Government of Alberta

Victims of Crime Financial Benefits Program

Injury Application

What is the Victims of Crime Financial Benefits Program?

The Victims of Crime Financial Benefits Program provides a financial benefit to eligible victims of violent crime in Alberta, as an acknowledgement of their victimization. Benefits are based on the victim's verified injuries. The program does not pay for any costs or losses related to the crime (i.e. personal property loss, damages, lost wages or medical costs). The program is administered under the *Victims of Crime Act and Regulation*. Benefit amounts are set in the *Victims of Crime Regulation.*

The Financial Benefits Program also has a death benefit. If you are applying for a victim who died as a result of violent crime, complete the **Death Benefit Application.**

Complete this application form if you were injured as a direct result of a violent crime.

Instructions

1. Please print clearly and complete all sections. Missing information will delay processing your application.
2. Sign the authorization found on section 6 and the declaration found on section 7. **Applications without the required signatures will be returned.**
3. Mail or fax the application and any attachments to:

   Victims of Crime Financial Benefits Program
   10th Floor, 10365 - 97 Street
   Edmonton, AB T5J 3W7
   Fax: 780-422-4213
4. Please tell the Financial Benefits Program if you change your address or telephone number.

You may be eligible for a financial benefit if:	You may NOT be eligible for a financial benefit if:
• you were a victim of one of the eligible offences listed in the *Victims of Crime Regulation;* • the crime happened in Alberta; • you reported the crime to police within a reasonable time; • you cooperated fully with the police investigation; and • your application was received within two years of the date of the incident.	• the crime did not happen in Alberta; • you were injured in a motor vehicle incident; • you have an extensive criminal record or criminal lifestyle; • your actions directly or indirectly contributed to your injuries; or • you were a witness to a crime (secondary victim).

We will request details of the incident and request a criminal record check from the police as part of the application process. We will consider your injuries if you meet all of the eligibility criteria. We will obtain the required medical/treatment information.

Your local Victim Services Unit can also assist you with completing your application. You can find your Victim Services Unit in the blue pages of the phone book or through your local police service.

If you have questions about your Financial Benefits application, call the program at 780-427-7217 or toll-free through Service Alberta at 310-0000 and enter 780-427-7217. Additional information is also available on our website at www.victims.alberta.ca.

The personal information provided on this form and attachments is collected under the authority of the *Victims of Crime Act* and managed in accordance with the *Freedom of Information and Protection of Privacy Act.* The information will be used for the purpose of determining and verifying eligibility for Financial Benefits. If you have any questions about the collection of this information, you can contact 780-427-7217.

This information will be used to contact you. If your address or telephone number changes, tell the Financial Benefits Program so we are able to contact you.

Section 1. Victim's Personal Information

This section provides the victim's contact information.

Name of Victim
Provide your first, middle and last name (i.e. John Patrick Smith).

Gender
Check the appropriate box.

Other names used
If you have changed your name, or use other names (i.e. maiden name), provide the other names.

Birth date
Provide your birth date using month, day, year (i.e. Nov 28, 2009).

Alberta Personal Health Number or Treaty Number
Provide your Alberta Health Number or Treaty Number.

Mailing Address
Provide your mailing address including the city or town, province and postal code.

Telephone Numbers
Provide your telephone number and any alternate telephone numbers where you can be reached or a message left. Include the area codes.

Email Address
Provide your email address, if you have one.

Section 2. Applicant's Contact Information (Application on Behalf of Victim)

This section provides the applicant's contact information. **You must be 18 years of age or older to be an applicant.**

Complete this section if you are an immediate family member or legal representative applying on behalf of a victim. If you are the victim, go to section 3.

DO NOT complete this section if you are just helping the victim to complete the application.

Name of applicant
Name of the person applying on behalf of the victim (i.e. Robert Smith).

Mailing Address
Provide your current mailing address including the city or town, province and postal code.

Telephone Numbers
Provide your telephone number and any alternate telephone numbers where you can be reached or a message left. Include the area code.

Email Address
Provide your email address if you have one.

What is your relationship to the victim
(i.e. mother, father, guardian, lawyer).

Are you the victim's legal guardian or legal representative?
Check the appropriate box.

If yes, provide a copy of the court order or authorization granting you legal authority or guardianship. Documentation is not required if you are the parent with custody of the victim.

The pages on the left side of the application provide instructions on how to complete the corresponding section on the right hand page

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Government of Alberta

Injury Application

Section 1. Victim's Personal Information

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Name of victim *(first, middle, last)*

Gender ☐ Male ☐ Female

Other names used *(i.e. nickname, maiden name)*

Birth date *(month/day/year)*

Alberta Personal Health Number or Treaty Number

Mailing Address

City/Town

Prov.

Postal Code

Phone Number *(include area code)*

Work Number *(include area code)*

Cell Number *(include area code)*

Email Address

Section 2. Applicant's Contact Information (Application on Behalf of Victim)

Complete this section if the victim is *under 18 years of age or otherwise unable to apply on his/her own.*

Name of person completing application:

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Name of applicant *(first, middle, last)*

Mailing Address

City/Town

Prov.

Postal Code

Phone Number *(include area code)*

Work Number *(include area code)*

Cell Number *(include area code)*

Email Address

What is your relationship to the victim *(i.e. mother, father, guardian, lawyer)*

Are you the victim's legal guardian or legal representative? ☐ Yes ☐ No

If yes, provide a copy of the court order or authorization granting you legal authority or guardianship. Documentation is not required if you are the parent with custody of the victim.

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Section 3. Crime Information

This section provides us with information about the crime and the investigating police service. We will use this information to request information from the police to verify your eligibility.

Type of Crime
Provide the type of crime (i.e. assault, robbery).

Date of Crime
Provide the date the crime occurred. Write the date: month, day, year (i.e. Nov. 28, 2009).

Was the Crime Reported to Police
Check the appropriate box.

Location of Crime
Provide the name of the city or town where the crime occurred.

Date Crime Reported to Police
Provide the date the crime was reported to police. Write the date: month, day, year (i.e. Nov. 28, 2009).

Police Service Crime Reported to
Provide the name of the police service the crime was reported to including city or town.

Police File Number
Provide the police file number, if you know it.

Offenders Name(s)
Provide the offenders name(s), if you know it/them.

Describe the Crime
Briefly tell us about the crime.

Two Year Time Limitation

There is a two year time limit to apply for benefits. However, an extension may be granted for incidents that occurred more than 2 years ago depending on the reason(s) for the delay.

Is this application being submitted within two years of the date of the crime?

Check the appropriate box.

If no, briefly explain your reasons for the delay.

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Section 3. Crime Information

Type of crime (i.e. assault, robbery)

Date of crime *(month/day/year)*

Location of crime *(town/city)*

Was crime reported to police?

☐ Yes ☐ No

Date crime reported *(month/day/year)*

Police service crime reported to (i.e. Edmonton Police Service, Vulcan RCMP)

Police file No.

Offender's name(s) *(if known)*

Briefly describe the crime

TWO YEAR TIME LIMITATION

Is this application being filed within two years of the date of the crime?

☐ Yes ☐ No

If no, briefly explain your reasons for the delay

Section 4. Victim's Injuries

This section provides us with information about the injuries you the victim, received as a direct result of the crime. This information will be used to verify the information you provide.

Please describe the injuries (physical and/or emotional) received as a result of the crime

Briefly describe the physical and/or emotional injuries you received as a direct result of the crime.

Did you receive medical treatment as a result of the crime?

Check yes or no.

Section 5. Victim's Medical Information - Hospitals

This section lists the hospitals who have treated your injuries resulting from the crime.

This information will be used to request the information we need to verify your injuries. We may not write to everyone you list.

Complete all fields, including addresses, for each hospital that provided treatment as a direct result of the crime.

Hospital

Provide the name of the hospital.

City

Provide the address of the hospital if you know it or the city or town the hospital is in.

Dates Treated

Provide the first date of treatment (admission) and the last date of treatment (discharge). Write the date: month, day, year (i.e. Nov. 28, 2009).

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Section 4. Victim's Injuries

Briefly describe the injuries *(physical and/or emotional)* received as a direct result of the crime

Section 5. Victim's Medical Information

Did you receive medical treatment as a result of the crime? ☐ Yes ☐ No

HOSPITAL

Address | City/Town | Prov. | Postal Code

Dates Treated *(month/day/year)*

FROM | TO

HOSPITAL

Address | City/Town | Prov. | Postal Code

Dates Treated *(month/day/year)*

FROM | TO

Section 5. Victim's Medical Information - Medical Professionals

Medical Professionals who Treated the Victim's Injuries

This section lists the people who have treated your injuries resulting from the crime.

Name of Medical Professional

Provide the name of the doctor or other medical professional (i.e. counsellor, dentist) who treated you for your injuries that resulted from the crime. We do not need the name of the Emergency doctor that treated you.

Address

Provide the complete address of the medical professional, including the city/town, province, postal code and telephone number. Without this, we will not be able to get information regarding your injuries.

Type of Medical Professional

Select the appropriate check box. If other, what type of medical professional are they (i.e. surgeon, physiotherapist). This will help us know what information to request.

Injuries Treated

For each medical professional please check if they treated your physical or emotional injuries or both. This will help us know what information to request.

Dates Treated

Provide the first date of treatment and the last date of treatment. Write the date: month, day, year (i.e. Nov. 28, 2009).

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Section 5. Victim's Medical Information

Medical professionals who treated your injuries.

NAME Telephone Number *(include area code)*

Address City/Town Prov. Postal Code

Type of Medical Professional

☐ Family Physician ☐ Counsellor ☐ Dentist ☐ Other *(please specify)*

Injuries treated: Dates Treated *(month/day/year)*

☐ Physical ☐ Emotional FROM TO

NAME Telephone Number *(include area code)*

Address City/Town Prov. Postal Code

Type of Medical Professional

☐ Family Physician ☐ Counsellor ☐ Dentist ☐ Other *(please specify)*

Injuries treated: Dates Treated *(month/day/year)*

☐ Physical ☐ Emotional FROM TO

NAME Telephone Number *(include area code)*

Address City/Town Prov. Postal Code

Type of Medical Professional

☐ Family Physician ☐ Counsellor ☐ Dentist ☐ Other *(please specify)*

Injuries treated: Dates Treated *(month/day/year)*

☐ Physical ☐ Emotional FROM TO

NAME Telephone Number *(include area code)*

Address City/Town Prov. Postal Code

Type of Medical Professional

☐ Family Physician ☐ Counsellor ☐ Dentist ☐ Other *(please specify)*

Injuries treated: Dates Treated *(month/day/year)*

☐ Physical ☐ Emotional FROM TO

Section 6. Authorization to Release Personal Information

This section authorizes the Financial Benefits Program to obtain information from the police to determine eligibility for financial benefits and from medical professionals to verify your injuries.

This authorization must be completed and signed or we cannot process your application.

Complete the victim's name and date of birth

Write the date of birth: month, day, year (i.e. Nov. 28, 1968).

READ THE AUTHORIZATION

Victim/Applicant's Signature

- If you are 18 years of age or over, sign and date the authorization.
- If you are under 18 years of age, your parent or guardian must sign the authorization.
- If you are applying on behalf of the victim, you can sign the authorization as the applicant.

Witness to your Signature

Any adult can be a witness to your signature. Have this person watch you sign the authorization. Then have them sign in the witness signature box.

Witness Name

Print the name of the witness.

Your application will be returned if this section is not signed and dated.

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Section 6. Authorization to Release Personal Information

Victim's Name

Victim's date of birth *(month/day/year)*

The Director of the *Victims of Crime Act* or any employee delegated by him/her (herein referred to as the "Director") has authority under section 13.1 of the *Victims of Crime Act* to collect the information necessary to determine eligibility for financial benefits and the amounts of 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.

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" with any information directly or indirectly related or unrelated to the alleged crime(s) identified in this application,

(b) The "Director" to have access to information regarding any related or unrelated federal offence convictions and associated sentences imposed on the victim,

(c) **any medical hospital/facility** to disclose personal health records, as requested in the attached letter of correspondence, which are directly or indirectly related to the incident identified in the application, to the "Director",

(d) **any health care professional/provider** to disclose personal health records/information, which is directly or indirectly related to the incident identified in the application, to the "Director",

(e) The "Director" to release information, including relevant sections of the application, to police, health care facilities, treatment professionals or other agencies as may be necessary to obtain the information requested under (a), (b), (c) or (d) for the purpose of making a determination on the application.

I understand that I may revoke this authorization at any time by advising the "Director" in writing. I understand that if this authorization is revoked, or if I fail to provide the information requested by the "Director", it may affect the ability of the "Director" to assess this application.

I understand why I have been asked to authorize disclosure of this information and I am aware of the risks or benefits of consenting or refusing to authorize disclosure of this information.

A photographic or facsimile copy shall be as valid as the original when presented to a health care facility, health care professional, police service or other agency by the "Director". The original or faxed authorization will be retained by the Victims of Crime Financial Benefits Program.

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 Signature

Date *(month/day/year)*

Witness Signature

Witness Name

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

This information is being collected under the authority of section 13.1 of the *Victims of Crime Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* and section 34 of the *Health Information Act* for the purpose of administering the Victims of Crime Financial Benefits Program. Should you have any questions regarding the collection of this information you may contact the Victims of Crime Financial Benefits Program, Alberta Solicitor General and Public Security at 780-427-7217 or 10th Floor, 10365 - 97 Street, Edmonton, AB T5J 3W7.

Section 7. Declaration

By signing this section, you declare the information provided to be correct. Providing false information may result in your application being denied.

Complete the Declaration.
Print your name on the line marked Victim/Applicant's Name.

Victim/Applicant's Signature
Sign the declaration.

Date
Date the declaration was signed, using month, day, year (i.e. July 1, 2010).

Your application will be returned if this section is not signed and dated.

Section 8. Optional Authorization

Would you like us to be able to discuss your file with another person?
Privacy legislation does not allow us to speak to anyone but the victim or applicant about your application and the information contained on it. We can speak to other people about the information on your file only with your written permission (authorization).

COMPLETE THE AUTHORIZATION ONLY IF YOU GIVE US PERMISSION TO SPEAK TO THE PERSON YOU NAME ABOUT YOUR FILE.

Print your name on the line marked Victim/Applicant's Name.

Print the name of the person you are giving authorization to on the line marked Name of person you are giving authorization to.

Telephone number of authorized person
Provide the telephone number of the authorized person.

Relationship to the Victim
Provide the relationship of the other authorized person to you (victim).

Signature
Signature of victim or applicant.

Date
Date signed, using month, day, year (i.e. July 1, 2010).

This authorization can be revoked at anytime by the victim/applicant.

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Section 7. Declaration

I am applying for financial benefits under the *Victims of Crime Act*, and

I, _____ declare the information in this application is true and correct.
Victim/Applicant's Name *(please print)*

Victim/Applicant Signature

Date *(month/day/year)*

Section 8. **OPTIONAL** Authorization

Authorization to discuss your file with another person

I, _____ authorize the Financial Benefits Program to discuss my file
Victim/Applicant's Name *(please print)*

with _____.
Name of person you are giving authorization to

Authorized person's telephone Number *(include area code)*

Relationship to the victim

Victim/Applicant Signature

Date *(month/day/year)*

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Additional Information

Use this page if you need extra space for any part of this application.

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Additional Information

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