CRIMINAL INJURIES COMPENSATION

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APPLICATION FORM

(Please read the document *'How To Complete Your Criminal Injuries Application Form'* before completing the form. If you require assistance, contact the Office of Criminal Injuries Compensation. **Please ensure you keep copies of all your documents**.

Criminal Injuries Compensation Act 2003

(A): APPLICANT'S DETAILS: Please write using BLOCK LETTERS in DARK INK

1. Full Name of Applicant:	Mr ☐ Mrs ☐ Ms ☐ Miss ☐		
	SURNAME:		
	GIVEN NAME(S):		
2. Capacity if claiming on behalf of applicant	**SURNAME:**		
	GIVEN NAME(S):		
	Relationship to Applicant (i.e. parent, guardian):		
3. Applicant's postal Address:			
4. Phone Numbers:	**Home:**		
	Work:		
	Mobile:		
5. Applicant's Date of Birth:		**6. Applicant's Occupation:**	
7. Extension of Time Required?	Yes ☐ No ☐ If yes, please attach a signed statement of reasons for late application.		

(B) ACKNOWLEDGEMENT OF APPLICATION

Please ensure you complete the following slip with your name and address so that we can acknowledge your application
NOTE: The address in the box is where the acknowledgement will be sent!

....

ACKNOWLEDGEMENT SLIP

We will provide you with the rest of this number by mail

Your CIC reference number is CI / _____-______

This box to be completed by the applicant or representative

Solicitor's Reference: ________________________

Name		This is to confirm that Criminal Injuries Compensation has received your application
Address		
City/Town/ Suburb	P/Code	

CHECKLIST - Have you:			
1.	Attached a signed and dated request for an extension of time if required, Q7?	Yes ☐	No ☐
2.	Attached a signed and dated statement of the incident Q18?	Yes ☐	No ☐
3.	Attached a signed and dated statement of the impact of the injury, Q28?	Yes ☐	No ☐
4.	Attached a treatment plan and estimate of cost for interim payment if sought, Q30?	Yes ☐	No ☐
5.	Attached an account for the report cost for interim payment if sought, Q30?	Yes ☐	No ☐
6.	Completed Table 1 for medical expenses and attached accounts, Q31?	Yes ☐	No ☐
7.	Attached a report and quote for future treatment costs if sought, Q32?	Yes ☐	No ☐
8.	Completed Table 2 for travel expenses if sought, Q33?	Yes ☐	No ☐
9.	Attached details of personal items damaged if sought, Q34?	Yes ☐	No ☐
10.	Attached supporting documents for loss of income if sought, Q35-37?	Yes ☐	No ☐
11.	Attached details for loss of support and funeral expenses if sought, Q39&40?	Yes ☐	No ☐
12.	Ticked the section under which your claim is made, Part G?	Yes ☐	No ☐
13.	Signed and dated the application form, Part H?	Yes ☐	No ☐
14.	Filled in the acknowledgement slip, Part B?	Yes ☐	No ☐
15.	Keep a copy of the application form and all documents attached to it?	Yes ☐	No ☐

(C) INCIDENT DETAILS: Please complete every section in BLOCK LETTERS with DARK INK

Please note this page is scanned for office use and must include ALL details, even if they are provided elsewhere in the application.

8. Date of incident and **Place of incident** (suburb):	
9. Nature of Incident: i.e. Assault	
10. Incident Report or Offence Report Number(s):	**(Please ensure that the whole number is included)**
11. Name of Victim of Offence:	
12. Person who reported the offence (complainant):	
13. Address of complainant at date of report:	
14. Date offence reported to police:	
15. Where offence was reported:	
16. Name of Police Officer who took the complaint:	
17. Name(s) of Offender(s) if known:	
18. Statement of Events:	Please attach signed statement outlining details of the incident(s) in full.

(D) PROSECUTION DETAILS

19. Was a person charged?:	Yes ☐ No ☐ If yes, please answer questions 19-27
20. What was the charge?	
21. Court where charge heard:	CPS/Magistrates Court ☐ District Court ☐ Supreme Court ☐ Children's Court ☐
22. Date of Hearing:	
23. Outcome(s):	
24. Offender(s) address: if known:	
25. Offender(s) assets: if known:	
26. Was Restitution Ordered?	Yes ☐ amount $ No ☐
27. Has Restitution been Received?	Yes ☐ No ☐ If yes, how much has been received: $

(E) CLAIMS INVOLVING INJURY: PLEASE USE DARK INK

28. Injury:	Yes ☐ No ☐ Attach signed statements of Injury & Impact, & medical reports. **If you answer No to this question, then you are not eligible for compensation.**	
29. Loss:	Yes ☐ No ☐ If yes answer questions 30 to 37: if you leave a question unanswered it will be taken that you make no claim for that item of loss.	
30. Interim Payment Claim:	Yes ☐ No ☐ If yes, answer (i) to (iv) below to indicate payment required.	
	(i) Name of Health Professional:	
	(ii) Address:	
	(iii) Treatment Plan and Estimate:	Please attach details.
	(iv) Report Cost:	Attach invoice or account.
31. Treatment and Report expenses:	Yes ☐ No ☐ If yes, please complete Tables 1 and 2 and attach receipts and Medicare or private insurance statement of benefits.	
32. Future treatment expenses:	Yes ☐ No ☐ If yes, please attach detailed report and quotation.	
33. Travel:	Yes ☐ No ☐ If yes, please complete Table 3 attached.	
34. Personal Items:	Yes ☐ No ☐ If yes, please attach description and estimated value.	
35. Loss of Earning or Earning Capacity:	Yes ☐ No ☐ If yes, please attach all supporting documents.	
	Centrelink:	Yes ☐ No ☐ If yes, please attach details.
	Estimate of Earnings Lost:	$ gross $ net
36. Workers Compensation:	Yes ☐ No ☐ If yes advise name of insurer and attach supporting documents.	
	Weekly Payments Received:	Yes ☐ No ☐ If yes, please attach details.
	Expense Received:	Yes ☐ No ☐ If yes, please attach details.
37. Any Other Benefits, Compensation, etc:	Yes ☐ No ☐ Provide full details.	

(F) CLAIMS BY PERSONAL REPRESENTATIVE on behalf of DECEASED VICTIM FOR LOSS SUFFERED BY A CLOSE RELATIVE: Please use separate forms if applying under part (e) and part (f)

38. Claim by a Personal Representative of a Deceased Person:	Yes ☐ No ☐ If yes, complete questions 39 & 40.	
39. Loss of Financial Support for Dependants:	Please attach detailed statement.	
40. Funeral Expenses:	Name of person who incurred the cost.	
	Receipt or Account.	Please attach.
	Relationship to victim.	
	DCD Burial Grant.	Yes ☐ No ☐ If yes, please attach details.
	Interim Payment for Funeral Cost.	Yes ☐ No ☐

(G) SECTION OF *CRIMINAL INJURIES COMPENSATION ACT 2003* UNDER WHICH CLAIM IS MADE:

☐	Section 12	Proved offence - Offender convicted
☐	Section 13	Alleged offence - Accused acquitted, applicant claims some other person committed the offence
☐	Section 14	Alleged offence - Accused acquitted due to unsoundness of mind
☐	Section 15	Alleged offence - Accused not mentally fit to stand trial
☐	Section 16	Alleged offence - Charge not determined
☐	Section 17	Alleged offence - No person charged

(H) DECLARATION

I,____ understand that:
(state name in full)

(i) pursuant to section 19(1)(b) the assessor may give written notice of the making of my application to the offender, and may if requested provide copies of supporting documents to the offender;
(ii) pursuant to section 19(1)(c) the assessor may seek and receive further information and evidence from any other source(s) the assessor thinks necessary;
(iii) pursuant to section 70 it is an offence knowingly to give false information in support of an application for compensation, the maximum penalty for which is a fine of $5,000.00;
(iv) pursuant to section 43 the assessor may deduct from any compensation award made to me any amount I owe under a compensation reimbursement order.

Signed: ____________________________

A: Applicant in person,
B: Personal Representative of deceased,
C: Parent or person acting in place of a parent where applicant under 18 years, **OR**
D: Applicant's Guardian or Administrator appointed under the *Guardianship and Administration Act 1990*

Dated: ____________________________

TABLE 1 Question 31: Report Expenses

DATE	PROVIDER	COST

PLEASE USE DARK INK

TABLE 2 Question 31: Treatment Expenses

Are you a member of a Private Health Fund Yes ☐ No ☐

"A" DATE	"B" PROVIDER	"C" SERVICE	"D" NUMBER	"E" COST	"F" M/CARE	"G" PRIVATE	"H" GAP
						TOTAL:	

TABLE 3 Question 33: Travel Expenses

DATE	NAME OF DOCTOR, DENTIST ETC	FROM (SUBURB or TOWN)	TO (SUBURB or TOWN)	TOTAL NUMBER OF KILOMETRES PER RETURN TRIP (USING PRIVATE VEHICLE ONLY)	RETURN FARE (BUS, TRAIN & TAXI ONLY)

AUTHORITY TO PAY UNPAID ACCOUNT OR INVOICE DIRECT TO SERVICE PROVIDER

If you would like any unpaid account for treatment, report costs or ambulance expenses paid by the Office of Criminal Injuries Compensation direct to the Service Provider from your compensation award, please complete the authority below and ensure you have enclosed a copy of the unpaid account or invoice and the address for payment.

I, ____________________________________ authorise the office of Criminal Injuries Compensation to pay the amount of
(Name of Applicant)

$____________. __ to ______________________________________ of ____

from the proceeds of any compensation award made to me on this Application.

________________________ ___________________________

(Signed) (Dated)