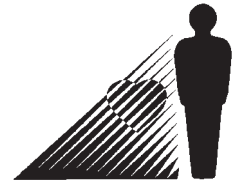


# VICTIMS OF CRIME FINANCIAL BENEFITS PROGRAM



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		
<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	
<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	
Last	First	Initial
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		
<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	
<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	
Last	First	Initial
Your relationship to the victim		
Complete Mailing Address		
Telephone numbers where we may contact you		
Home	Work	Cell/Messages
Email:		

# 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 authorization will be retained by the Victims of Crime Financial Benefits Program**

# 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:	City:

Hospital:	Hospital:
City:	City:

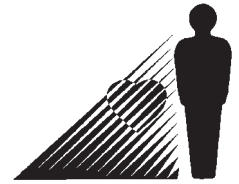
### Names of doctors or other professionals providing treatment for your injuries.

Name	Telephone
Address	City
	Province
	Postal Code
<input type="checkbox"/> Family Physician <input type="checkbox"/> Dentist <input type="checkbox"/> Therapist/Counsellor <input type="checkbox"/> Specialist _____ <input type="checkbox"/> Other _____	

Name	Telephone
Address	City
	Province
	Postal Code
<input type="checkbox"/> Family Physician <input type="checkbox"/> Dentist <input type="checkbox"/> Therapist/Counsellor <input type="checkbox"/> Specialist _____ <input type="checkbox"/> Other _____	

Name	Telephone
Address	City
	Province
	Postal Code
<input type="checkbox"/> Family Physician <input type="checkbox"/> Dentist <input type="checkbox"/> Therapist/Counsellor <input type="checkbox"/> Specialist _____ <input type="checkbox"/> Other _____	

# VICTIMS OF CRIME FINANCIAL BENEFITS PROGRAM



## Authorization to Disclose Personal Health Information

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

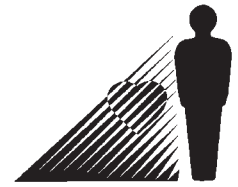
Any photographic or facsimile copy shall be as valid as the original when presented to a health care facility or professional by the Director of the Victims of Crime Financial Benefits Program OR his/her designate.

\_\_\_\_\_  
Victim/Applicant's Signature

\_\_\_\_\_  
Date

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

# VICTIMS OF CRIME FINANCIAL BENEFITS PROGRAM



## Section 5. Death Benefit

Names of spouse/partner and/or children. If there are none, provide the names of parents or siblings.

Date of Birth (m/d/y)

Relationship to Deceased

Names of spouse/partner and/or children. If there are none, provide the names of parents or siblings.	Date of Birth (m/d/y)	Relationship to Deceased

## 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

