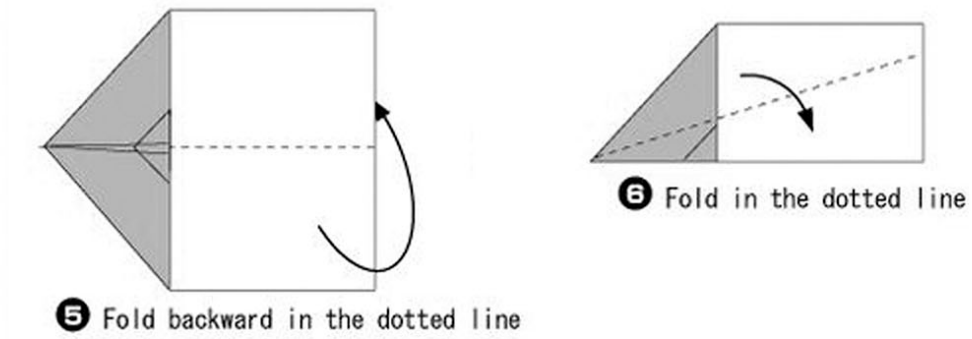
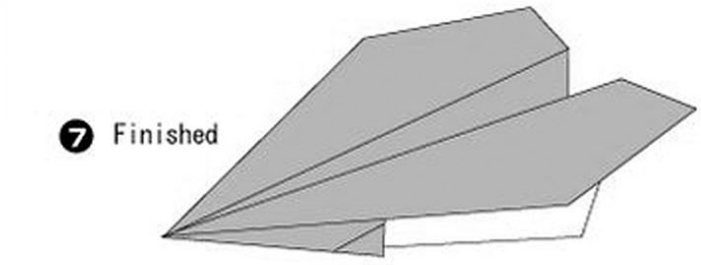
Pelephone	Mail address		

You can choose to send it by air-mail or slow-mail.









Ready to send !

SECTION 4. CRIME INFORMATION	Date of Crime	Date Reported to Police	Country Where Crime Occurred

Police Department	Police Case Number	Investigating Officer's Name

Did the crime involve? ❒ Domestic or Family Violence ❒ Bullying ❒ Elder Abuse ❒ Hate Crime ❒ Mass Violence

Type of Crime (check all that apply)

❒ Assault	❒ Child Physical Abuse	❒ Torture	❒ Burglary
❒ Homicide	❒ Child Sexual Abuse	❒ Other Barbarity Crime	❒ Fraud/Financial Crime
❒ Robbery	❒ Child Pornography	❒ Stalking	❒ Terrorism
❒ Adult Sexual Assault	❒ Human Trafficking	❒ Arson	❒ Other
	❒ Kidnapping		

Briefly describe crime. Attach additional pages if necessary.

Nature of the prejudices suffered by the victim		Briefly describe the prejudices sustained. Add pages if necessary.
❒ Physical injury	❒ Harm to the victim's health ❒ Attacks on physical integrity (injuries, physical pain, etc.) ❒ Decrease in work capacity	
❒ Moral prejudice	❒ Anxiety ❒ Psychological suffering ❒ Attempt to reputation	
❒ Material damage	❒ Financial loss ❒ damages or degradations on movable properties ❒ damages or degradations on immovable properties	
❒ Pleasure prejudice : damage resulting from the deprivation of some satisfactions of everyday life		
❒ Indirect damage: material or moral injury caused by the death or damage suffered by a relative of the victim. Indicate the name (first, last, m.i) and the date of birth of the concerned persons. Add additional pages if necessary.		

Offender 1

Address	City	State	Zip Code

Phone	Email Address

The offender is a physical entity ❒		The offender is a moral entity ❒	
Name (last, first, m.i.)	Date of Birth (MM/DD/YY)	Name	Date of Creation (MM/DD/YY)
Gender ❒ Male ❒ Female		❒ Private Company ❒ Public Administration ❒ State ❒ Other	
Is Offender Deceased? ❒ No ❒ Yes		Is Offender still in activity ? ❒ No ❒ Yes	
If yes, do Offender inheritors benefit of the crime ? ❒ No ❒ Yes		If no, are Offender's benefit(s) of the crime sustaining another moral entity activities ? ❒ No ❒ Yes	

If yes, briefly describe inheritor(s) and inheritance(s). Attach additional pages if necessary

Claimant's Name (last, first, m.i.)	Date of Birth (MM/DD/YY)	SLAVERY CRIMES VICTIMS REPARATIONS APPLICATION FORM

SLAVERY CRIMES VICTIMS REPARATIONS APPLICATION FORM

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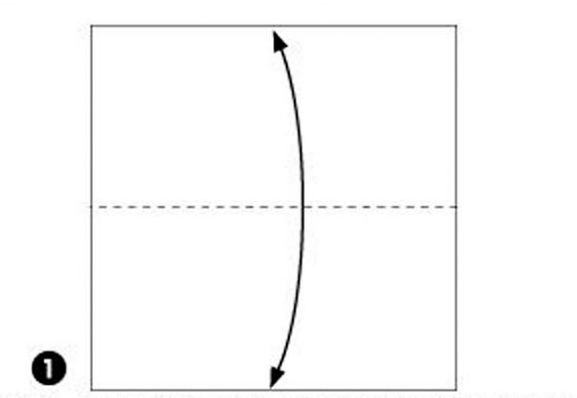

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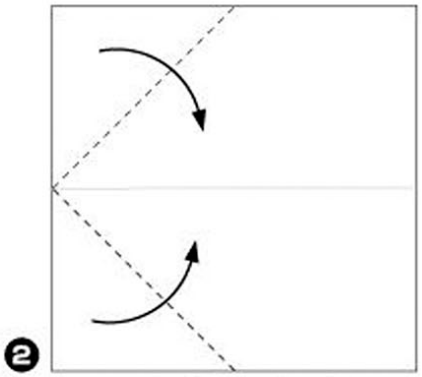

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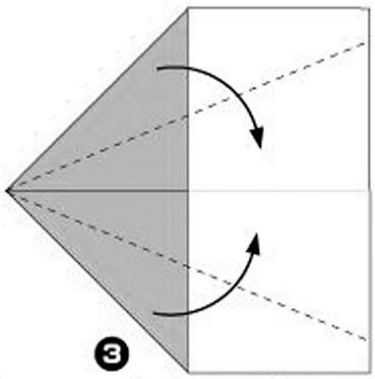

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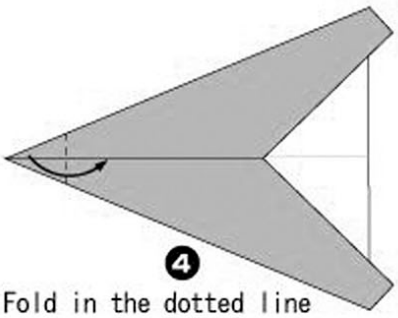

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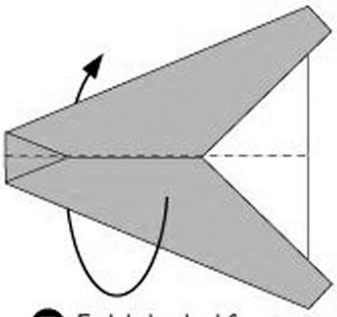

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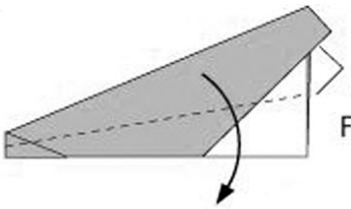
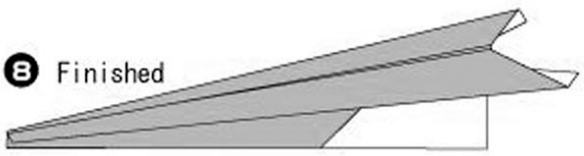


❻ Fold in the dotted line

❼ Fold in the dotted lines and adjust in 90 degrees



❽ Finished

Ready to send !

Offender 2			
Address	City	State	Zip Code
Phone	Email Address		

The offender is a physical entity ❒		The offender is a moral entity ❒	
Name (last, first, m.i.)	Date of Birth (MM/DD/YY)	Name	Date of Creation (MM/DD/YY)
Gender ❒ Male ❒ Female		❒ Private Company ❒ Public Administration ❒ State ❒ Other	
Is Offender Deceased? ❒ No ❒ Yes		Is Offender still in activity ? ❒ No ❒ Yes	
If yes, do Offender inheritors benefit of the crime ? ❒ No ❒ Yes		If no, are Offender's benefit(s) of the crime sustaining another moral entity activities ? ❒ No ❒ Yes	
If yes, briefly describe inheritor(s) and inheritance(s). Attach additional pages if necessary			

Other Offender(s)	Attach other pages if necessary.

SECTION 5. FEDERAL REPORTING INFORMATION	The following **voluntary** information is for the victim for whom this application was filed and is used for statistical purposes only to comply with federal regulations.			
Ethnicity ❒ American Indian/ Alaskan Native ❒ Asian	❒ Black/African African descendent ❒ Hawaiian/Other Pacific Islander	❒ Hispanic/Latino ❒ Multi-Racial ❒ Other ❒ White	Country of Birth	Was the victim disabled prior to the crime? ❒ No ❒ Yes

SECTION 6 - REQUESTED REPARATIONS	Your request is confidential. Specify here the nature of the repairs you want to get through the relevant justice services.	
❒ Collective reparation	❒ Individual reparation	
❒ Memory actions ❒ Community actions (specify the collecting structure)	❒ Financial compensation ❒ Land distribution	❒ Welfare ❒ Other
Describe briefly. Attach additional pages if necessary.		

SECTION 7. REPRESENTATION BY OTHERS	The Justice Dept is authorized to release private and confidential data about this claim to the representatives listed below.

ATTORNEY INFORMATION			**VICTIM ASSISTANCE PROGRAM INFORMATION**		
Are you represented in this matter by a private attorney? ❒ No ❒ Yes			Are you working with an advocate? ❒ No ❒ Yes		
Name of Attorney			Name of Advocate		
Law Firm			Victim Assistance Program		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Phone	Fax		Phone	Fax	

Claimant's Name (last, first, m.i.)	Date of Birth (MM/DD/YY)	**SLAVERY CRIMES VICTIMS REPARATIONS APPLICATION FORM** 3 of 6

SLAVERY CRIMES VICTIMS REPARATIONS APPLICATION FORM

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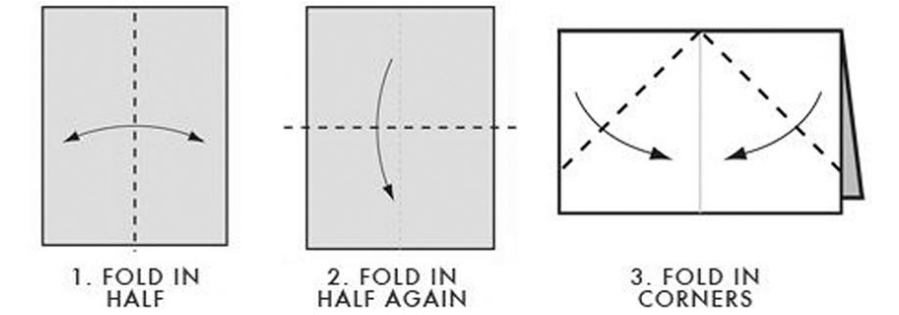
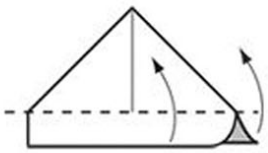


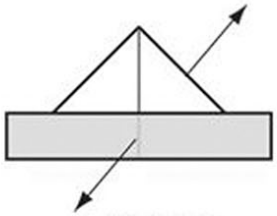
1. FOLD IN HALF

2. FOLD IN HALF AGAIN

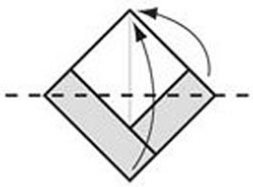
3. FOLD IN CORNERS



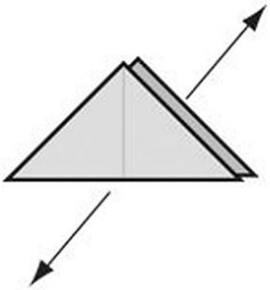
4. FOLD UP EDGES ON BOTH SIDES



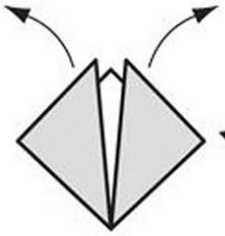
5. PULL THE SIDES OUT AND FLATTEN



6. FOLD FRONT AND BACK LAYERS UP



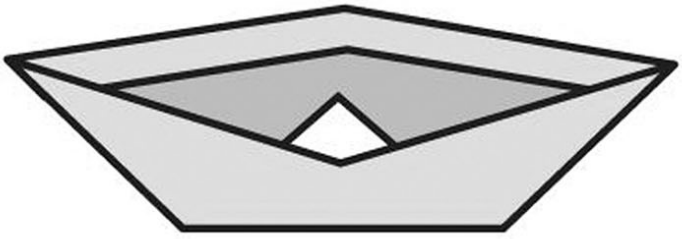
7. PULL SIDES APART AND FLATTEN



8. PULL TOP FLAPS OUTWARDS

9. SQUISH THE BOTTOM AND PULL THE SIDES UP

10. TA DAAA!



Ready to send !

SECTION 10. MEDICAL AND DENTAL EXPENSES	List the healthcare providers who treated crime related injuries, including pharmacies. Attach itemized bills and receipts, if available. **Providers must also be listed on the release form on page 6.**	
Provider	Address	Phone
Provider	Address	Phone
Provider	Address	Phone
Provider	Address	Phone

SECTION 11. MENTAL HEALTH COUNSELING EXPENSES	List the mental health providers who treated the victim and/or claimant. Attach itemized bills if available. **Providers must also be listed on the release form on page 6.**		
Patient	Counselor/Clinic	Address	Phone
Patient	Counselor/Clinic	Address	Phone
Patient	Counselor/Clinic	Address	Phone

COMPLETE SECTIONS 12 & 13 ONLY IF THE VICTIM DIED AS A RESULT OF THE CRIME

SECTION 12. FUNERAL EXPENSES	List all funeral homes/cemeteries that provided services. Attach a copy of funeral and burial contracts, if available. Attach receipts if you had travel/lodging expenses to attend the funeral.	
Funeral Home/Cemetery	Address	Phone
Funeral Home/Cemetery	Address	Phone

SECTION 13. LOSS OF SUPPORT FOR DEPENDENTS OF DECEASED VICTIMS	Loss of support benefits are paid to dependents (spouse/partner, minor children) of the deceased victim. The legal guardian must file on the minor child's behalf.	
Was the victim providing support to a spouse/partner at the time of his/her death? ❒ No ❒ Yes		
Spouse/Partner	Address	Phone
Does the victim have dependent children under the age of 18? ❒ No ❒ Yes		

Child	Guardian	Address	Phone
Child	Guardian	Address	Phone
Child	Guardian	Address	Phone

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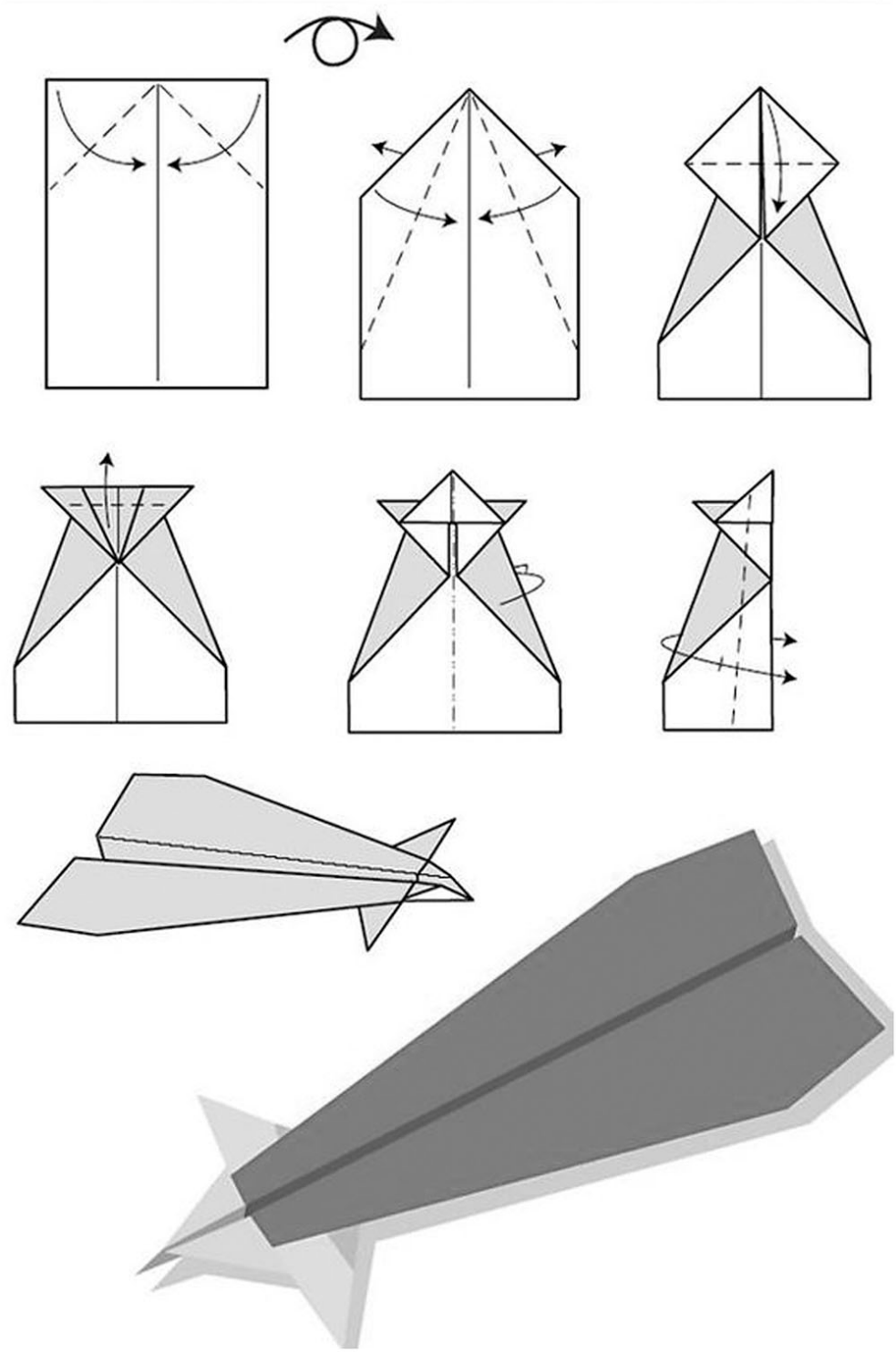

Claimant's Name (last, first, m.i.)	Date of Birth (MM/DD/YY)	**SLAVERY CRIMES VICTIMS REPARATIONS APPLICATION FORM** 5 of 6

COMPLETE SECTIONS 15 AND 18

SECTION 14. ASSIGNMENT OF SUBROGATION RIGHTS	
I agree that the Board is subrogated to the extent of reparations awarded and to all my rights to recover benefits for economic loss from another source. I assign such rights to the Board so that they may protect their subrogation interest. I agree to inform the Board in writing if I pursue a civil suit or receive any restitution moneys related to the crime.	

SECTION 15. INFORMED CONSENT TO RELEASE PATIENT INFORMATION			
I consent to the release of all patient health care records for _____, Date of Birth_____/_____/_____, including reports of alcohol or drug abuse and psychiatric treatment, to the Slavery Crimes Victims Reparations Board from all providers of medical and mental health treatment services, including but not limited to the providers listed below. I authorize SCVRB staff to complete this section on my behalf, if necessary.			
1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.
The consent to release patient information covers the time period of: / / to: / /			

SECTION 16. AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION
I authorize any law enforcement agency, employer, insurance company, social service agency, victim advocacy program, county, state or federal prosecutor's office, or any other federal, state or local government agency to release all records and information that the Board determines will help in deciding my eligibility or level of benefits in this claim. I specifically authorize the _____ Department of Revenue to release a copy of my tax returns to the Board for the purpose of determining my lost wages.
I authorize the Slavery Crimes Victims Reparations Board to release private and confidential data about my claim to the court administrator, prosecutor, and any officers of the court and probation and parole officials for the purpose of assessing the economic impact of the crime upon me and for determining the amount of restitution to be paid by the offender.
I authorize the Board to release private and confidential data about my claim to a local Emergency Fund administrator for the purpose of coordinating benefits.

SECTION 17. MISCELLANEOUS CONSENTS/AGREEMENTS
I agree that any reparations awarded may be paid directly to the provider of the service on my behalf.
I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment by a health provider.
I understand that my refusal to provide information or not allow access to information needed to analyze my claim may result in the denial of reparations.
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the redisclosure of protected health information may not be protected by federal privacy rules.
This consent will remain in effect for one year from the date of my signature. I consent to the release of healthcare records created after the date of my signature below. I understand that I may revoke this authorization at any time by submitting a written notification to the Board. This revocation will not apply to information that has already been released in response to this authorization.
A photocopy of this consent form may be accepted as the original.

SECTION 18. VICTIM AND CLAIMANT SIGNATURES	The victim must sign and date the application form. If the victim is deceased, under the age of eighteen or an incapacitated adult victim, the claimant must sign and date the application form.		
I have read and understand the statements in Sections 14-17 above. I hereby certify that the information contained in this application is true and correct to the best of my knowledge. I understand that it is a gross misdemeanor to knowingly file a false claim.			
Victim/Patient Signature	Victim/Patient Printed Name	Date of Birth	Date Signed
Claimant Signature	Claimant Printed Name	Date of Birth	Date Signed
Claimant's relationship to victim		Reason victim cannot sign claim form ❒ Deceased ❒ Minor ❒ Incapacitated Adult	

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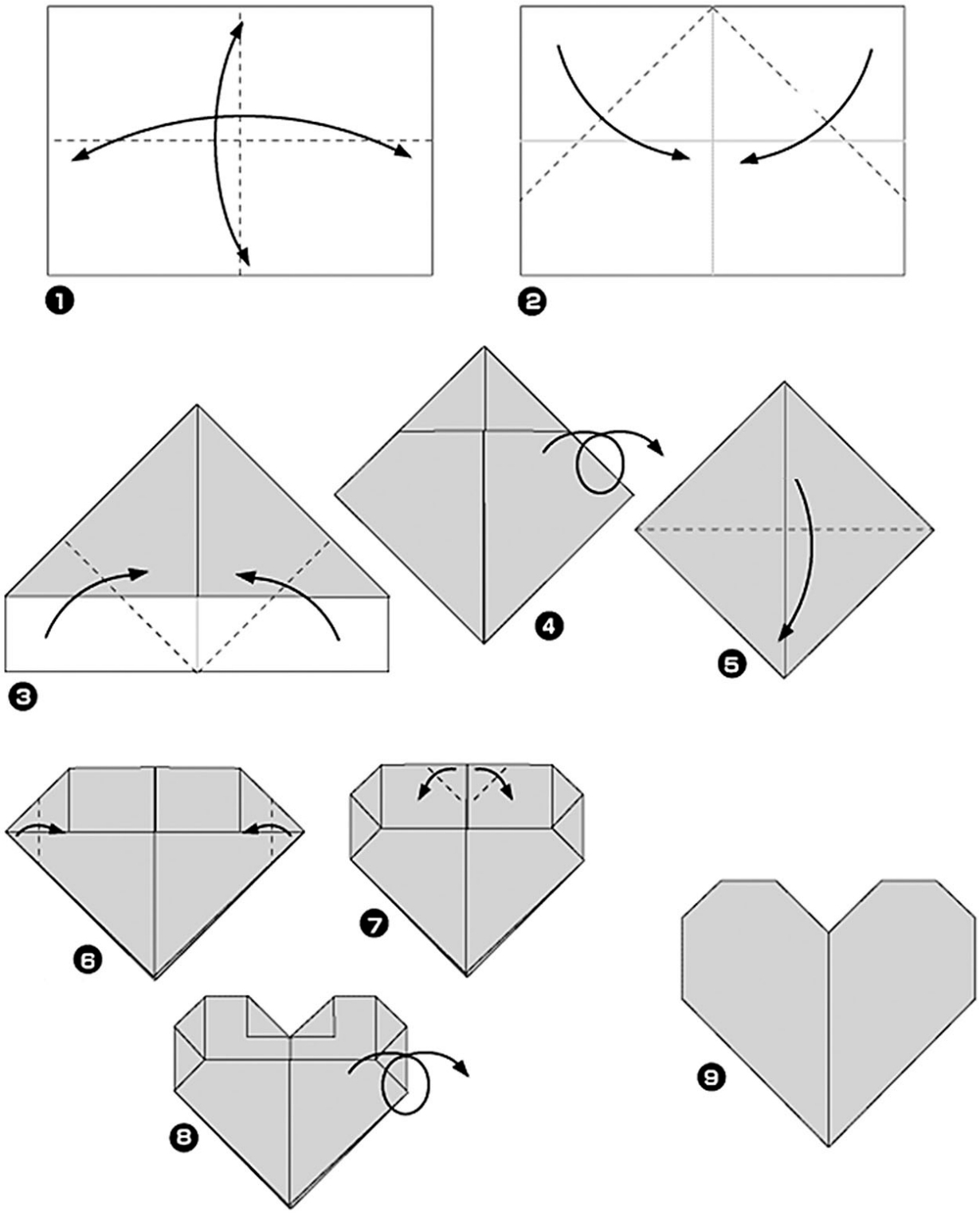

Claimant's Name (last, first, m.i.)	Date of Birth (MM/DD/YY)	**SLAVERY CRIMES VICTIMS REPARATIONS APPLICATION FORM** 6 of 6