



## Criminal Injuries Compensation Commission FORM A

### APPLICATION FOR CRIME VICTIM COMPENSATION

An application must be completed and filed for each victim. If victim is a minor or is mentally incompetent, the applicant (person filing for victim) must be an adult who is responsible for victim's welfare. Please fill out this application as completely and accurately as possible. Claims will be thoroughly investigated and verified. Type or print legibly. **Unsigned or not witnessed applications may be returned unprocessed.**

**You may qualify for financial assistance through Guam's Criminal Injuries Compensation, if you answer "YES" to the following requirements:**

- (a) YOU ARE FILING THIS APPLICATION WITHIN 18 MONTHS AFTER THE DATE OF INJURY, DEATH, OR PROPERTY DAMAGE;
- (b) Are a resident of Guam as defined in 3 GCA §9123;
- (c) The act or omission resulted in the death or injury to the victim;
- (d) The act or omission occurred in Guam, or if it occurred outside of the jurisdiction of Guam, the person can prove that the State in which the crime occurred does not have a crime victim's compensation statute;
- (e) The act or omission resulted from a violent crime enumerated in 8 GCA § 161.55.<sup>1</sup>
- (f) The compensation is for the benefit of the victim or persons as provided for in 8 GCA §161.50(a) (1) through (4).

If you answered YES to all of the above questions, please fill out the attached application and mail it to the address below. If you need help filling out the application, please call a Victim Witness Ayuda Service (VWAS) Advocate through the Guam Office of the Attorney General at (671) 475-2587 or (671) 475-3324. You have 18 months after the date of injury, death, or property damage to file an application.

#### **Types of expenses we cover include:**

Medical, dental, hospital, funeral, counseling, loss of wages & support, physical rehabilitation, transportation.

**There is NO award for earnings lost while attending court or earnings lost by family members. Loss of earnings is only payable if the victim is employed and working at the time of the incident.**

**Expenses incurred as a result of the incident must first be submitted to all readily available prior resources for payment (your insurance company, Medicare, and Medicaid). Those expenses not fully covered by prior resources will be considered for payment.**

**You are not required to be a U.S. Citizen to apply for Crime Victim Compensation.**

#### **Mail the completed application to:**

**Office of the Attorney General  
Criminal Injuries Compensation Commission  
590 S. Marine Corps Dr., Ste. 706, Tamuning, Guam, 96913  
FAX: (671) 475-3354 Telephone: (671)475-2587 or (671) 475-3324  
Website: [www.guamag.org](http://www.guamag.org) E-Mail: [law@guamag.org](mailto:law@guamag.org).**

For Office Use Only-STAMP RECEIVE

CICC # :

Rec'd by & Date Rec'd :

Response Letter Date (20 business days):

<sup>1</sup> For violent crimes listed in the Guam Code Annotated, please see next page.

# **Guam Criminal Injuries Compensation Commission**

## **Violent Crimes as listed in 8 GCA §161.55**

(a) The crimes to which this Chapter applies are the following:

- (1) Aggravated Murder (9 GCA, § 16.30);
- (2) Murder (9 GCA, § 16.40);
- (3) Manslaughter (9 GCA, § 16.50);
- (4) Aggravated Assault (9 GCA, § 19.20);
- (5) Assault (9 GCA, § 19.30);
- (6) Kidnapping (9 GCA, § 22.20);
- (7) Felonious Restraints (9 GCA, § 22.20);
- (8) Child Stealing (9 GCA, § 22.40);
- (9) Custodial Interference (9 GCA, § 22.50);
- (10) Criminal Sexual Conduct in the First Degree (9 GCA, § 25.15);
- (11) Criminal Sexual Conduct in the Second Degree (9 GCA, § 25.20);
- (12) Criminal Sexual Conduct in the Third Degree (9 GCA, § 25.25);
- (13) Criminal Sexual Conduct in the Fourth Degree (9 GCA, § 25.30);
- (14) Assault with Intent to Commit Criminal Sexual Conduct (9 GCA, § 25.35);
- (15) Driving under the Influence of Alcohol and Controlled Substances (16 GCA, § 18102);
- (16) Conviction Involving a Child (16 GCA, § 18109), provided a child under the age of sixteen (16) was injured as a result of an accident in which the vehicle operated by the person charged with the above violation was involved;
- (17) Vehicular Negligence with Injury to a Person Other than the Driver (16 GCA, § 18110);
- (18) Vehicular Homicide (16 GCA, § 18111);
- (19) Drinking While Driving a Motor Vehicle upon any Highway (16 GCA, §18119), provided a person other than the driver was injured as a result of such drinking and driving;
- (20) Stalking (9 GCA, § 19.70); and

(21) Family Violence (Third Degree Felony and Misdemeanor) and Violation of a Court Order (Misdemeanor) (9 GCA, Chapter 30).

(b) For the purpose of this Chapter, the operation of a motor vehicle, boat or aircraft that results in an injury or death shall not constitute a crime, unless the injuries were intentionally inflicted through the use of such vehicle, boat or aircraft or unless the conduct constitutes a violation of Title 16, Guam Code Annotated, § 18101, et seq. (The Safe Streets Act).

(c) Any fine imposed pursuant to Section 80.50 of [Title 9, Guam Code Annotated] for conviction of any crimes specified in Subsections (a) (1) through (14) and (20) and (21) of this Section shall be paid into the Criminal Injuries Compensation Fund established by Section 161.90 of this Chapter.

**SOURCE:** Added by P.L. 20-155:2 (Mar. 21, 1990) as 9 GCA § 86.55; amended by P.L. 23-132:5 (Dec. 30, 1996). Subsection (a)(21) added by P.L. 24-014:45 (Apr. 21, 1997). Subsection (c) repealed and reenacted by P.L. 24-014:46 (Apr. 21, 1997). Amended and moved to this title and chapter by P.L. 27-138:4 (Dec. 30, 2004).

2013 NOTE: References in subsection (c) to Title 9 have been altered to reflect the chapter's current location in this title.



# GUAM CRIMINAL INJURIES COMPENSATION APPLICATION FORM

For Office Use Only-STAMP RECEIVE

Claim Number: **CICC#**  
 Response Letter Date:  
 (20 Business Days)  
 Rec'd by & Date Rec'd:

## For Office / Victim Assistance Program Use Only

|       |                |                   |
|-------|----------------|-------------------|
| Date: | Advocate name: | Advocate e-mail:  |
|       |                | Advocate phone #: |

### PLEASE PRINT LEGIBLY:

|  |  |   |
|--|--|---|
| Who referred you to this program?        |  |   |
| <input type="checkbox"/> Police          | <input type="checkbox"/> Victim Advocate           | <input type="checkbox"/> Medical Provider |
| <input type="checkbox"/> OAG Prosecution | <input type="checkbox"/> Child Protective Services | <input type="checkbox"/> Other _____      |

### Section 1. Victim Information:

(Person who was injured, deceased, or property owner with damage)

|   |   |   |                                  |                                |
|---|---|---|----------------------------------|--------------------------------|
| First Name:   | Middle Name:  | Last Name:                              |                                  |                                |
| Mailing Address:  | Apt #:  | City:                                   | State:                           | Zip:                           |
| Home Phone:   | Work Phone:   | Cell Phone:                             |                                  |                                |
| Physical Address:   |   | Email address                           |                                  |                                |
| Driver's License Number:  | Date of Birth:  | Language Spoken                         |                                  |                                |
| Gender :<br><input type="checkbox"/> Male <input type="checkbox"/> Female | If victim is deceased, date of death:<br>Month                      Day                      Year |   |                                  |                                |
| What kind of assistance are you applying for? Check all that apply        |   |   |                                  |                                |
| <input type="checkbox"/> Loss of Earnings                                 | <input type="checkbox"/> Counseling   | <input type="checkbox"/> Medical        | <input type="checkbox"/> Funeral | <input type="checkbox"/> Other |
| <input type="checkbox"/> Dental   | <input type="checkbox"/> Physical Rehabilitation  | <input type="checkbox"/> Transportation |                                  |                                |

### Section 2. Applicant Information:

(Complete this section if the victim is a minor, incapacitated, or deceased)

|   |   |  |  |                                  |
|---|---|--|--|----------------------------------|
| First Name:   | Middle Name:                                  | Last Name:                                     |  |                                  |
| Mailing Address:  | Apt #:  | City:  | State:                                 | Zip :                            |
| Home Phone:   | Work Phone:                                   | Cell Phone:                                    |  |                                  |
| Physical Address:   |   | Email Address:                                 |  |                                  |
| Driver's License Number:  | Date of Birth:                                | Language Spoken                                |  |                                  |
| Gender:<br><input type="checkbox"/> Male <input type="checkbox"/> Female            | Your relationship to the victim:              |  |  |                                  |
| What kind of assistance are you applying for? Check all that apply. (Homicide only) |   |  |  |                                  |
| <input type="checkbox"/> Loss of Support:   | <input type="checkbox"/> Survivor Counseling: | <input type="checkbox"/> Medical Reimbursement | <input type="checkbox"/> Other Expense | <input type="checkbox"/> Funeral |



**Section 6. Prior Resource Information** (please attach copies of insurance card). **Your provider must bill your primary insurance first:**

| If yes, please enter information in the box provided:  | Company Name: | Phone Number: | Policy Number: |
|--|---------------|---------------|----------------|
| Do you have medical insurance?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |               |               |                |
| Do you have dental insurance?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |               |               |                |
| If the crime involved an auto, do you have auto insurance?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |               |               |                |
| If the crime involved an auto, does the offender have auto insurance?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |               |               |                |
| If the crime happened in your home / on your property, do you have homeowners insurance?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                           |               |               |                |
| If the crime happened at your place of work, do you have a Workers Compensation claim?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                             |               |               |                |
| Are you eligible for any other benefits?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |               |               |                |
| Have you received or expect to receive any payment as a result of this crime?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, source _____ Amount _____ |               |               |                |

**Section 7. Medical/Counseling Expense Information**

(Please attach copies of all bills if available)

Did you receive medical treatment as a result of the crime?  Yes       No

Please list providers for crime-related injuries, paid or unpaid:

| Provider's Name: | Specialty: | Address: | City: | State: | Zip: | Telephone: |
|------------------|------------|----------|-------|--------|------|------------|
|                  |            |          |       |        |      | ( )        |
|                  |            |          |       |        |      | ( )        |
|                  |            |          |       |        |      | ( )        |
|                  |            |          |       |        |      | ( )        |
|                  |            |          |       |        |      | ( )        |
|                  |            |          |       |        |      | ( )        |

**Section 8. Additional Counseling**

Did anyone besides the victim receive or will be requesting counseling because of the crime? (survivor counseling, child witness to domestic violence, family/child sex abuse)  Yes       No

| Name of Family Member: | Date of Birth: | Social Security (last 4 digits): | Relationship to Victim: | Insurance Carrier: |
|------------------------|----------------|----------------------------------|-------------------------|--------------------|
|                        |                |                                  |                         |                    |
|                        |                |                                  |                         |                    |

### Section 9. Loss of Earnings / Support

(Loss of Earnings only payable to direct victims who lost wages due to the injury. Loss of support only payable to surviving dependants of homicide victims)

|  |  |                  |                       |      |
|--|--|------------------|-----------------------|------|
| Was Person Employed on Date of Injury?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | Date Left Work:  | Date Returned:        |      |
| Employer's Name:   |  | Phone:<br>(    ) | Fax Number:<br>(    ) |      |
| Address:   |  | City:            | State:                | Zip: |
| Name, address & phone of doctor who certified victim unable to work:                               |  |                  |                       |      |

### Section 10. For Homicide Claims Only

At the time of death, was the victim contributing to the financial support of dependants?( please list additional dependants on the backside of this sheet)

Yes  No

| Name of Dependent: | Date of Birth: | Address: | Relationship to Victim: |
|--------------------|----------------|----------|-------------------------|
|                    |                |          |                         |
|                    |                |          |                         |
|                    |                |          |                         |

### Section 11. Funeral Expense Information (Please attach bills if available)

Please list all unpaid funeral expenses and out of pocket payments made as a result of this crime

| Provider of Services: | Address: | City: | State: | Zip: | Phone: | Paid by: |
|-----------------------|----------|-------|--------|------|--------|----------|
|                       |          |       |        |      |        |          |
|                       |          |       |        |      |        |          |

Please **do not** contact me when conducting surveys or research on victims' issues.

(If you do not check this box, you may be contacted via e-mail or US mail. Your personal information will not be released to anyone.)

**Criminal Injuries Compensation Commission**

590 S. Marine Corps Dr., Ste. 706

Tamuning, Guam, 96913

Or deliver to Victim Witness Ayuda Services through the Office of the Attorney General.

**For more information call:**

(671) 475-2587 or (671) 475-3324

**Visit our website:**

www.guamag.org

## Information Release

The Criminal Injuries Compensation Commission (CICC) is required to investigate all applications for compensation filed pursuant to 8 GCA Chapter 161. This authorization to disclose records will be used to gather pertinent information from law enforcement, employment, insurance, financial and medical facilities, and other providers to determine whether an applicant is eligible to receive compensation. Information that is confidential by law shall remain confidential.

### MEDICAL AND OTHER RELEASE:

BY SIGNING THIS APPLICATION I HEREBY CONSENT TO RELEASE RECORDS between CICC and any hospitals, physicians, counselors, medical facilities and services, any insurer including social security and disability benefits, any employers, and any social services or governmental law enforcement agency for purposes relating to my CICC application.

I ALSO HEREBY CONSENT TO RELEASE TO CICC any document(s) related to disability information or income from other sources and/or my medical records even if it contains information about drugs, alcohol, mental health, or HIV testing.

I EXPRESSLY AND VOLUNTARILY AUTHORIZE DISCLOSURE of my records for the purpose stated above. I further understand that I am not giving permission for any disclosure other than that described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

### My Promise to the Program

BY SIGNING THIS APPLICATION I HEREBY AGREE to immediately inform the CICC when any crime-related recovery is expected or received. I further agree to pay back the CICC from those recoveries a sum that is equal to the amount of the total CICC award. I acknowledge and agree that the sources of recovery this subrogation agreement will pertain to include, but are not limited to, the following types of recovery sources: court-imposed restitution, civil judgments against the offender or other liable/obligated third parties, any insurance settlements, or settlements/benefits from any other governmental or private agency. I further agree to refund to CICC all sums of money paid by CICC pursuant to this claim, if the claim is at any time determined to be in error, false or fraudulent.

BY SIGNING THIS APPLICATION I UNDERSTAND THAT UNDER PENALTIES OF UNSWORN FALSIFICATION, I declare that the information in this application is true and accurate. I, or we, authorize the Criminal Injuries Compensation Commission to verify any information on this application.

**Signature of Victim/Applicant:**

**Date:**

**Adult Witness to the Above Victim/Applicant Signatures (witness signature is required)      Date:**

**Signature of 14-17 Year Old:**

**Date:**

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**CRIMINAL INJURIES COMPENSATION COMMISSION**  
**590 S. Marine Corps Dr., Ste. 706**  
**Tamuning, Guam, 96913**  
**Phone: (671) 475-2587 or (671) 475-3324**

**Nondiscrimination**

To be eligible to receive federal funds for distributing purposes of crime victims' compensation, the CICC must comply with the nondiscrimination requirements of the Federal Victims of Crime Act of 1984. To insure it meets those requirements regarding nondiscrimination, the CICC must collect information about the victim's race, religion, sex, national origin, age, and any handicapping condition. The information you provide will not be used in any manner to determine acceptance or denial of your claim and will be kept confidential.

Recipients of funds under the Act are subject to Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000(d) (prohibiting discrimination in Federally-funded programs on the basis of race, color, or national origin), Section 504 of the Rehabilitation Act of 1974, as amended: Subtitle A, Title II of the Americans with Disabilities Act (ADA); and Department of Justice implementing regulations on disability discrimination, 28 CFR Part 35 and Part 39; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1974; and the Department of Justice Nondiscrimination Regulations, 28 CFR Part 42, Subparts C, D, E, and G.

**Federal Reporting Information:**

The following voluntary information is used for statistical purposes only to comply with federal regulations:

Is the Victim Disabled?

Yes  No

Was the Victim Disabled Prior to the Date of Crime?

Yes  No

Ethnicity of Victim:

Chamorro  FSM (please specify): \_\_\_\_\_

Caucasian

Filipino  Asian (please specify): \_\_\_\_\_

Other : \_\_\_\_\_