

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

Describe the victim's injuries, briefly: ANXIETY, DEPRESSION, PANIC ATTACKS  
SLEEP DEPRIVATION

Did the victim receive any medical treatment?  Yes  No (If No, skip to section 10.) \*RECENTLY BEGAN TRAUMA THERAPY.

Tell us about the health professionals who treated the victim for injuries related to this crime:

	Full Name	Complete Address	Phone #
First Hospital			( )
Other Hospital			( )
First Doctor (not in hospital)			( )
Other Doctor			( )
First Dentist			( )
Victim's Counselor	[REDACTED]		

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

Dependent	Name	Social Security #	Date of Birth	Relationship to Victim
	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
	Address			Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Dependent	Name	Social Security #	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Dependent	Name	Social Security #	Date of Birth	Relationship to Victim
	Address			Are you the legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No

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 #:			
Counselor's name, address and phone #:			
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 #.**

	Policy or ID #	Name of person(s) covered by this insurance
Primary Insurance Company	[REDACTED]	[REDACTED]
Major Medical Insurance Company	BLUE SHEET	
Other Insurance (Union, Dental, Vision, etc.)		
Medicare		
Medicaid		
Workers' Compensation		
Auto Insurance	PROGRESSIVE	
Other insurance		



**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).**

How many dependents do you have? 1

What is your total annual income (from ALL sources)? If you are not sure, estimate: \$ 150k

List ALL your assets and ALL your debts below. If you are not sure, estimate. Attach additional pages, if needed.

Your Assets – If none, enter zero (0).		Your Debts – How much do you owe now?	
Savings, stocks, bonds	\$ <u>12k</u>		If none, enter zero (0).
Real Property (house, etc.)	\$ <u>2.6M</u>	Mortgage	\$ <u>1.3M</u>
Proceeds from life insurance	\$ <u>0</u>	Loans	\$ <u>3M</u>

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

If Yes:

BRAD EDWARDS

Lawyer's Name

Address

**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 with \_\_\_\_\_.

\_\_\_\_\_ shall be deemed as effective as the original

Oct 22nd 2019

Date

Email: \_\_\_\_\_ Language you prefer to speak:  English  Spanish  Simplified Chinese  
 Traditional Chinese  Haitian Creole  Italian  Korean

Interpreter Needed:  Yes  No

Russian  Other \_\_\_\_\_

**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