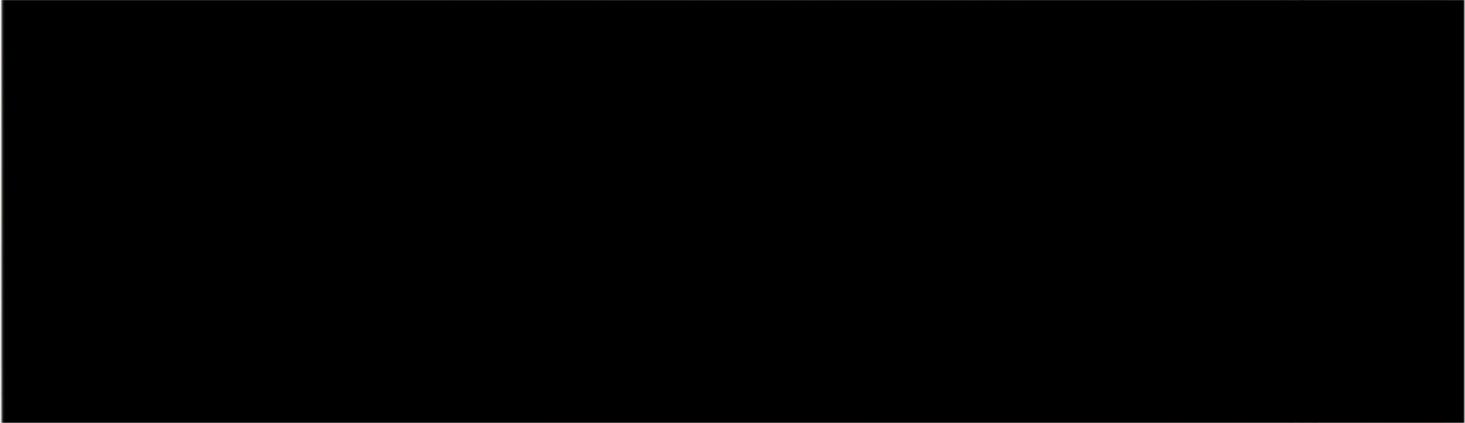
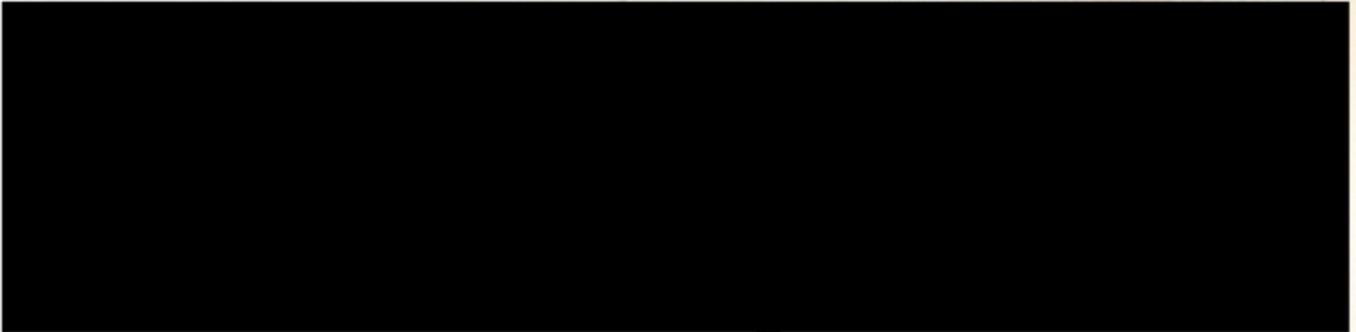


9 If the victim was injured or died because of this crime, fill out below.



10 Tell us about the victim's dependents or others who depended on the victim for support. (If none, skip to 11.)



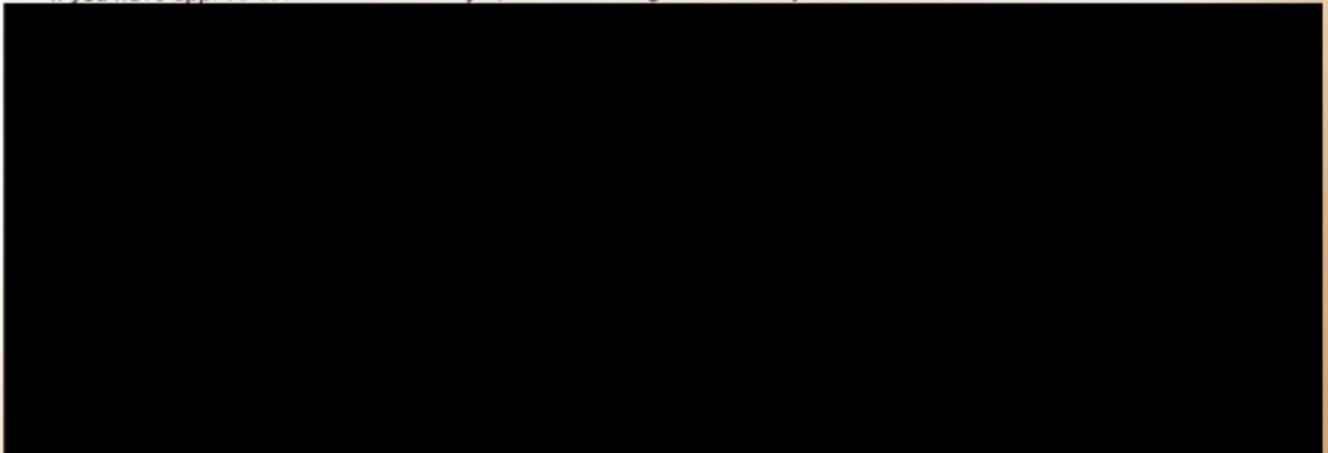
If more than 3 dependents, attach a separate sheet and check here:

11 Did anyone besides the victim receive counseling because of this crime? (If no, skip to 12.)

Who received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			
Who else received counseling?	Relationship to Victim	Insurance company billed for counseling	Policy or ID #
Counselor's name, address and phone #:			

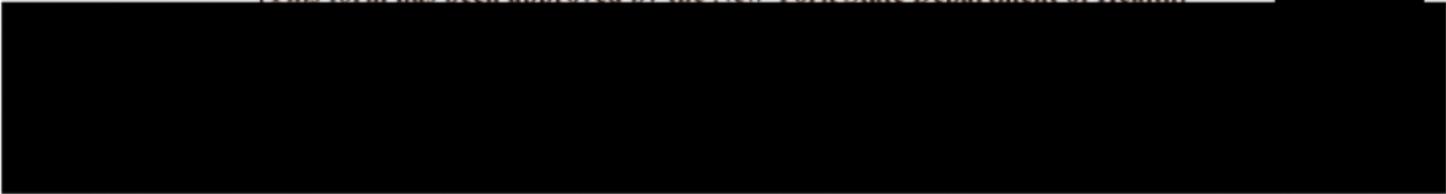
If more than 2 people received counseling because of this crime, check here and attach a separate sheet to describe.

12 List any insurance covering the victim or the victim's dependents. If no insurance, write "None" below. If you have applied but are not covered yet, write "Pending" under Policy or ID #.



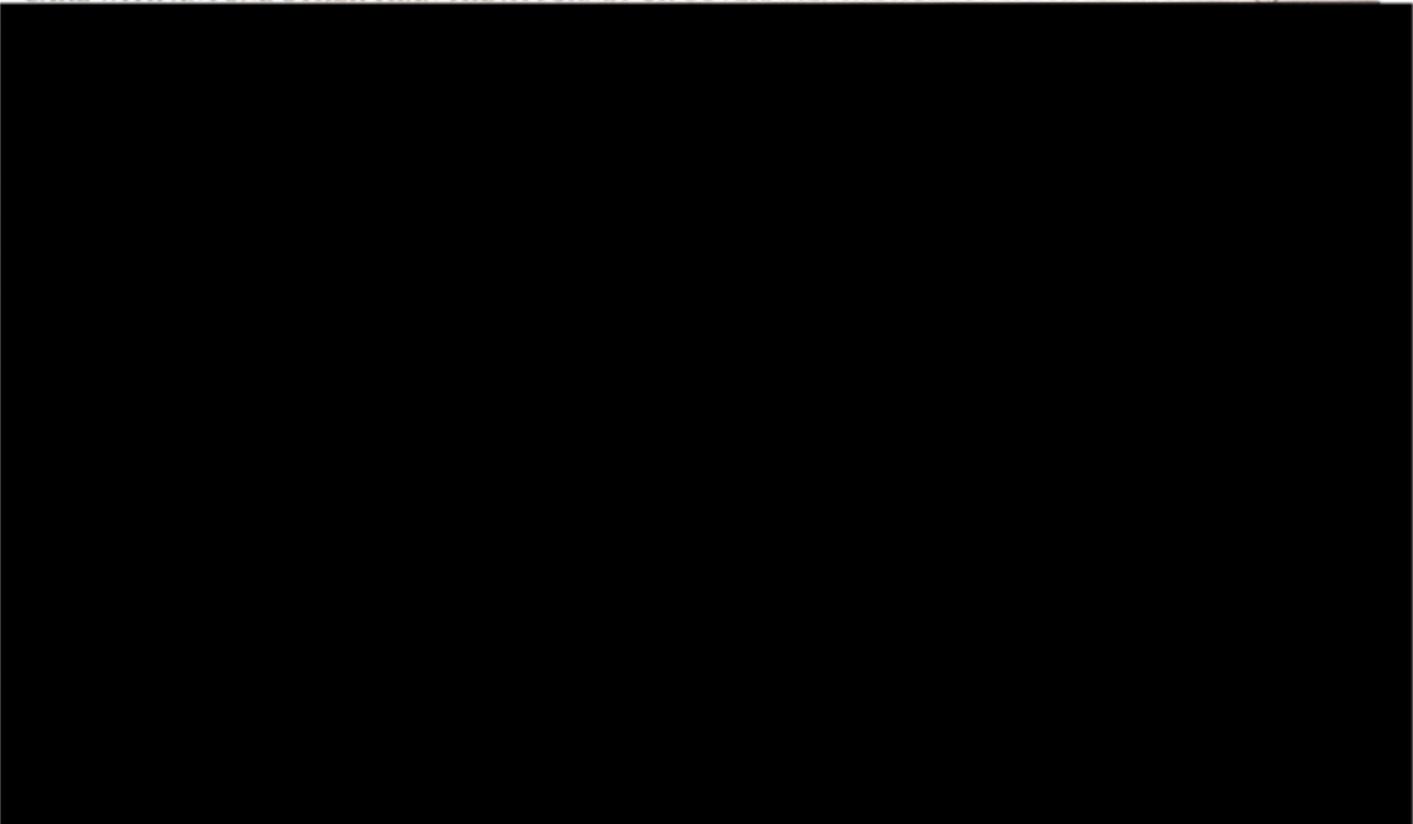


**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**  
**[This form has been approved by the New York State Department of Health]**



In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV\* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**



\* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

**13 If the victim died, tell us about any life insurance and death benefits.**

*(If the victim did not die, or does not have any life insurance or death benefits, skip to 14.)*

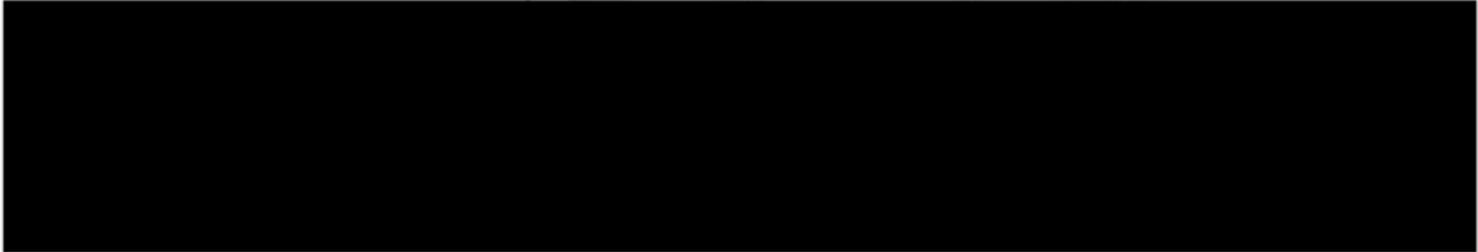
	Company Name	Address	Phone #	Policy or ID #
Life Insurance	_____	_____	( ) _____	_____
Pension Plan	_____	_____	( ) _____	_____
Other Insurance/Plan	_____	_____	( ) _____	_____
Medicaid	_____	_____	( ) _____	_____
Workers' Compensation	_____	_____	( ) _____	_____

If any other insurance or death benefits, list here: \_\_\_\_\_

Do any of these policies cover the victim's burial expenses?  Yes  No

Has anyone applied for the Social Security Death Benefit?  Yes  No

**14 Tell us about your financial situation. You MUST fill out ALL sections below. If none, enter zero (0).**



**15 Is a private lawyer (not DA) representing you?**  Yes  No



**16 Authorization to speak with representative:**

If you would like to give permission to a family member, friend or other person to speak to OVS regarding your claim, enter here.

Name of Person	Address	Phone #
_____	_____	( ) _____

**17 Victim/Claimant's Authorization:**

I ACKNOWLEDGE that accepting an award from the Office of Victim Services (OVS) creates a lien in favor of the State of New York on any recovery relating to the crime upon which this claim is based, including any judgment, settlement or order of restitution. I further authorize any funeral director, attorney, employer, police or other public authority, insurance company or any person who rendered services to the above, or having knowledge of the same, to furnish the OVS or its representatives the following information: Workers' Compensation records, information relating to the crime or any injuries or death suffered as the result of the crime, and information relating to this claim. If an award is made, I authorize the OVS to make payments directly to the provider of services. I also authorize the OVS to share my information and records compiled for this claim with the local Victim Assistance Program (VAP) in order for the VAP to assist the OVS in processing my claim and making its determination. If a private lawyer has been indicated above, I also authorize the OVS to share my information and records compiled for this claim with the lawyer in order for him/her to act as my representative. I understand a separate Notice of Appearance from my lawyer will be needed in addition to this authorization. If a family member, friend or other person is indicated above, I authorize the OVS to share my information and records compiled for this claim



**To process your claim, mail us the following documents. (Keep a copy for your records.)**

- All bills and receipts for services listed on this form
- Your completed, signed claim form
- One completed HIPAA form for **each service provider** listed on this form (You can photocopy the HIPAA form.)
- Letters from any insurers denying or authorizing payment for the services listed on this form.

**Remember:** You must bill your insurance company or benefits plan **before** the OVS can pay.

**Mail your documents to:** New York State Office of Victim Services  
AE Smith Building  
80 S. Swan Street  
Albany, NY 12210-8002