PUBLIC PROTECTION CABINET

(Amendment)

802 KAR 3:010. Crime victims compensation. +E

RELATES TO: KRS 12.027, 49.260 - 49.490, 216B.015, 216B.400, EO 2020-708

STATUTORY AUTHORITY: KRS 49.020, 49.300(1)

NECESSITY, FUNCTION, AND CONFORMITY: Executive Order 2020-708 ("Order") requires that the Kentucky Claims Commission be abolished and the Office of Claims and Appeals be established to include the Crime Victim's Compensation Board. The Order also sets forth the powers and duties of the Crime Victims Compensation Board and authorizes the Board to promulgate regulations necessary to immediately carry out the provisions and purposes of the Order and the Board's statutory authority. KRS 49.300(1) authorizes the Crime Victims Compensation Board [~~commission~~] to promulgate administrative regulations that are necessary to carry out the provisions of KRS 49.270 through 49.490. This administrative regulation establishes procedures for crime victims to file claims for compensation.

Section 1. Definition. "Board" means the Crime Victims Compensation Board.

Section 2 [~~1~~]. Filing Claims. (1) A claim shall be:

(a) Legibly written, typed, or printed on the Crime Victim Compensation Form;

(b) Signed by the claimant and the counsel representing the claimant, if any.

(2) A claim shall be filed by:

(a) In person or by private delivery to the Crime Victim's Compensation Board, 500 Mero Street, 2 SC1, Frankfort, KY 40601;

(b) Mail to the address listed above; or

(c) Electronic mail to crimevictims@ky.gov, if the document can be sent in one (1) electronic message.

[; and (c)Filed by mail, electronic mail to crimevictims@ky.gov, or delivered in person to the commission].

(3) [(2)] If applying for lost wages or loss of support, a claim shall be supplemented by:

(a) A notarized Employment Verification form; and

(b) If requested by the Board [commission] staff:

1. A Physician Statement form; or

2. A Mental Health Counselor's Report form.

Section 3 [2]. Kentucky Medical Assistance Program. (1) The Board [commission] shall cross-reference every claim with those claims that appear in the Kentucky Medical Assistance Program (KMAP) database maintained by the Cabinet for Health and Family Services.

(2) If a crime victim is covered by Medicare or Medicaid, the Board's [commission's] staff will provide the Board [commission] a list of:

(a) All itemized medical charges for which that victim seeks compensation; and

(b) The victim's services covered by medical assistance as reported in KMAP.

(3) Upon making an award to a Medicaid-eligible crime victim, the Board [commission] shall not consider any medical bills submitted by or on behalf of the victim

for any KMAP-covered services.

(4) If the Board [~~commission~~] makes an award to a victim who received medical assistance for a KMAP-covered service, the KMAP as final payor shall not be responsible for the payment of any portion of that claim awarded by the Board [~~commission~~].

Section 4. Attorney's Fees. If a claimant is represented by an attorney and the attorney so requests, the board, may, as a part of any award or by separate order subsequent to the award, allow a reasonable attorney's fee for the filing of a claim and any subsequent proceedings. Such fee shall not exceed fifteen (15) percent of the amount of the award, and shall be paid out of the award and not in addition to the award. No attorney representing a claimant shall contract for or receive as a fee any sum larger than fifteen (15) percent of the amount of the award. Any fee contract in violation of this provision shall be void.

Section 5 [~~3~~]. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Crime Victim Compensation Form", August 2020 [~~February 2018~~];

(b) "Employment Verification", August 2020 [~~February 2018~~];

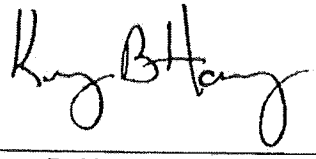
(c) "Physician Statement", August 2020 [~~February 2018~~]; and

(d) "Mental Health Counselor's Report", August 2020 [~~February 2018~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of Claims and Appeals [~~Kentucky Claims Commission~~], 500 Mero St 2SC1[~~130 Brighton Park Boulevard~~], Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. and is available online at http://cvcb.ky.gov/Pages/default.aspx.

802 KAR 3:010

APPROVED BY AGENCY:



Kerry B. Harvey, Secretary
Public Protection Cabinet

9/2/2020

Date

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall be held at 10:00 am on November 24, 2020, in Room 239CW of the Mayo-Underwood Building, 500 Mero Street, Frankfort, Kentucky 40601. In the event the declaration of a State of Emergency in Executive Order 2020-215 and the State of Emergency Relating to Social Distancing in Executive Order 2020-243 are not rescinded by this time, this hearing will be done by video teleconference. Members of the public wishing to attend may utilize the following link:

Join Zoom Meeting
https://us02web.zoom.us/j/81484140906?pwd=bVdMMlpTTnhHL0QxTDA2elBkcGhYdz09

Meeting ID: 814 8414 0906
Passcode: GTwPY1

Individuals interested in being heard at this hearing shall notify this agency in writing by five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made.

If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted through 11:59 PM EST on November 30, 2020. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person below.

Contact Person: Leah Cooper Boggs
Title: Executive Advisor
Address: 500 Mero Street 218NC
Phone: +1 (502) 352-8095
Fax: +1 (502) 564-3969
Email: LBoggs@ky.gov

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Regulation No. 802 KAR 3:010

Contact Person: Leah Cooper Boggs
Phone Number: 502-352-8095
Email: lboggs@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation sets forth the procedures for crime victims wishing to file a claim for compensation.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with Governor's Executive Order 2020-708, which immediately abolishes the Kentucky Claims Commission and establishes Crime Victims Compensation Board and the Office of Claims and Appeals in the Public Protection Cabinet.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The proposed regulatory language conforms with KRS 12.080 which authorizes the Governor to prescribe general rules for the conduct of departments; and KRS 49.020(5) which authorizes the promulgation of regulations to carry out the duties of the office.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The proposed regulation removes references to the abolished Kentucky Claims Commission and inserts language regarding the Crime Victims Compensation Board and the new Office structure and processes.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: See (1)(d).

(b) The necessity of the amendment to this administrative regulation: See (1)(b)

(c) How the amendment conforms to the content of the authorizing statutes: See (1)(c).

(d) How the amendment will assist in the effective administration of the statutes: See (1)(d).

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: The Public Protection Cabinet, the Office of Claims and Appeals, the Crime Victims Compensation Board, and any person or entity filing a claim with the Crime Victims Compensation Board and the Office of Claims and Appeals.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: None known, beyond updating documentation to reflect the new Office structure and the Crime Victims Compensation Board.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There are no expected expenditures because of this administrative regulation. Current staff will implement the provisions once promulgated.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Currently, crime victim claims are determined by the Kentucky Claims Commission. The Kentucky Claims Commission has a backlog of tax appeal cases. By separating the functions and creating the Crime Victims Compensation Board, claims of crime victims will be more efficiently processed.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: None. Current staff and agency funds will provide implementation.

(b) On a continuing basis: None.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Current agency budgetary funding will be used to implement and enforce this administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No additional funding or increase in fees is needed.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: No fees are directly or indirectly established or increased by the administrative regulation.

(9) TIERING: Is tiering applied? (Explain why or why not): Tiering is not applicable as the proposed language will be applied equally to all entities impacted by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation No. 802 KAR 3:010

Contact Person: Leah Cooper Boggs
Phone Number: 502-352-8095
Email: lboggs@ky.gov

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Public Protection Cabinet, Office of Claims and Appeals, and the Crime Victims Compensation Board.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 13B, 49.020, 49.220.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. The administrative regulation should not create any additional expenses or revenues for any state or local government agency after implementation. It is only updating references to the newly created Office of Claims and Appeals and the Crime Victims Compensation Board, and establishing procedures to file claims under the new office structure.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? No revenues are expected to be generated by the provisions of this administrative regulation. This administrative regulation does not contain any fees or charges for filing a claim with the Crime Victims Compensation Board.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? There are no additional costs.

(d) How much will it cost to administer this program for subsequent years? See 3.(c).

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

SUMMARY OF CHANGES TO MATERIAL INCORPORATED BY REFERENCE

The "CVC Compensation Form", is the 4-page form on which crime victims file a claim for compensation for damages which occurred as a result of being a victim of a crime. KRS 49.330 allows for the filing of a claim. The form was amended to change the name from "Kentucky Claims Commission" to "Crime Victims Compensation Board." A revision date was also added.

The "Employment Verification Form" is a one page form in which an employer verifies lost wages of a crime victim. KRS 49.340 requires the collection of this information. The form was amended to change the name from "Kentucky Claims Commission" to "Crime Victims Compensation Board." A revision date was also added.

The "Mental Health Counselor Report" is a one page form documenting the mental health trauma and treatment required of a crime victim as a result of a crime. KRS 49.340 requires the collection of this information. The form was amended to change the name from "Kentucky Claims Commission" to "Crime Victims Compensation Board." A revision date was also added.

The "Physician Statement" is a one page form for a physician to document injuries of a crime victim resulting from a crime. KRS 49.340 requires the collection of this information. The form was amended to change the name from "Kentucky Claims Commission" to "Crime Victims Compensation Board." A revision date was also added.

Crime Victims Compensation Board – Crime Victim Compensation Form
500 Mero Street, Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

This form must be legibly written, typed, or printed, and must be signed. Incomplete submissions may not be considered. All answers may be supplemented with additional explanatory pages.

Section 1: Claimant Information

Claimant's Name: _____ SSN or Gov't ID#: _____

Relationship to Victim _____

Address: _____

Telephone #: (Primary) _____ (Other) _____ E-Mail: _____

Section 2: Victim and Offender Information

Victim's Name: _____ SSN or Gov't ID # _____

Date of Birth: ___/___/_____ Male __ Female __ Age at time of Crime ____

Address: _____

Telephone #: (Home) _____ (Other) _____

E-Mail: _____

Name of Offender(s): _____

Was the Offender charged with a crime? __Yes __No

If yes, what charge? _____

If yes, in what Court? District: _____ Circuit: _____ Juvenile: _____

Type of Crime (Check all that apply)

- Arson
- Assault
- Burglary
- Child Physical Abuse / Neglect
- Child Pornography
- Domestic Assault
- DUI / DWI
- Fraud / Financial Crimes
- Homicide (Murder)
- Human Trafficking
- Kidnapping
- Other Vehicular Crimes
- Robbery
- Sexual Assault Adult
- Sexual Assault Child
- Stalking
- Terrorism
- Other

Section 3: Financial Information

Employment at time of crime: __ Full __ Part __ Self __ Unemployed Time missed from work as a result of crime: __Yes __No

Are you applying for lost wages? __Yes __No Are you applying for loss of support? __Yes __No
These claims require completion of the Employment Verification Form. Where applicable, these claims also require completion of the Physician Statement and Mental Health Counselor's Report.

Total monthly income prior to incident: $_____
Income or payment sources at time of incident: $_____Wages $_____Social Security $_____Worker's Compensation
$_____Insurance $_____Medicare $_____Medicaid $_____Veteran's Benefits
$_____ Other (please specify) _____

Total monthly income as a result of incident: $_____
Income or payment sources as a result of incident: $_____Wages $_____Social Security $_____Worker's Compensation

$_____Insurance $_____Medicare $_____Medicaid $_____Veteran's Benefits
$_____ Other (please specify) _____

Section 4: Crime Incident Information

Date of incident ___/___/____ Time of incident __:__ a.m./p.m.

Location where the incident occurred: _____
(Please be specific so as to provide exact location)

Date reported ___/___/____ Reported To:_____
Law Enforcement Agency

If not reported within 48 hours of discovery, please explain: _____

Describe the incident:

_____

_____

_____

_____

_____

_____

Describe any injuries:

_____

_____

_____

_____

Section 5: Expenses

Each expense must be listed below to be considered. Each must be a direct result of the crime, and documentation must include date, type, and charge for service. If you need additional space please attach a separate page or the itemized bill(s).

5a. Medical Expenses

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

5b. Mental Health Expenses

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

5c. Funeral/Burial Expenses

Date of Death ___/___/_____ Funeral Home _____ Address _____

Total Funeral Expenses: $_____ Paid? __ Yes __ No If yes, by whom? _____ Relationship to Victim: _____

Benefits available and amounts: $_____ Life Insurance $_____ Worker's Compensation $_____Funeral/Burial Insurance

$_____ Social Security $_____ Estate $_____ Donations (including crowd-funding websites) Other: _____

Section 6. Federal Government Information *(optional/for statistical use only)*

Ethnic Group (Victim)
( ) Caucasian
( ) African American
( ) American Indian or Alaskan Native
( ) Hispanic / Latino
( ) Multiracial
( ) Asian
( ) Native Hawaiian / Other Pacific Islander
( ) Other

Are you (please check all that apply)
( ) U.S. Citizen ( ) Handicap ( ) Kentucky Resident

Who referred you to the compensation program?
( ) Law Enforcement ( ) Hospital ( ) Victim Advocate
( ) Prosecutor ( ) Judge ( ) Other _____

Is this a Federal Crime? ( ) Yes ( ) No

Section 7. Restitution and Civil Lawsuit

Has the victim or claimant filed or plan to file a civil suit relating to the injury received as a result of the crime? __ Yes __ No

If yes, Attorney:_____ Telephone: _____ E-mail: _____

Has the Offender been ordered by a court to pay restitution to the victim or claimant? __Yes __No If yes, amount: $_____

Has the victim received any of the ordered restitution? __ Yes __ No If yes, amount: $_____

Section 8. Authorization and Subrogation

I hereby certify, subject to penalty, fine, or imprisonment that the information contained in this form and all attachments is true and correct to the best of my knowledge.

SUBROGATION: In consideration of the payment received from the Crime Victims Compensation Board, in the event I recover damages or compensation from the offender or from any other public or private source as a result of the injuries or death which was the basis of my claim for compensation from the fund, I agree to repay such amount up to the full amount I received from the fund. I understand that compensation from any other public or private source includes but is not limited to: receipt of insurance, Medicare, Medicaid, Workers Compensation, disability pay, etc. I further agree and understand that no part of recovery due the Crime Victims Compensation Board may be diminished by any collection fees or for any other reason whatsoever.

Should I choose to recover damages or compensation for the injury or death from any sources, I agree to promptly notify the Crime Victims Compensation Board by sending copies of any pleadings, settlement proposals and any other documents relative thereto. I further agree to fully cooperate with the Crime Victims Compensation Board should the Board decide to institute an action against any person or entity for the recovery of all or any part of the compensation I received from the fund.

MEDICAL/PSYCHIATRIC/EMPLOYMENT RELEASE: I hereby authorize any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility, or any other person or firm to release any and all information requested by the Crime Victims Compensation Board. I understand and acknowledge that my mental health records may contain confidential remarks made by me, information regarding drug or alcohol abuse, HIV status, or other personal data. I further agree and hold blameless any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility or any staff person of any and all liability for the release of these records.

YOUR SIGNATURE: _____ DATE: _____

Attorney's Name*: _____ Address: _____

Telephone: _____ E-mail Address: _____

Attorney's Signature: _____ Date: _____

*You are not required to have an attorney assist in submitting your application. However, if an attorney does assist you, the attorney must sign the application as well.

Crime Victims Compensation Board [~~Kentucky Claims Commission~~] – Crime Victim Compensation Form
500 Mero Street, Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

This form must be legibly written, typed, or printed, and must be signed. Incomplete submissions may not be considered. All answers may be supplemented with additional explanatory pages.

Section 1: Claimant Information

Claimant's Name: _____ SSN or Gov't ID#: _____

Relationship to Victim _____

Address: _____

Telephone #: (Primary) _____ (Other) _____ E-Mail: _____

Section 2: Victim and Offender Information

Victim's Name: _____ SSN or Gov't ID # _____

Date of Birth: ___/___/_____ Male __ Female __ Age at time of Crime ____

Address: _____

Telephone #: (Home) _____ (Other) _____

E-Mail: _____

Name of Offender(s): _____

Was the Offender charged with a crime? __Yes __No

If yes, what charge? _____

If yes, in what Court? District: _____ Circuit: _____ Juvenile: _____

Type of Crime (Check all that apply)

- Arson
- Assault
- Burglary
- Child Physical Abuse / Neglect
- Child Pornography
- Domestic Assault
- DUI / DWI
- Fraud / Financial Crimes
- Homicide (Murder)
- Human Trafficking
- Kidnapping
- Other Vehicular Crimes
- Robbery
- Sexual Assault Adult
- Sexual Assault Child
- Stalking
- Terrorism
- Other

Section 3: Financial Information

Employment at time of crime: __ Full __ Part __ Self __ Unemployed Time missed from work as a result of crime: __Yes __No

Are you applying for lost wages? __Yes __No Are you applying for loss of support? __Yes __No
These claims require completion of the Employment Verification Form. Where applicable, these claims also require completion of the Physician Statement and Mental Health Counselor's Report.

Total monthly income prior to incident: $_____
Income or payment sources at time of incident: $_____Wages $_____Social Security $_____Worker's Compensation
$_____Insurance $_____Medicare $_____Medicaid $_____Veteran's Benefits
$_____ Other (please specify) _____

Total monthly income as a result of incident: $_____
Income or payment sources as a result of incident: $_____Wages $_____Social Security $_____Worker's Compensation

$_____Insurance $_____Medicare $_____Medicaid $_____Veteran's Benefits
$_____ Other (please specify) _____

Section 4: Crime Incident Information

Date of incident ___/___/____ Time of incident __:__ a.m./p.m.

Location where the incident occurred: _____
(Please be specific so as to provide exact location)

Date reported ___/___/____ Reported To:_____
Law Enforcement Agency

If not reported within 48 hours of discovery, please explain: _____

Describe the incident:

_____

_____

_____

_____

_____

_____

Describe any injuries:

_____

_____

_____

_____

Section 5: Expenses

Each expense must be listed below to be considered. Each must be a direct result of the crime, and documentation must include date, type, and charge for service. If you need additional space please attach a separate page or the itemized bill(s).

5a. Medical Expenses

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

5b. Mental Health Expenses

Provider Name	Total Amount Charged	Amount Insurance Covered	Claimant/Victim Out of Pocket	Current Balance

5c. Funeral/Burial Expenses

Date of Death ___/___/_____ Funeral Home _____ Address _____

Total Funeral Expenses: $_____ Paid? __ Yes __ No If yes, by whom? _____ Relationship to Victim: _____

Benefits available and amounts: $_____ Life Insurance $_____ Worker's Compensation $_____Funeral/Burial Insurance

$_____ Social Security $_____ Estate $_____ Donations (including crowd-funding websites) Other: _____

Section 6. Federal Government Information *(optional/for statistical use only)*

Ethnic Group (Victim)
( ) Caucasian
( ) African American
( ) American Indian or Alaskan Native
( ) Hispanic / Latino
( ) Multiracial
( ) Asian
( ) Native Hawaiian / Other Pacific Islander
( ) Other

Are you (please check all that apply)
( ) U.S. Citizen ( ) Handicap ( ) Kentucky Resident

Who referred you to the compensation program?
( ) Law Enforcement ( ) Hospital ( ) Victim Advocate
( ) Prosecutor ( ) Judge ( ) Other _____

Is this a Federal Crime? ( ) Yes ( ) No

Section 7. Restitution and Civil Lawsuit

Has the victim or claimant filed or plan to file a civil suit relating to the injury received as a result of the crime? __ Yes __ No

If yes, Attorney:_____ Telephone: _____ E-mail: _____

Has the Offender been ordered by a court to pay restitution to the victim or claimant? __Yes __No If yes, amount: $_____

Has the victim received any of the ordered restitution? __ Yes __ No If yes, amount: $_____

Section 8. Authorization and Subrogation

I hereby certify, subject to penalty, fine, or imprisonment that the information contained in this form and all attachments is true and correct to the best of my knowledge.

SUBROGATION: In consideration of the payment received from the Crime Victims Compensation Board ~~[Kentucky Claims Commission]~~, in the event I recover damages or compensation from the offender or from any other public or private source as a result of the injuries or death which was the basis of my claim for compensation from the fund, I agree to repay such amount up to the full amount I received from the fund. I understand that compensation from any other public or private source includes but is not limited to: receipt of insurance, Medicare, Medicaid, Workers Compensation, disability pay, etc. I further agree and understand that no part of recovery due the Crime Victims Compensation Board ~~[Kentucky Claims Commission]~~ may be diminished by any collection fees or for any other reason whatsoever.

Should I choose to recover damages or compensation for the injury or death from any sources, I agree to promptly notify the Crime Victims Compensation Board ~~[Kentucky Claims Commission]~~ by sending copies of any pleadings, settlement proposals and any other documents relative thereto. I further agree to fully cooperate with the Crime Victims Compensation Board ~~[Kentucky Claims Commission]~~ should the Board ~~[Commission]~~ decide to institute an action against any person or entity for the recovery of all or any part of the compensation I received from the fund.

MEDICAL/PSYCHIATRIC/EMPLOYMENT RELEASE: I hereby authorize any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility, or any other person or firm to release any and all information requested by the Crime Victims Compensation Board ~~[Kentucky Claims Commission]~~. I understand and acknowledge that my mental health records may contain confidential remarks made by me, information regarding drug or alcohol abuse, HIV status, or other personal data. I further agree and hold blameless any hospital, physician, funeral director, employer, insurance company, social service bureau, Social Security office, mental health counselor or facility or any staff person of any and all liability for the release of these records.

YOUR SIGNATURE: _____ DATE: _____

Attorney's Name*: _____ Address: _____

Telephone: _____ E-mail Address: _____

Attorney's Signature: _____ Date: _____

*You are not required to have an attorney assist in submitting your application. However, if an attorney does assist you, the attorney must sign the application as well.

Crime Victims Compensation Board
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

EMPLOYMENT VERIFICATION

Complete only if applying for lost wages/ loss of support.
To be completed and signed by EMPLOYER only. *This form must be NOTARIZED.*

Employee's Name: _____ Social Security #: _____

Date of Crime: _____ Victim was employed at the time of crime ( ) Yes ( ) No

If SELF-EMPLOYED, attach copies of State and Federal taxes for the two-year period prior to the crime.

Employer's Name: _____ Telephone: _____

_____

Address City State Zip Code

Victim missed time from work because of injuries related to the crime: ( ) Yes ( ) No

If yes, from _____ to _____

The items listed below are to be **weekly amounts:**
Gross Earnings: $_____ Net Take Home Earning Per Week: $ _____

Federal Tax Withheld: $ _____ State Tax Withheld : $ _____ Social Security Withheld: $ _____

Other Deductions (itemized): $ _____ Typical days worked per week: M T W TH F Sat Sun
Attach additional pages if necessary.

Victim has returned to work: ( ) Yes ( ) No Victim's wage continued while off work: Please Circle ( ) Yes ( ) No

If the victim's wage continued while off work, complete the following:

Deductions	Amount Per Week	Starting Date	Ending Date
Workers Comp	$		
Unemployment	$		
Insurance – Health	$		
Insurance – Other	$		
Vacation	$		
Sick	$		
Employers Group	$		
Disability	$		
Union	$		
Other	$		

_____ _____
Employer's Name and Title Employers Signature

The following must be completed by a Notary:

SUBSCRIBED AND SWORN TO BEFORE ME BY _____

THIS _____ DAY OF _____, 20____

MY COMMISSION EXPIRES: _____

Signature: _____

Seal or Stamp affixed here

Revised August 2020

Crime Victims Compensation Board [~~Kentucky Claims Commission - Crime Victims Compensation~~]
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

EMPLOYMENT VERIFICATION

Complete only if applying for lost wages/ loss of support.
To be completed and signed by EMPLOYER only. *This form must be NOTARIZED.*

Employee's Name: _____ Social Security #: _____

Date of Crime: _____ Victim was employed at the time of crime ( ) Yes ( ) No

If SELF-EMPLOYED, attach copies of State and Federal taxes for the two-year period prior to the crime.

Employer's Name: _____ Telephone: _____

_____

Address City State Zip Code

Victim missed time from work because of injuries related to the crime: ( ) Yes ( ) No

If yes, from _____ to _____

The items listed below are to be **weekly amounts:**
Gross Earnings: $_____ Net Take Home Earning Per Week: $ _____

Federal Tax Withheld: $ _____ State Tax Withheld : $ _____ Social Security Withheld: $ _____

Other Deductions (itemized): $ _____ Typical days worked per week: M T W TH F Sat Sun
Attach additional pages if necessary.

Victim has returned to work: ( ) Yes ( ) No Victim's wage continued while off work: Please Circle ( ) Yes ( ) No

If the victim's wage continued while off work, complete the following:

Deductions	Amount Per Week	Starting Date	Ending Date
Workers Comp	$		
Unemployment	$		
Insurance – Health	$		
Insurance – Other	$		
Vacation	$		
Sick	$		
Employers Group	$		
Disability	$		
Union	$		
Other	$		

_____ _____
Employer's Name and Title Employers Signature

The following must be completed by a Notary:

SUBSCRIBED AND SWORN TO BEFORE ME BY _____

THIS _____ DAY OF _____, 20____

MY COMMISSION EXPIRES: _____

Signature: _____

Seal or Stamp affixed here

Revised August 2020

Crime Victims Compensation Board
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

PHYSICIAN STATEMENT

Complete only if applying for lost wages/ loss of support.
To be completed and signed by PHYSICIAN only.

Victim / Patient Name: _____

Type of Injury: _____

Date of Injury: _____ Date(s) victim/patient unable to work: _____to _____

Victim/Patient suffered permanent disability: ( ) Yes ( ) No

If yes, please state the victim's percentage of permanent disability to the body as a whole in accordance with the AMA Guidelines:

_____

Description of injury/trauma resulting from crime and comments:

Name of Physician: _____ Specialty: _____

Office Address: _____
Address City State Zip Code

Telephone: _____ State License Number: _____

_____ _____
Physician's Signature Date

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MENTAL HEALTH COUNSELOR'S REPORT

Complete only if applying for mental therapy or where applicable for lost wages.
To be completed by COUNSELOR only. *Treatment plan must be attached.*

Victim/Claimant receiving treatment: _____

Date of crime: _____ Date(s) victim/claimant unable to work: _____ to _____

The trauma and treatment is a direct result of this crime ( ) Yes ( ) No

Presenting Complaint: _____

Diagnosis of Record:

_____

Description of psychological trauma resulting from crime:

Health Insurance: _____
Company Name Phone Number/ Extension

_____
Address City State Zip Code

****PLEASE ATTACH PATIENT TREATMENT PLAN****

Name of Physician/Therapist/Counselor: _____ Specialty: _____

Office Address: _____
Address City State Zip Code

Telephone: _____ State License Number: _____

_____ _____
Physician/Therapist/Counselor Signature Date

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Address City State Zip Code

Telephone: _____ State License Number: _____

_____ _____
Physician/Therapist/Counselor Signature Date

Revised August 2020

STATEMENT OF EMERGENCY

802 KAR 3:010E

This emergency administrative regulation is being promulgated pursuant to KRS 13A.190(1)(a)(1) in order to meet an imminent threat to the public health, safety, or welfare. This administrative regulation must be filed as soon as possible in order to comply with the provisions of Executive Order 2020-708, which abolished the Kentucky Claims Commission on September 1, 2020, and established the Office of Claims and Appeals and the Crime Victims Compensation Board in the Public Protection Cabinet. As a result, the Public Protection Cabinet must immediately implement new procedures and regulations for filing claims pursuant to the authority of this new office. An ordinary administrative regulation alone is not sufficient because the new office must be established to seamlessly continue service to crime victims who have incurred costs because of the crime, not impede current claims, or create a backlog. This emergency administrative regulation shall be replaced by an ordinary administrative regulation, which is being filed with the Regulations Complier along with this emergency administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.

9/2/2020
Date

Andy Beshear, Governor

9/2/2020
Date

Kerry B. Harvey, Secretary
Public Protection Cabinet