We help put the pieces back together
New Jersey Victims of Crime Compensation Office (VCCO) compensates victims of crime for losses and expenses resulting from certain criminal acts. For your convenience, below are the most frequently asked questions. However, we urge you to visit our website for more information at www.njvictims.org. You can also contact your Victim/Witness Coordinator which is located in each County Prosecutor’s Office. A link to those offices is on the VCCO website.

What crimes are covered?
The crimes covered include but are not limited to, assault, homicide, sexual assault, kidnapping and all domestic violence incidents.

How much help can I get from the New Jersey Victims of Crime Compensation Office (VCCO)?
The VCCO can award up to $25,000* for all expenses. However, many types of benefits have caps. Examples of expense types and the respective caps for some of them are:

- Emergency relocation costs: $3,000
- Care of child or dependent: $6,500
- Mental Health counseling: $20,000
- Funeral expenses: $7,500
- Attorney fees: $10,000
- Loss of earnings or support
- Victim rights in criminal proceedings.
- Hospital, physician and physical therapy
- Attorney fees for assistance in filing a claim and representing you in the appeal process.

How do I qualify for assistance?
If you are a victim or claimant (person filing for a victim or dependents of the victim) you must show that:

- Crime is eligible under the statute.
- You are a resident of the State of New Jersey or the crime occurred in this State.
- You have compensable financial losses as a result of the criminal act.
- The crime was reported to law enforcement within 9 months, and you submitted this application within 5 years from the date of the crime. Consideration will be taken if “good cause” exists for delayed filing.
- You cooperated with police and prosecutor’s office. However, eligibility is not dependent upon conviction or prosecution of the offender.
- Insurance and other payment sources such as restitution paid by the offender will not cover the bills submitted.
- With the exception of homicide cases, you did not contribute to your injuries, provoke the incident, and were not responsible for or participated in the crime that caused your injuries.
- You do not have any outstanding VCCO assessments imposed for convictions.
- You do not have any outstanding warrants for indictable offenses or pending criminal charges in Superior Court.

What common losses are not covered?
- Property damage or loss, except crime scene clean up.
- Pain and suffering.

*Additional $35,000.00 can be awarded for catastrophic benefits for victims with permanent disabilities.
NJ VCCO Claim Application Instructions

■ Please read the instructions prior to starting the application. Include copies of as much related information (i.e. copies of itemized receipts, bills, insurance statements) as you have. The more information we have now, the sooner your application can be processed. However, you can always forward additional information at a later time.

■ The Agency will send you a confirmation letter. Please be aware that if you are submitting your application through another Agency, there will be a delay in the VCCO receiving it.

■ In addition to calling to obtain status, you can also email us at njvictims@njvictims.org.

■ If you moved or if your phone number changes, please let us know.

■ Due to the high volume of the claims we receive and according to the law, the turn around time for processing a claim is 3 months of receipt of all documentation.

■ The key to processing the claim expeditiously is receipt of all documentation from you, the hospitals, doctors, law enforcement, employers, governmental agencies, etc.

SECTION 1: Victim Information (Required Section)
Print the name of the person injured at the crime scene. This should be the same person listed as the “Victim” on the law enforcement report. Complete the rest of this section with information about the victim.

SECTION 2: Claimant Information (Required Section)
Print the name of the person applying for compensation if different than the victim. This person may also be the adult assuming responsibility for the crime related bills or the financially responsible person (e.g. parent, guardian, spouse) of a minor, incapacitated or incompetent person injured as a result of the crime.

SECTION 3: Additional Information
Print the name of a person that the VCCO may contact if we are unable to reach you.

SECTION 4: Crime Information (Required Section)
Print details about the crime here. Attach a copy of the incident report. If you don’t have one, the VCCO will request one from the police and/or prosecutor. The law enforcement incident report on the crime is necessary to determine your eligibility and process the claim.

Where can I get help with this application?
Contact your County Office of Victim/Witness Advocacy or the VCCO at:
Phone: (877) 658-2221
Phone: (973) 648-2107
Fax: (973) 648-3937
www.NJVictims.org
njvictims@njvictims.org

Mail all applications to Newark office at:
VCCO
50 Park Place, 5th floor
Newark, NJ 07102
SECTION 5: Services Requested (Required Section)
Please review the possible benefits available and select which services are being requested. Supporting documentation will be requested for each benefit that is selected.

SECTION 6: Insurance Information (Required Section)
If you have insurance that may cover some of your crime-related bills, list your insurance information here.

SECTION 7: Medical/Counseling Providers
List the names of doctors, hospitals and others who have provided services. If you already have itemized bills, please send copies with your application.

SECTION 8: Employment Information
List your job information if you have not been able to work because of crime-related injuries or to take care of someone with crime related injuries.

SECTION 9: Dependent Information
In an incident of homicide, list the victim’s dependents who depended upon the victim for support.

SECTION 10: Attorney Information
Complete this section if you hired a lawyer to represent you in this claim, assist you in court, settle an insurance claim or file a lawsuit related to this crime.

SECTION 11: Referral Source Information
Print the name of the victim advocate or other professional who assisted you with this application.

SECTION 12: Legal Responsibility and Signature (Required Section)
This application is a legal document that must be read and signed by the adult Claimant.

SECTION 13: Authorization to Obtain Records (Required Section)
This Authorization to Obtain Records is necessary to obtain information from your doctors, hospital, employer, police and prosecutor, so that the VCCO can process your claim.

SECTION 14: Assignment of Interest (Required Section)
This is a legal agreement that must be signed in order for the VCCO to pay compensation to you.

SECTION 15: Authorization for Release of Information Under the Health Insurance Portability and Accountability Act (Required Section)
This authorization is necessary to obtain information from your health care providers under federal law. It must be completed, signed and dated in order for the VCCO to process your claim.

SECTION 16: Section to Provide Additional Details (If Needed)
Claim Application

**SECTION 1: VICTIM INFORMATION**

The victim is the same person listed as a victim on the crime incident report. *(complete a separate application for each victim)*

The claimant is the person applying for compensation. Do not complete SECTION 2 if the victim is the claimant.

<table>
<thead>
<tr>
<th>Mr.</th>
<th>Mrs.</th>
<th>Ms.</th>
<th>Mx.</th>
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</thead>
</table>

Full Legal Name of Victim ___________________________ Last Name ___________ First Name ___________ Middle Initial ___________

Social Security Number _______ - _______ - _______ Date of Birth _____ / _____ / ______

Check if Victim is:  
- ☐ Deceased (date of death _____ / _____ / _____ )  
- ☐ Under 18  
- ☐ Incompetent  
- ☐ Disabled

Home Mailing Address ___________________________ Last Name ___________ First Name ___________ Middle Initial ___________

City ___________________________ County ___________________________ State _______ Zip Code ___________

Home Phone ( _____ ) _______ - _______ Work Phone ( _____ ) _______ - _______

Cell Phone ( _____ ) _______ - _______ Email ___________________________

Sex:  
- ☐ Male  
- ☐ Female  
- ☐ Undesignated/Non-Binary

Race/Ethnicity:  
- ☐ Asian  
- ☐ African American  
- ☐ American Indian/Alaska Native  
- ☐ Latino  
- ☐ Middle Eastern  
- ☐ Native Hawaiian/Pacific Islander  
- ☐ Caucasian  
- ☐ Multiple Races ___________________________  
- ☐ Other ___________________________

Marital Status:  
- ☐ Single  
- ☐ Married  
- ☐ Divorced  
- ☐ Separated  
- ☐ Widowed

**SECTION 2: CLAIMANT INFORMATION**

Claimant Definition: “Claimant” means the person applying for compensation, who may or may not be the victim of the crime that forms the basis for the claim application for compensation. Do not complete this section if you are the victim stated above.

<table>
<thead>
<tr>
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<th>Ms.</th>
<th>Mx.</th>
<th>(Choose One)</th>
</tr>
</thead>
</table>

Full Legal Name of Claimant ___________________________ Last Name ___________ First Name ___________ Middle Initial ___________

Social Security Number _______ - _______ - _______ Date of Birth _____ / _____ / ______

The Claimant is the Victim’s  
- ☐ Spouse  
- ☐ Parent  
- ☐ Sibling  
- ☐ Child  
- ☐ Other ___________________________

Home Mailing Address ___________________________ Last Name ___________ First Name ___________ Middle Initial ___________

City ___________________________ County ___________________________ State _______ Zip Code ___________

Home Phone ( _____ ) _______ - _______ Work Phone ( _____ ) _______ - _______

Cell Phone ( _____ ) _______ - _______ Email ___________________________
SECTION 4: CRIME INCIDENT INFORMATION

If available, attach a copy of the following: police report, incident report, TRO, FRO, etc.

Date of Crime _____ / _____ / ______ Date Reported _____ / _____ / ______

Name as it Appears on Incident Report __________________________________________

Name of Law Enforcement Agency ________________________________________________

Location/Address of Crime ______________________________________________________

City __________________________________ County ___________ State ______ Zip Code ______

Police Complaint Number ______________________________ Prosecutor’s File Number ______

Type of Crime

☐ Arson  ☐ Kidnapping  ☐ Aggravated assault  ☐ Indecent acts with children

☐ Bias crime  ☐ Manslaughter  ☐ Human trafficking  ☐ Lewd, indecent or obscene acts

☐ Burglary**  ☐ Robbery  ☐ Domestic violence  ☐ Disorderly conduct offenses

☐ Murder  ☐ Sexual assault  ☐ Motor vehicle offenses**

☐ Stalking  ☐ Simple assault  ☐ Threats to do bodily harm

Brief Description of Incident and Your Injuries: ______________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Name(s) of Offender(s), if known: ________________________________________________

Relationship to Offender(s), if any: _______________________________________________

Was the victim living in the same household with the offender at the time of the crime? ☐ Yes ☐ No

Has restitution been ordered? ☐ Yes ☐ No

Did you file a police report within 9 months? ☐ Yes ☐ No*

Is this claim filed within 5 years of the crime? ☐ Yes ☐ No*

* If you answer “No” to either of the above two questions, you must provide the Agency with legitimate reasons showing “good cause” for your failure to file timely reports. (See Section 16A or B for space to provide reasons). **Certain conditions apply
SECTION 5: SERVICES REQUESTED

Please select which service(s) are being requested. Depending on the services selected, additional information may be required.

- **Medical**: Medical expenses directly related to a crime related injury and not totally covered by insurance or charity care.

- **Counseling**: Mental health counseling expenses related to the incident and not covered by insurance. The maximum allowance for counseling expenses is as follows: Homicide Survivor $20,000, Injured victim $20,000, Secondary victim(s) $7,000, Group Counseling $50 a session per victim.

- **Dental**: Dental expenses directly related to a crime related injury and not totally covered by insurance.

- **Prescription**: Prescription expenses directly related to a crime related injury and not totally covered by insurance.

- **Relocation**: The maximum allowance for relocation assistance is $3,000. The VCCO may consider relocation expenses where there is a need to protect the health and safety of the victim and/or their family. The Office may consider expenses such as the security deposit payable directly to the landlord, temporary shelter, moving services, monthly rental and mortgage cost differential, first month’s rent, one month’s rent if relocation occurred within one year of filing the application and/or personal expense items deemed reasonable and necessary.

- **Funeral**: The maximum allowance for funeral expenses is $7,500. The office may consider expenses such as the funeral costs, flowers, repast expenses, cemetery costs and grave markers/headstones.

- **Transportation to Funeral**: $500 per person with a maximum reimbursement of $3,000. This may include air fare or railroad expenses.

- **Loss of earnings (victim)**: Loss of earnings to a victim that were incurred directly due to the crime related injury while in a no pay status. The VCCO cannot consider reimbursement if the victim was paid through accrued vacation or sick time. Maximum loss of earnings considered is $600 per week with a maximum of 104 weeks.

- **Loss of earnings (claimant)**: When the claimant was employed at the time of the incident, but missed time from work for having to care for the victim as a result of their injuries. The VCCO cannot consider reimbursement if the claimant was paid through accrued vacation or sick time. Maximum loss of earnings considered is $600 per week with a maximum of $7,000.

- **Loss of support (homicide claim)**: Loss of support may be considered when the victim was supporting the claimant/household at the time of their death. Maximum loss of support to be considered is $600 per week not to exceed 48 months.

- **Loss of support (from the offender)**: Loss of support may be considered where it can be determined the offender was supporting the household prior to the incident and is now incarcerated, a fugitive or has ceased providing support due to the incident. Maximum loss of support considered is $600 per week not to exceed 48 months.

- **Stolen cash reimbursement**: (Senior citizen or permanently disabled persons only) VCCO may reimburse cash (minimum $50) stolen directly from the person of an eligible crime victim where the monetary loss was reported to police. Maximum reimbursement is $1,000.
SECTION 5: SERVICES REQUESTED continued

- **Attorney fees** (victims’ rights in certain criminal and/or civil proceedings that are directly related to the VCCO claim): VCCO can assist with certain fees when the representation is related to the criminal matter upon which the claim is based. Attorney fees are payable at $275 per hour not to exceed $10,000 maximum allowance.

- **Attorney representation with filing claim**: Attorney fees payable at $275 per hour or 15% of the total award whichever is less.

- **Domestic help**: VCCO may reimburse domestic help expenses arising as a direct result of the crime. Domestic help may include housecleaning, laundry, cooking, companionship and other services related to providing day to day living support for the victim. Maximum reimbursement is $6,500.

- **Day care services**: VCCO may reimburse child care or day care expenses for a minor child (14 years old or less) or for an adult where the need for such services is a direct result of the crime. Maximum reimbursement is $6,500.

- **Medical equipment**: VCCO may reimburse reasonable charges for reasonably needed products such as wheelchairs, braces, splints, crutches, walkers and other personal adaptive equipment required to meet the victim’s disability needs.

- **Medically related transportation**: VCCO may reimburse transportation costs for the victim’s visits to treating physicians and other health care facilities. Maximum reimbursement is 31 cents per mile not to exceed $10 per day and $3,000 total.

- **Crime Scene Clean up**: VCCO may compensate the reasonable and necessary costs for the cleaning of a victim’s residence and/or personal vehicle where the injurious crime occurred or where the direct costs have become the direct victim or claimant’s financial responsibility. Compensation includes the actual clean-up costs, reasonable replacement value of bedding, carpeting, doors, windows, locks or furniture which has been rendered damaged or useless as a result of the crime or the collection of evidence. Maximum allowance for crime scene clean-up shall not exceed $4,000 in the aggregate.

- **Bereavement**: Loss of earnings may be paid to members of the victim’s family for funeral attendance and bereavement for a period of no more than two weeks. Maximum loss of earnings to be considered is $600 per week.

- **Court Attendance**: Loss of earnings may be paid to victims and secondary victims for court attendance. Maximum loss of earnings to be considered is $600 per week with a maximum allowance of $7,000 for all secondary victim expenses.

- **Court Attendance transportation**: VCCO may reimburse transportation costs for the victim/claimant’s court attendance. Maximum reimbursement is 31 cents per mile not to exceed $10 per day and $3,000 total.

**Supplemental Compensation for Catastrophically Injured (CAT)**: A catastrophically injured crime victim is defined as a person who has been determined by the Office to have sustained a severe long-term or life-long injury. Compensation for loss of earnings, loss of support, property damage and pain and suffering is excluded from catastrophic injury compensation. The VCCO may make one or more supplemental awards solely for the purpose of providing rehabilitative assistance and services to direct victims who have been catastrophically injured.

- **Please check if you believe you may meet these criteria and wish to apply for CAT assistance.**
SECTION 6: HEALTH INSURANCE/BENEFITS INFORMATION

Please identify any Health and/or Automobile Insurance coverage. The insurance information provided may be used to notify a provider of medical services that there is another source of payment before the VCCO can consider compensation in accordance with N.J.A.C. 13:75-1.19.

<table>
<thead>
<tr>
<th>Medical Insurance</th>
<th>〇 Yes 〇 No</th>
<th>Carrier ____________________________</th>
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<tr>
<td>〇 Yes 〇 No</td>
<td>Policy No. ______________________</td>
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<tr>
<th>Secondary Medical Insurance</th>
<th>〇 Yes 〇 No</th>
<th>Carrier ____________________________</th>
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<tr>
<td>〇 Yes 〇 No</td>
<td>Policy No. ______________________</td>
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<th>Dental Insurance</th>
<th>〇 Yes 〇 No</th>
<th>Carrier ____________________________</th>
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<th>Automobile Insurance</th>
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<th>Carrier ____________________________</th>
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<td>〇 Yes 〇 No</td>
<td>Policy No. ______________________</td>
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If neither the victim nor the offender has auto insurance, and the incident involves a motor vehicle, then the claimant must apply to the New Jersey Property Liability Insurance Guaranteed Association (NJPLIGA) within 180 days from the date of the incident.

Have you applied to NJPLIGA? 〇 Yes 〇 No

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<thead>
<tr>
<th>Worker’s Compensation</th>
<th>〇 Yes 〇 No</th>
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<tr>
<th>Home Owner’s/Renter’s Insurance</th>
<th>〇 Yes 〇 No</th>
<th>Carrier ____________________________</th>
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<td>〇 Yes 〇 No</td>
<td>Policy No. ______________________</td>
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Charity Care 〇 Yes 〇 No Date of charity care application _____ / _____ / _____

If you checked no, VCCO is the payer of the last resort, the victim’s/claimant’s primary insurance or charity care will come first. Please apply for charity care at the hospital where the victim was treated.

SECTION 7: MEDICAL/COUNSELING PROVIDERS

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<tr>
<th>Hospital/Doctor Name</th>
<th>Date(s) of Treatment</th>
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<tr>
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SECTION 8: LOST WAGES/SUPPORT INFORMATION

Complete if you have lost time from work because of your injuries or to take care of an injured victim.
(If more than one employer, please attach additional sheets)

☐ Victim loss of Earnings  ☐ Claimant Loss of Earnings  ☐ Loss of Support

Employee Name ________________________________

Company Phone (_______) _______ - _________  Company Fax (_______) _______ - _________

Company/Business Name ________________________________

Company/Business Address ________________________________

City __________________________ County __________________ State ________ Zip Code ____________

Dates absent from work due to crime related injuries: _____ / _____ / ______ to _____ / _____ / ______

Did the incident occur while on the job?  ☐ Yes  ☐ No

If injured on the job, does your employer have Worker’s Compensation?  ☐ Yes  ☐ No

Have you applied for State/ Private Disability or Family Leave for reimbursement for lost wages?  ☐ Yes  ☐ No

If YES, supply all notices received from State/Private Disability or Family Leave.

Is your household losing income/paychecks due to the crime?  ☐ Yes  ☐ No

Are you missing work to care for the victim?  ☐ Yes  ☐ No

☐ If available, please supply your pay stubs from the week before the crime, the week you returned to work and a letter from your doctor stating your period of disability.

☐ If you are self-employed, you must supply copies of your income tax returns and business tax returns for the last 2 years before the crime.

☐ Loss of support may be awarded for dependents of homicide victims. Please supply copies of the victim’s income tax returns for the last three years.

SECTION 9: DEPENDENT INFORMATION

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

Dependent Name ________________________________ Relationship to Victim __________________

Address ________________________________ Date of Birth _____ / _____ / ______

Social Security Number _______ - _______ - ____________

Are you the legal guardian?  ☐ Yes  ☐ No

Dependent Name ________________________________ Relationship to Victim __________________

Address ________________________________ Date of Birth _____ / _____ / ______

Social Security Number _______ - _______ - ____________

Are you the legal guardian?  ☐ Yes  ☐ No

Dependent Name ________________________________ Relationship to Victim __________________

Address ________________________________ Date of Birth _____ / _____ / ______

Social Security Number _______ - _______ - ____________

Are you the legal guardian?  ☐ Yes  ☐ No

Is there anyone else who depended upon the victim for court ordered support?  ☐ Yes  ☐ No
### SECTION 10: ATTORNEY INFORMATION

**A. Type of representation:**
- VCCO Application
- Civil Suit
- Victim rights in criminal matters/criminal proceedings

Name of Attorney

Address

City __________________________ County ______________ State _______ Zip Code ____________

Phone (______) _______ - __________

**B. Type of representation:**
- VCCO Application
- Civil Suit
- Victim rights in criminal matters/criminal proceedings

Name of Attorney

Address

City __________________________ County ______________ State _______ Zip Code ____________

Phone (______) _______ - __________

**C. I intend to file a lawsuit at a later date**
- Yes
- No

### SECTION 11: REFERRAL INFORMATION

Who referred you to the VCCO?
- Police
- Friend/Relative
- Prosecutor
- Victim Witness Coordinator
- Hospital
- Funeral Home
- Domestic Violence/Rape Crisis Center
- Brochure/Poster
- Internet
- Medical professional
- Other _______________________

### SECTION 12: LEGAL AUTHORIZATION AND SIGNATURE

*This is a legal document which must be signed by an adult.*

**Program Qualification:**
I understand that I am responsible for all bills and the compensation program is designed to pay certain costs not covered by another source. Submitting this application does not entitle me to benefits.

**Reimbursement:**
I agree to repay the VCCO if I receive money from another source up to the amount paid on my behalf. This includes any payment I may receive from the offender, any insurance policy or settlements, judgments, or civil law suits.

I have provided accurate and truthful information to the best of my knowledge, information and belief. I have not knowingly withheld, concealed or misrepresented any information that would have a material bearing on my eligibility for benefits or compensation. I understand that if any of the information I have provided is knowingly false, I may be subject to civil and criminal punishment.

X ___________________________ Date _______________________

Signature of Victim/Claimant

*Legal representative must sign if the victim is under 18, legally declared incompetent or deceased.*
SECTION 13: AUTHORIZATION TO OBTAIN RECORDS

I, _______________________________, authorize the NJ Victims of Crime Compensation Office (VCCO) or its agent, representative or bearer to inspect, review and make copies, including photostatic copies, of all medical records and records pertaining to employment, earnings, income or grant from any agency, attendance and any other records pertaining to or related to employment or economic assistance, and police and prosecutors reports necessary to determine qualification for my claim for compensation. Photocopies of this authorization will be considered as valid as the original.

X _______________________________ Date ____________________

Signature of Victim/Claimant

Legal representative must sign if the victim is under 18, legally declared incompetent or deceased.

SECTION 14: ASSIGNMENT OF INTEREST

I, _______________________________, understand that New Jersey law requires me to reimburse the NJ Victims of Crime Compensation Office (VCCO) for any monies I may receive from other sources. I shall contact the VCCO upon receipt of such additional monies from the offender, civil law suit, restitution, insurance program, or any other governmental or private agency.

I further assign and give to the VCCO the right to be directly reimbursed for two-thirds of the VCCO’s award to me from the proceeds of any civil law suit I have started or will start arising out of this incident.

I also assign and give to the VCCO the right to be reimbursed from Probation, the Juvenile Justice Commission, the Department of Corrections for the amount to be paid to me in the way of restitution ordered by the court in any criminal proceedings related to the incident. Reimbursement to the VCCO shall be limited to expenses for which the VCCO has awarded compensation to me.

I certify that I am signing this Assignment of Interest freely and voluntarily. I understand that this Assignment must be signed in order to receive compensation. I further certify that if at any time I initiate a civil lawsuit, I will provide a copy of this Assignment of Interest to my attorney with the instruction that my attorney is bound by its terms. I understand that the VCCO is relying in good faith on this Assignment in order to pay compensation to me.

X _______________________________ Date ____________________

Signature of Victim/Claimant

Legal representative must sign if the victim is under 18, legally declared incompetent or deceased.
SECTION 15: AUTHORIZATION FOR RELEASE OF
INFORMATION UNDER THE HEALTH INSURANCE
PORTABILITY AND ACCOUNTABILITY ACT

Patient's Name __________________________ Social Security Number ______ - ______ - ______
Date of Birth ______ / ______ / ______ Phone (______) ______ - ______
Address ________________________________________________________________
City __________________________ County __________________ State ______ Zip Code ______

I authorize the use and disclosure of health information about me as described below

Facility authorized to release my health information: ________________________________

Agency or individual(s) authorized to receive my health information: ____________________

Health information that may be used/disclosed is limited to the following:

☐ Discharge Summary ☐ History & Physical ☐ Consultation(s) ☐ Lab
☐ Operative Notes(s) ☐ Pathology Report ☐ Imaging/X-ray ☐ Entire Record
☐ Other (specify) ______________________________________________________

Health information that may be used/disclosed is limited to the following treatment dates:

Health information to be released to the above named agency/individual is to be used/disclosed for the following purpose(s) (include Research or Marketing, if appropriate):

To determine the amount of compensation the patient is entitled to receive, including the payment of any outstanding bills for services rendered by the facility to the patient.

Health information identifies you (the patient) by name, and includes other demographic information about you. Health information may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc. I hereby discharge the releasing facility its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization shall be valid for the entire duration of the processing of my compensation claim at the NJVCCO and shall terminate at such time the NJVCCO has rendered a final decision for my compensation benefits. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPPA) privacy regulations.

Patient’s or Authorized Personal Representative’s Signature ____________ Date ____________ Time ____________

☐ A.M. ☐ P.M.

Relationship to Patient / Authority to Act on Patient’s Behalf ____________ Interpreter, if Utilized ____________

Witness Signature ____________ Expiration Date or Event ____________

X ____________