

Victims Compensation Application Form

Claim No. _____

Date Received _____

(Office Use Only)

VICTIM INFORMATION

Name: _____
First Name Middle Name Last Name

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ / _____ / _____
month date year Male Female

Health Registration Number: _____ Province: _____

APPLICANT FORM (If applicant is not the victim)

Applicant Name: _____
First Name Middle Name Last Name

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Relationship to Victim: _____

DEPENDANT INFORMATION (If dependant is not the applicant)

Dependant's Name: _____
First Name Middle Name Last Name

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Relationship to Victim: _____

Victims Services, Ministry of Justice
Room 610, 1874 Scarth Street, Regina, Saskatchewan S4P 4B3
Phone: (306) 787-3500 Fax: (306) 787-0081
Toll free: 1-888-286-6664 TTY: 1-866-445-8857

INFORMATION RELATING TO THE CRIME

Please indicate the type of crime that occurred*:

Assault Murder Robbery Sexual Assault Other (please specify) _____

Location of Crime: _____

Street Address

City/Town

Province

Name of Law Enforcement Agency: _____

Name of Accused: _____

Date of Incident: _____ / _____ / _____
month date year

Date Reported: _____ / _____ / _____ Police File Number (if known): _____
month date year

Eligible offences are identified in *The Victims of Crime Regulations, 1997*.

Note: Property crimes are NOT eligible for compensation.

EMPLOYMENT INFORMATION (Only the victim is eligible for lost wages)

1. Were you employed when the crime occurred? Yes No

2. Did you miss work and lose pay as a result of crime-related injuries? Yes No

(If you answered no to either of these questions, do not complete this section, as you are not eligible for lost wages.)

Victim's Social Insurance Number: _____

Employer Name: _____

Address: _____

Contact Person: _____ Tel: _____ Fax: _____

Dates absent from work due to crime-related injuries: _____

Name and address of physician authorizing disability:

Name

Address

Telephone

Did you receive or will you receive any of the following:

Sick Pay Workers' Compensation Disability Pay Vacation Pay Social Assistance

Employment Insurance Other If none, check here

Please provide details of any benefits checked above: (use additional page if required)

Name of Benefit Provider

Address

Amounts

EXPENSES	AMOUNT	STATUS	
AMBULANCE	\$ _____	<input type="checkbox"/> Paid (<i>Attach Receipt</i>)	<input type="checkbox"/> Not Paid (<i>Attach Invoice</i>)
MEDICAL	\$ _____	<input type="checkbox"/> Paid (<i>Attach Receipt</i>)	<input type="checkbox"/> Not Paid (<i>Attach Invoice</i>)
EYE GLASSES	\$ _____	<input type="checkbox"/> Paid (<i>Attach Receipt</i>)	<input type="checkbox"/> Not Paid (<i>Attach Invoice</i>)
TRAVEL EXPENSES*	\$ _____	<input type="checkbox"/> Paid (<i>Attach Receipt</i>)	<input type="checkbox"/> Not Paid (<i>Attach Invoice</i>)

Reason for expense: _____

* For approved counselling and medical appointments.

DAMAGED CLOTHING \$ _____ *Receipts are required for claims over \$100; maximum claim \$250. (Does Not include jewellery or other personal items.)*

*PRESCRIPTION DRUGS \$ _____ Paid (*Attach Receipt*) Not Paid (*Attach Invoice*)
 (*Non-prescription items **are not eligible** for reimbursement.)

Name and address of physician who authorized medication:

 Name Address

DENTAL \$ _____ Paid (*Attach Receipt*) Not Paid (*Attach Invoice*)

Name and address of dentist:

 Name Address

Is future dental work required as a result of this incident? Yes No

If yes, please provide an estimate for costs: \$ _____

Is any of this dental work covered by an insurance plan? Yes No

Name and address of insurer:

 Name Address

COUNSELLING \$ _____ *Counselling can only be provided during the victim's involvement in the criminal justice process. Victims should first try to access counselling services through their health region's mental health services.*

FUNERAL EXPENSES \$ _____ Paid (*Attach Receipt*) Not Paid (*Attach Invoice*)

Name and address of funeral home:

 Name Address

If any of the above-mentioned expenses were covered by other sources, please provide details:

 Name of agency paying expenses Address

 Details

AUTHORIZATION FOR RELEASE OF INFORMATION

I Authorize:

1. The doctor, dentist, optometrist, chiropractor or other health care professional who treated the victim's injuries (physical and/or psychological) to give to the minister or designate, on request, medical or other reports.
2. The police or other law enforcement authorities to give to the minister or designate, on request, a copy of police reports, statements or other information relevant to this application.
3. The Workers' Compensation Board or other authority from which the victim or dependant received payments from provincial or federal funds to give to the minister or designate, on request, information relevant to this application.
4. The victim's employer(s), union or similar authority to give to the minister or designate, on request, information as to the earnings of or payments to the victim or dependant.
5. Any accident, disability, sickness or life insurance/assurance company or private pension scheme from which payments have been received or are to be received to give to the minister or designate, on request, information relevant to this application.
6. The Saskatchewan Ministry of Social Services, Aboriginal Affairs and Northern Development Canada or any other authority from which payments were received to give to the minister or designate, on request, information relevant to this application.
7. Human Resources and Social Development Canada (Employment Insurance or Canada Pension Plan) to give to the minister or designate, on request, information as to benefits received or to be received by the victim or dependant relevant to this application.
8. Canada Revenue Agency to give to the minister or designate, on request, information as to the victim's employment income.
9. The minister or designate to share the status of my application with the appropriate Police-based Victim Services program.

I understand that the minister or designate may notify the above authorities that I have submitted an application pursuant to *The Victims of Crime Act, 1995*.

Date

Signature of Victim or Dependant

If this application is made on behalf of a victim or dependant, please complete the following:

Name of Applicant: _____

Address: _____

Relationship to the Victim or Dependant: _____