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: _____/_____/_____ Male ☐ Female ☐
month date year

Email Address: _____

Health Registration Number: _____ Province: _____

APPLICANT INFORMATION (If the victim is a minor or dependant)

Applicant Name: _____
First Name Middle Name Last Name

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Relationship to Victim: _____

Victims Services, Ministry of Justice
Room 610, 1874 Scarth Street, Regina, Saskatchewan S4P 4B3
Phone: (306) 798-2667
Toll free: 1-833-798-2667 TTY: 1-866-445-8857

e-mail: victimsservices@gov.sk.ca
website: www.saskatchewan.ca/victimsservices

Saskatchewan

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

3. 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

Saskatchewan

EXPENSES	AMOUNT	STATUS
AMBULANCE	$ _____	☐Paid *(Attach Receipt)* ☐Not Paid *(Attach Invoice)*
MEDICAL	$ _____	☐Paid *(Attach Receipt)* ☐Not Paid *(Attach Invoice)*
EYE GLASSES	$ _____	☐Paid *(Attach Receipt)* ☐Not Paid *(Attach Invoice)*
TRAVEL EXPENSES*	$ _____	☐Paid *(Attach Receipt)* ☐Not Paid *(Attach Invoice)*

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. V ictims 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

Saskatchewan

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 orApplicant

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: _____