KEN PAXTON
ATTORNEY GENERAL of TEXAS

Streamlining Success:

Advocacy Strategies for Smoother Benefit Processing

Beyond the Application

Application approval is only the beginning of a claimant's relationship with the Crime Victims’ Compensation Program.

Beyond the Application

Enclosed is information regarding crime-related costs which may be reimbursable. Read the information carefully and contact me with any questions. It is your responsibility to return all requested information.

- **Medical Bills, Mental Health Counseling, and Prescriptions**
  These expenses include bills from hospitals, doctors, dentists, ambulances, mental health counselors, pharmacies, and other qualified health care providers. If you have medical insurance (including Medicaid or Medicare), the provider must submit your bills to your insurance first. The CVC Program may reimburse you for out-of-pocket costs like co-pays or deductibles. For crime-related prescriptions, submit a copy of the label printout attached to your medication, including the medication name, prescribing doctor, purchase date and amount paid. If you have Medicaid, you should have no out-of-pocket expenses; however, if you receive a bill, you may submit it to the CVC Program for review.

- Complete the attached Insurance Affirmation.
- Submit a copy of your medical insurance card, which includes the date your coverage began. If your medical insurance changes or ends, submit a copy of the letter from the insurance provider showing the coverage change or end date.

- If claimants seeking counseling benefits do not have the same medical insurance as the victim, submit a copy of the claimant's medical insurance card which includes the date the coverage started.

- Submit all crime-related medical bills to the CVC Program for review.

  If you have not made a payment on a medical bill, you can ask your medical service providers to submit itemized bills directly to the CVC program.

  If you have already made payments to the medical service providers and would like to be reimbursed, send any invoices or receipts you have. The medical service provider will need to provide detailed billing forms to you or the CVC Program. This includes a copy of the CMS-1500 or an itemized bill including all ICD-9/10 diagnoses, all HCPCS/CPT procedure codes, any payments or adjustments on the patient's account, and an explanation of benefits showing payment or denial if medical insurance is available to the patient. You may need to follow up with the provider directly to ensure the required information is submitted to the CVC Program.

- If you are receiving, or plan to receive, crime-related counseling, submit the name and address of the mental health provider. If medical insurance is available, submit the EOB with the itemized bill(s). Submit all receipts if you pay out of pocket.

- **Loss of Earnings**
  Loss of earnings is based upon the amount of the victim's net earnings at the time of the crime for the length of time the victim is unable to work because of the crime-related disability. The CVC Program will contact the employer(s) directly. All income must be verified by the employer, the IRS, or the Texas Workforce Commission. Additional information may be requested if the victim's net salary cannot be verified this way. The CVC Program will also contact the treating medical provider directly for documentation supporting any disability that extends over 14 days after the crime date.

  The CVC Program may consider disability insurance, worker's compensation disability benefits, Social Security benefits, and any other income which is received because of the crime as a collateral resource. **You are required to inform your case manager if the victim is currently receiving these benefits, starts receiving these benefits at some future time, returns to work, or if there are any changes to these benefits by submitting copies of all correspondence regarding these benefits to your case manager.**

  For crimes occurring on or after 7/15/16, the maximum weekly wage paid by the CVC Program is $700.

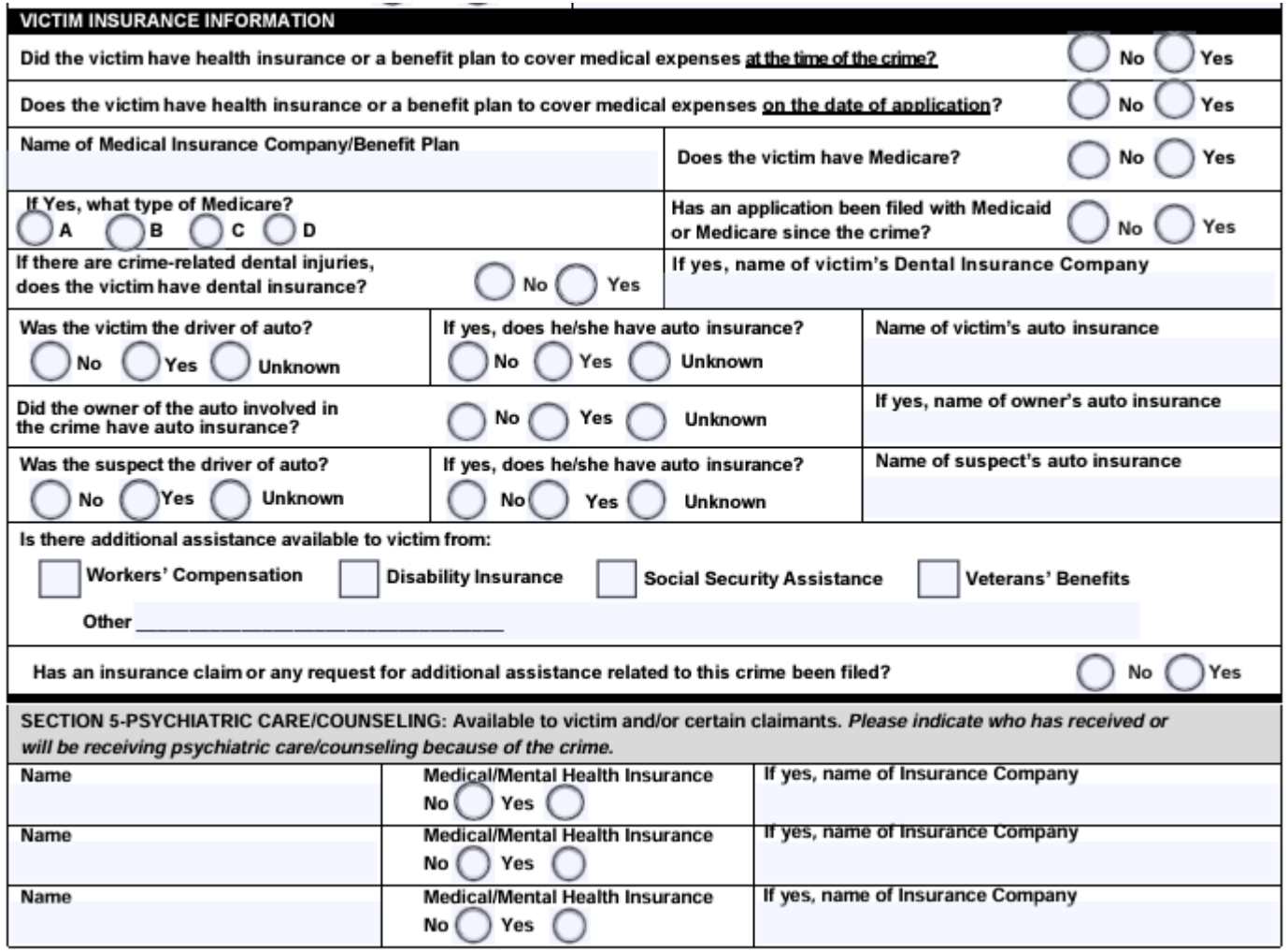
- To pay loss of earnings to the victim, the CVC Program requires employment information. Please complete all sections of the enclosed Victim Loss of Earnings Affirmation and return to your case manager. If the victim is requesting loss of earnings for a crime-related disability lasting over 14 days immediately following the date of crime, the treating medical provider's contact information must be included on the form.

- Victims or claimants who are self-employed, independent contractors, or contract laborers will need to submit verification of their income for tax year [%TaxYearLW%]. Acceptable forms of verification include a tax transcript from the IRS, a copy of IRS Form 1099-Misc with the employer's EIN, or proof of earnings reported directly to Texas Workforce Commission (TWC). You may call the IRS at 1-800-908-9946 to obtain a computer printout, free of charge.

  Please note, if you have reported a loss of income to the IRS, additional information may be requested. If you are unable to provide any information to the CVC Program that verifies your self-employed income, loss of earnings may be denied.

Under federal and state laws, the CVC Program is the payer of last resort. That means that if there are other government programs, personal insurance policies, or settlements available, you should also seek reimbursement from them, if you have not done so already. It is important that these other resources meet their legal obligations whenever possible. Notify the CVC Program of any amounts you receive as soon as possible.

Medical and Counseling Costs



VICTIM INSURANCE INFORMATION

Did the victim have health insurance or a benefit plan to cover medical expenses at the time of the crime? ◯ No ◯ Yes

Does the victim have health insurance or a benefit plan to cover medical expenses on the date of application? ◯ No ◯ Yes

Name of Medical Insurance Company/Benefit Plan

Does the victim have Medicare? ◯ No ◯ Yes

If Yes, what type of Medicare? ◯ A ◯ B ◯ C ◯ D

Has an application been filed with Medicaid or Medicare since the crime? ◯ No ◯ Yes

If there are crime-related dental injuries, does the victim have dental insurance? ◯ No ◯ Yes

If yes, name of victim's Dental Insurance Company

Was the victim the driver of auto? ◯ No ◯ Yes ◯ Unknown

If yes, does he/she have auto insurance? ◯ No ◯ Yes ◯ Unknown

Name of victim's auto insurance

Did the owner of the auto involved in the crime have auto insurance? ◯ No ◯ Yes ◯ Unknown

If yes, name of owner's auto insurance

Was the suspect the driver of auto? ◯ No ◯ Yes ◯ Unknown

If yes, does he/she have auto insurance? ◯ No ◯ Yes ◯ Unknown

Name of suspect's auto insurance

Is there additional assistance available to victim from:

☐ Workers' Compensation ☐ Disability Insurance ☐ Social Security Assistance ☐ Veterans' Benefits

Other _____

Has an insurance claim or any request for additional assistance related to this crime been filed? ◯ No ◯ Yes

SECTION 5-PSYCHIATRIC CARE/COUNSELING: Available to victim and/or certain claimants. *Please indicate who has received or will be receiving psychiatric care/counseling because of the crime.*

Name	Medical/Mental Health Insurance	If yes, name of Insurance Company
	No ◯ Yes ◯	
Name	Medical/Mental Health Insurance	If yes, name of Insurance Company
	No ◯ Yes ◯	
Name	Medical/Mental Health Insurance	If yes, name of Insurance Company
	No ◯ Yes ◯	

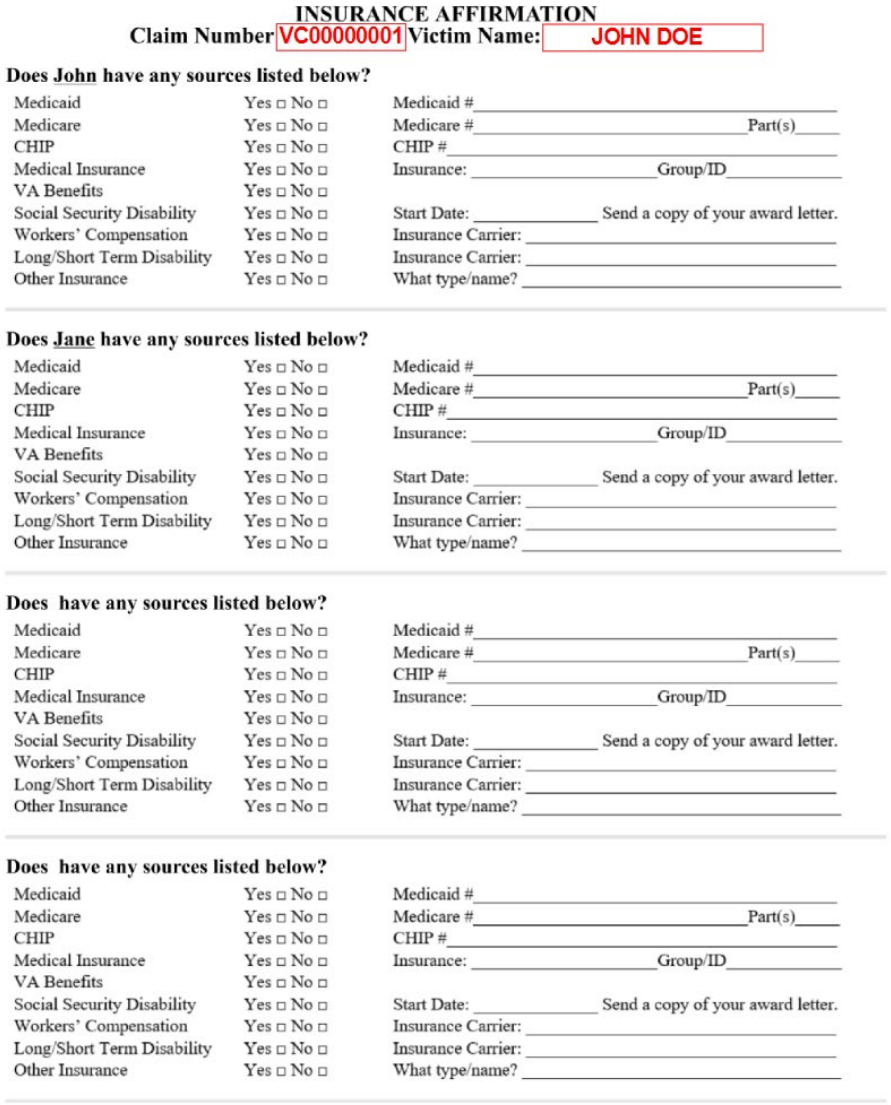
For the Victim:

- Ensure all necessary details regarding **medical insurance** are provided for coverage of **medical expenses** and **counseling services**.

For the Claimant:

- Ensure all necessary details regarding **medical insurance** are provided for coverage of **counseling services**.

Medical and Counseling Costs



INSURANCE AFFIRMATION

Claim Number VC00000001 Victim Name: JOHN DOE

Does John have any sources listed below?

Medicaid	Yes ☐ No ☐	Medicaid #_____
Medicare	Yes ☐ No ☐	Medicare #_____ Part(s)____
CHIP	Yes ☐ No ☐	CHIP #_____
Medical Insurance	Yes ☐ No ☐	Insurance: _____ Group/ID_____
VA Benefits	Yes ☐ No ☐	
Social Security Disability	Yes ☐ No ☐	Start Date: _____ Send a copy of your award letter.
Workers' Compensation	Yes ☐ No ☐	Insurance Carrier: _____
Long/Short Term Disability	Yes ☐ No ☐	Insurance Carrier: _____
Other Insurance	Yes ☐ No ☐	What type/name? _____

Does Jane have any sources listed below?

Medicaid	Yes ☐ No ☐	Medicaid #_____
Medicare	Yes ☐ No ☐	Medicare #_____ Part(s)____
CHIP	Yes ☐ No ☐	CHIP #_____
Medical Insurance	Yes ☐ No ☐	Insurance: _____ Group/ID_____
VA Benefits	Yes ☐ No ☐	
Social Security Disability	Yes ☐ No ☐	Start Date: _____ Send a copy of your award letter.
Workers' Compensation	Yes ☐ No ☐	Insurance Carrier: _____
Long/Short Term Disability	Yes ☐ No ☐	Insurance Carrier: _____
Other Insurance	Yes ☐ No ☐	What type/name? _____

Does have any sources listed below?

Medicaid	Yes ☐ No ☐	Medicaid #_____
Medicare	Yes ☐ No ☐	Medicare #_____ Part(s)____
CHIP	Yes ☐ No ☐	CHIP #_____
Medical Insurance	Yes ☐ No ☐	Insurance: _____ Group/ID_____
VA Benefits	Yes ☐ No ☐	
Social Security Disability	Yes ☐ No ☐	Start Date: _____ Send a copy of your award letter.
Workers' Compensation	Yes ☐ No ☐	Insurance Carrier: _____
Long/Short Term Disability	Yes ☐ No ☐	Insurance Carrier: _____
Other Insurance	Yes ☐ No ☐	What type/name? _____

Does have any sources listed below?

Medicaid	Yes ☐ No ☐	Medicaid #_____
Medicare	Yes ☐ No ☐	Medicare #_____ Part(s)____
CHIP	Yes ☐ No ☐	CHIP #_____
Medical Insurance	Yes ☐ No ☐	Insurance: _____ Group/ID_____
VA Benefits	Yes ☐ No ☐	
Social Security Disability	Yes ☐ No ☐	Start Date: _____ Send a copy of your award letter.
Workers' Compensation	Yes ☐ No ☐	Insurance Carrier: _____
Long/Short Term Disability	Yes ☐ No ☐	Insurance Carrier: _____
Other Insurance	Yes ☐ No ☐	What type/name? _____

Information and Documentation Needed:

- Complete medical insurance information
- Crime-related counseling and medical bills
  - Explanation of Benefits (EOB) if medical insurance is involved
  - CMS-1500 Form for physician or doctor billing
  - UB-04 Form for hospital or facility billing

Lost Wages and Travel

Consecutive Victim Lost Wages:

- Wages lost by a victim due to a medical disability.

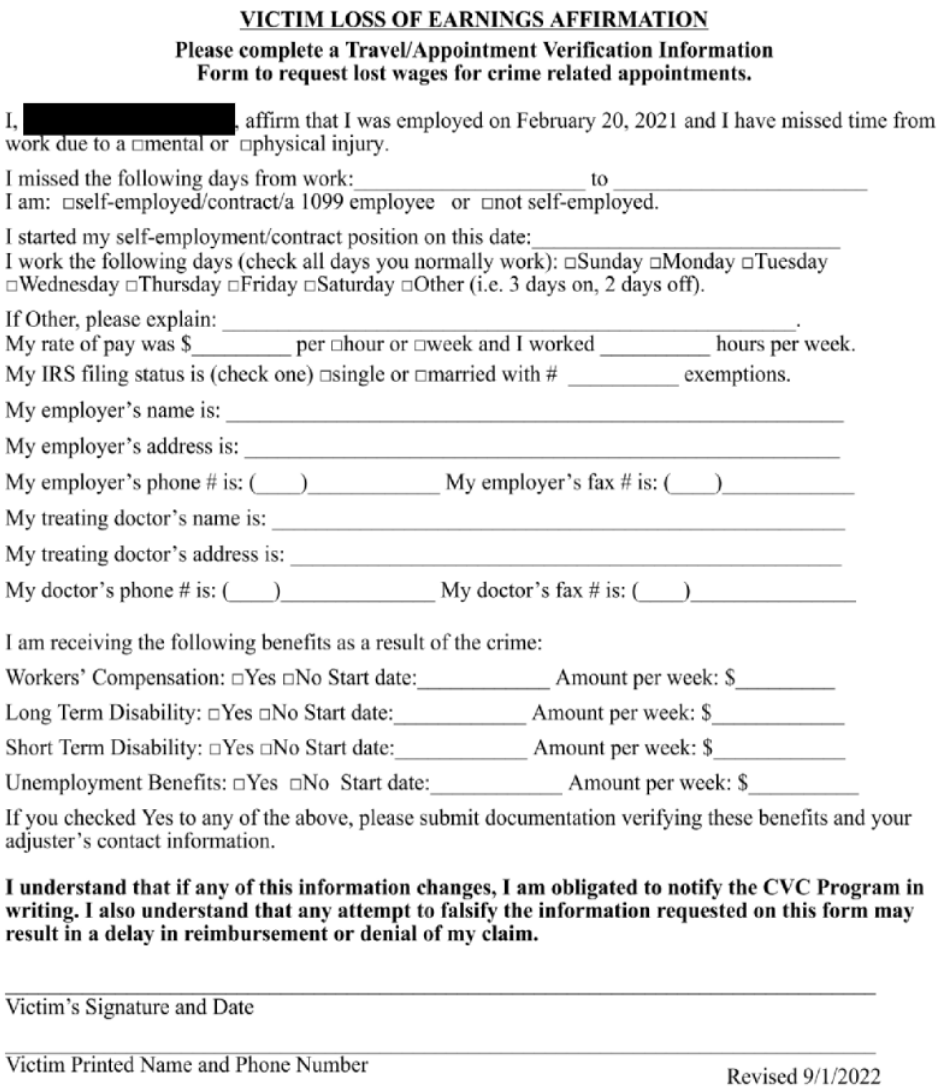
Consecutive Claimant Lost Wages:

- Wages lost by a claimant due to bereavement or the victim's medical disability.

Travel and Non-Consecutive Lost Wages:

- Travel and/or Wages lost for specific crime-related appointments.

Consecutive Victim Lost Wages



VICTIM LOSS OF EARNINGS AFFIRMATION

Please complete a Travel/Appointment Verification Information Form to request lost wages for crime related appointments.

I, [redacted], affirm that I was employed on February 20, 2021 and I have missed time from work due to a □mental or □physical injury.

I missed the following days from work:_____ to _____
I am: □self-employed/contract/a 1099 employee or □not self-employed.

I started my self-employment/contract position on this date:_____
I work the following days (check all days you normally work): □Sunday □Monday □Tuesday □Wednesday □Thursday □Friday □Saturday □Other (i.e. 3 days on, 2 days off).

If Other, please explain: _____.
My rate of pay was $_____ per □hour or □week and I worked _____ hours per week.
My IRS filing status is (check one) □single or □married with # _____ exemptions.

My employer's name is: _____

My employer's address is: _____

My employer's phone # is: (____)_____ My employer's fax # is: (____)_____

My treating doctor's name is: _____

My treating doctor's address is: _____

My doctor's phone # is: (____)_____ My doctor's fax # is: (____)_____

I am receiving the following benefits as a result of the crime:

Workers' Compensation: □Yes □No Start date:_____ Amount per week: $_____

Long Term Disability: □Yes □No Start date:_____ Amount per week: $_____

Short Term Disability: □Yes □No Start date:_____ Amount per week: $_____

Unemployment Benefits: □Yes □No Start date:_____ Amount per week: $_____

If you checked Yes to any of the above, please submit documentation verifying these benefits and your adjuster's contact information.

I understand that if any of this information changes, I am obligated to notify the CVC Program in writing. I also understand that any attempt to falsify the information requested on this form may result in a delay in reimbursement or denial of my claim.

_____
Victim's Signature and Date

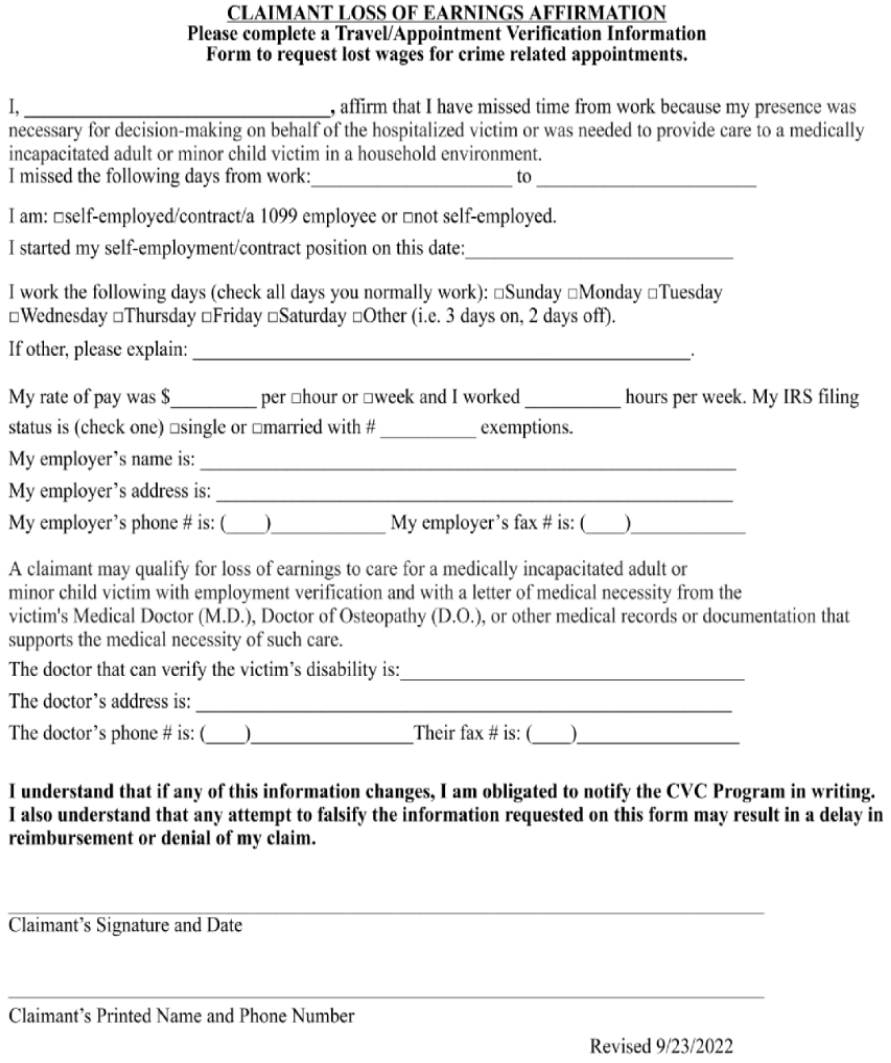
_____
Victim Printed Name and Phone Number

Revised 9/1/2022

Completed Victim Loss of Earnings Affirmation providing:

- Complete disability period
- Employer name and address
- Relevant tax documentation for self-employed individuals
- Name and mailing address of their treating physician
- Complete collateral source information

Consecutive Claimant Lost Wages



CLAIMANT LOSS OF EARNINGS AFFIRMATION
Please complete a Travel/Appointment Verification Information Form to request lost wages for crime related appointments.

I, _____, affirm that I have missed time from work because my presence was necessary for decision-making on behalf of the hospitalized victim or was needed to provide care to a medically incapacitated adult or minor child victim in a household environment.
I missed the following days from work:_____ to _____

I am: □self-employed/contract/a 1099 employee or □not self-employed.

I started my self-employment/contract position on this date:_____

I work the following days (check all days you normally work): □Sunday □Monday □Tuesday □Wednesday □Thursday □Friday □Saturday □Other (i.e. 3 days on, 2 days off).

If other, please explain: _____.

My rate of pay was $_____ per □hour or □week and I worked _____ hours per week. My IRS filing status is (check one) □single or □married with # _____ exemptions.

My employer's name is: _____

My employer's address is: _____

My employer's phone # is: (___)_____ My employer's fax # is: (___)_____

A claimant may qualify for loss of earnings to care for a medically incapacitated adult or minor child victim with employment verification and with a letter of medical necessity from the victim's Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), or other medical records or documentation that supports the medical necessity of such care.

The doctor that can verify the victim's disability is:_____

The doctor's address is: _____

The doctor's phone # is: (___)_____Their fax # is: (___)_____

I understand that if any of this information changes, I am obligated to notify the CVC Program in writing. I also understand that any attempt to falsify the information requested on this form may result in a delay in reimbursement or denial of my claim.

_____
Claimant's Signature and Date

_____
Claimant's Printed Name and Phone Number

Revised 9/23/2022

Due to a Victim's Disability

Completed Claimant Loss of Earnings Affirmation providing:

- Complete period of loss
- Employer name and address
- Relevant tax documentation for self-employed individuals
- The name and mailing address of the victim's treating physician

Consecutive Claimant Lost Wages

Due to Bereavement

Completed Travel Form:

- The complete period of loss
- Employer name and address
- Relevant tax documentation for self-employed Individuals

NOTE: Request relevant funeral travel on the same form

Travel and Non-Consecutive Lost Wages

TRAVEL / APPOINTMENT VERIFICATION FORM
MAKE SURE THIS FORM IS SIGNED AND COMPLETE TO PREVENT DELAYS IN PROCESSING.

Victim/Claimant requesting reimbursement:	Social Security Number	Person attending appointment (if different than the person requesting reimbursement):	VC00000001

Were you subpoenaed for trial on any of the listed dates? Yes ____ No ____ If "Yes," submit your travel expenses to the District Attorney's office for reimbursement.

Reimbursement Type Check all that apply for the appointment date listed.	Date(s) of appointments/ leave request. Note how many hours you were at the appointment.	Start Address Complete **physical** address/ city/ state/ zip code of your residence. If you are starting from a location other than your residence, please include an explanation for this.	Destination Address Name and complete **physical** address/ city/ state/ zip code of location of your appointment. **Destination must be 20 miles from the start address.**	Appointment Type Explain the type of appointment (medical, counseling, execution, funeral). For medical appointments, provide the diagnosis code or be as specific as possible.	Appointment Verification Signature or printed name/phone number of the person that can verify your medical/ counseling/criminal justice appointment. If submitting bills or records as proof, please note "Records/Bill attached." For funeral, note "Attended funeral."
☐ Travel ☐ Lost wages ☐ Bereavement Wages (Before 9/1/2023, limited to 10 days up to $1,000; current limit is $3,333.)					
☐ Travel ☐ Lost wages					
☐ Travel ☐ Lost wages					
☐ Travel ☐ Lost wages					
☐ Travel ☐ Lost wages					

Travel over 60 miles may be eligible for lodging and food reimbursement at state rates. Receipts are required for lodging. Receipts are not required for food reimbursement. Submit receipts for parking and toll road charges. If commercial travel (airplane, bus, train, taxi, car rental) was used, submit a copy of your receipt(s). Gas receipts are only needed if you rented a vehicle.

If you are requesting lost wages to attend crime related medical/counseling appointments, criminal justice proceedings, or the victim's funeral, the CVC Program will contact your employer directly to verify your income and the dates/hours you missed work. If you are self-employed, please submit proof of your self-employed income as instructed on the previous page.

Employer Name:	Employer Address:	Employer Phone: Employer Fax:
➡ Victim / Claimant Signature:		Date:

Funeral Expenses

Documentation Needed:

- Funeral Purchase Agreement
  - signed by both the funeral home and a *valid* claimant
- Any receipt of payment that includes
  - Name of the payer
  - Total amount paid
- Life Insurance Assignment
  - Detailing the beneficiary if applied towards the service(s)

Loss of Support – Surviving Victim's Dependents

Information Needed (based on financial support provided by the suspect):

Suspect's income details:

- Paycheck stubs
- Employment letter
- Relevant tax transcript

Child Support Payment Ledger detailing the payments made by the suspect

Loss of Support – Deceased Victim's Dependents

Information Needed (based on financial support provided by the victim):

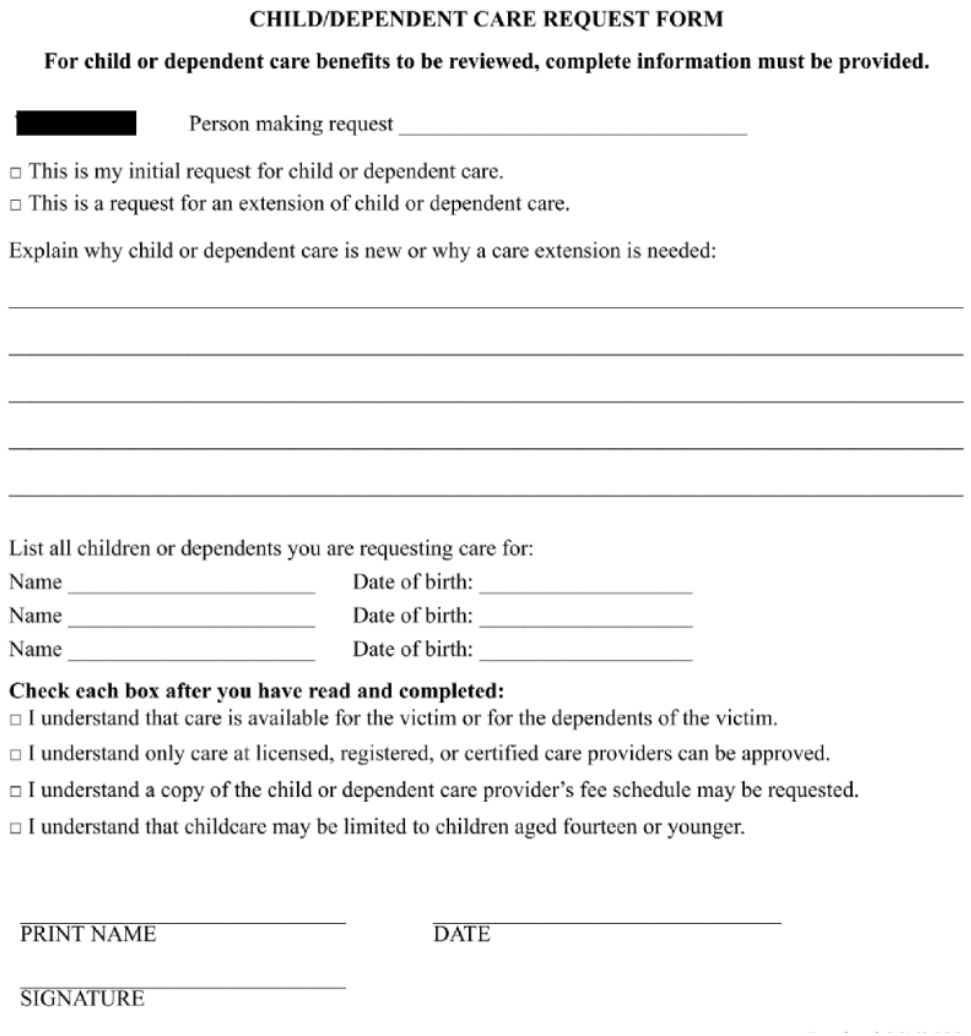
Victim's income details:

- Paycheck stub
- Employment letter
- Relevant tax transcript

Social Security benefit or denial letters for age-appropriate dependents

NOTE: New guardianship of the victim's children may need to be established

Childcare Assistance



CHILD/DEPENDENT CARE REQUEST FORM

For child or dependent care benefits to be reviewed, complete information must be provided.

[redacted] Person making request _____

□ This is my initial request for child or dependent care.
□ This is a request for an extension of child or dependent care.

Explain why child or dependent care is new or why a care extension is needed:

_____

_____

_____

_____

_____

List all children or dependents you are requesting care for:

Name _____ Date of birth: _____
Name _____ Date of birth: _____
Name _____ Date of birth: _____

Check each box after you have read and completed:

□ I understand that care is available for the victim or for the dependents of the victim.
□ I understand only care at licensed, registered, or certified care providers can be approved.
□ I understand a copy of the child or dependent care provider's fee schedule may be requested.
□ I understand that childcare may be limited to children aged fourteen or younger.

_____ _____
PRINT NAME DATE

_____
SIGNATURE

Documentation Needed:

- Child/Dependent added to the claim
- An explanation of how childcare has become a new expense
- If this is an extension request,
  - An explanation of why an extension is needed
- Childcare facility fee schedule
- Any collateral sources being received
- If approved, a billing invoice that includes
  - Child name
  - Service dates
  - Total amount
  - Payments made
  - Name of payer (if applicable)

Relocation!!! Relocation!!! Relocation!!!

Please join us for the breakout session
Rent and Relocation Updates
at 1:30pm

For an in-depth discussion about relocation documentation and updates from SB49.

For More Information

Office of the Attorney General

Crime Victim Services Division

CVC Program

P.O. Box 12198

Austin, TX 78711-2198

www.texasattorneygeneral.gov

(512) 936-1200 or (800) 983-9933 Main Number

crimevictims@oag.Texas.gov