Date App. Rec'd.__________

Date all Supporting Documentation Rec'd.__________

ITVERP Claim Number:

____

U. S. Department of Justice
Office of Justice Programs
Office for Victims of Crime

OMB Number 1121-0309
Expiration: 05/31/2013

For Official Use Only

INTERNATIONAL TERRORISM VICTIM EXPENSE REIMBURSEMENT PROGRAM APPLICATION

Please type or print clearly. Attach additional paper, if necessary.

A. Application Type

Check only one. (Reminder: All applications must include an original signature and original receipts.)

❑ Itemized Application
❑ Interim Emergency Payment Application
❑ Supplemental Application (If filling out a Supplemental Application, provide Original Claim Number: __________)

B. Victim Information

To help process your application more quickly, please read the Application Instructions for information on the required documents to be included with your application.

Please provide the following personal information on the **victim**:

VICTIM'S FULL NAME (First, Middle, Last)		
STREET ADDRESS		
CITY	STATE	ZIP
TELEPHONE	FAX	COUNTRY
DOB	EMAIL (optional)	

Please Complete One:	Gender:
❑ Social Security Number: _______________ ❑ Employee Identification Number: ____________ ❑ Other Identification Number (e.g., passport, driver's license, etc.): __________________	❑ Male ❑ Female

PLACE OF BIRTH		COUNTRY OF CITIZENSHIP	
EMPLOYER (If applicable)			
EMPLOYER STREET ADDRESS			
CITY	STATE	ZIP	COUNTRY
CONTACT PERSON (If known)		TELEPHONE	FAX
CONTACT PERSON'S EMAIL (optional)			

Victim's known children, dependents, or recipients of support (continue on Supplemental Sheet, under Section B-1):

NAME	DOB	RELATIONSHIP

Do you know of anyone else who may be eligible for expense reimbursement under this program who is not listed on this application? ❑ Yes ❑ No

B. Victim Information (Continued)

If Yes, please list all (additional information may be listed on the Supplemental Sheet in Section B-2):

NAME	RELATIONSHIP
FULL ADRESS	TELEPHONE
	FAX
EMAIL (optional)	

Victim Eligibility (check all that apply):	Is the Victim (check all that apply):

❑ United States Citizen/National
❑ United States Government Officer
❑ United States Government Employee:
    ❑ Foreign Service National
    ❑ Foreign Service Officer
    ❑ Civil Servant
❑ Other:_________________________
	❑ Deceased
	❑ Minor
	❑ Incapacitated
	❑ Incompetent
	(If the victim is deceased, a minor, incapacitated, or incompetent, please go directly to Section C. If the victim is *none* of these, please *skip Section C* and go directly to Section D.)

C. Claimant Information

Please provide the following information on the claimant.
(This section should be completed *only* if filing on behalf of a victim. If the victim and the claimant are the same person, the applicant may proceed directly to Section D.)

CLAIMANT'S FULL NAME (First, Middle, Last)		
STREET ADDRESS		
CITY	STATE	ZIP
TELEPHONE	FAX	COUNTRY
DOB	EMAIL (optional)	

Please Complete One:	Gender:	Relationship to Victim:
❑ Social Security Number: ________________ ❑ Employee Identification Number: _____________ ❑ Other Identification Number (e.g., passport, driver's license, etc.): ________________________________	❑ Male ❑ Female Country of Citizenship: ________________________	❑ Spouse ❑ Child ❑ Parent ❑ Sibling ❑ Representative ❑ Other:___________

D. Crime Information

Please provide the following information about the act of international terrorism:

DATE OF CRIME
LOCATION OF CRIME (INCLUDE CITY AND COUNTRY)
BRIEFLY DESCRIBE CRIME (Use Supplemental Attached Form, if needed)
INJURIES TO VICTIM AS A RESULT OF THE CRIME ❑ Physical ❑ Emotional ❑ Property
BRIEFLY DESCRIBE INJURIES (Use Supplemental Attached Form, if needed)
LEAD INVESTIGATIVE AGENCY (if known)

E. Expenses

To help process your application more quickly, please consult the Application Instructions for information on the required documents to be included with your application.

Please check all applicable expenses or losses for which you are seeking reimbursement or payment from OVC. You may include related travel expenses for any of the following categories.

❑ Medical Expenses (including dental and rehabilitation costs) $___________________

❑ Mental Health Care Services $___________________

❑ Property Loss, Repair, and Replacement $___________________

❑ Description of Property Loss: ____
____

❑ Funeral and Burial Expenses $___________________

❑ Miscellaneous Expenses $___________________ (e.g., temporary lodging, local transportation, telephone costs, emergency travel)

Total Amount Requested $___________________

Do you anticipate incurring additional cost(s) related to this act of international terrorism, which may result in a claim for additional reimbursement or payment? ❑ Yes ❑ No

**Please note that it is not required to convert expenses to U.S. dollars.*

F. Collateral Sources (Other Sources of Financial Help)

To help process your application more quickly, please consult the Application Instructions for information on the required documents to be included with your application.

Do you currently have (or in the past had) any other source(s) of financial help that may cover your expenses?
❑ Yes ❑ No

If "yes", please acknowledge all of the sources of reimbursement or payment applied for or received in relation to this crime:

❑ Medical/Health Insurance
❑ Medicare/Medicaid
❑ Property/Auto Insurance
❑ Military/Veterans' Benefits
❑ Funeral/Burial Insurance
❑ Disability Insurance
❑ Vocational Rehabilitation Benefits
❑ Homeowners/Renters Insurance
❑ Restitution
❑ Emergency Assistance Programs
❑ Other (please list):____

____

Have you previously received any funds from, or has any of your expenses been paid for the victim on this form by, the U.S. Department of Justice (or any of its bureaus or offices such as the Office for Victims of Crime or the FBI) or its Emergency Assistance Programs?
❑ Yes ❑ No If "yes", how much? $___________________ For what? ______________________________

Please provide additional information on all of the above sources checked or received/identified (continue on Supplemental Sheet, Section F):

SOURCE	POLICY NUMBER (If applicable)
COMPANY (If applicable)	TELEPHONE
NAME OF INDIVIDUAL REIMBURSED	FAX
EMAIL (optional)	

Please Complete One:
❑ Social Security Number: _______________
❑ Employee Identification Number: ____________
❑ Other Identification Number (e.g., passport, driver's license, etc.): _______________

Status of Collateral Sources:
❑ Claim Pending; Amount ___________
❑ Claim Approved; Amount __________

Any unsatisfied judgment against a foreign government will be considered a collateral source of financial help, and your ITVERP reimbursement will be reduced accordingly, unless you agree to **NOT** sue the United States Government for satisfaction of that judgment by signing and dating the following:

I waive any right I may have to sue the United States Government for satisfaction and enforcement of my unsatisfied judgment against the foreign government for the act of terrorism for which I am claiming reimbursement from ITVERP.

Name Date

G. Service Provider Information

To help process your application more quickly, please consult the Application Instructions for information on the required documents to be included with your application.

Please supply the following information on individuals or agencies that provided services to the victim related to the act of international terrorism (continue on Supplemental Sheet, Section G).

NAME OF SERVICE PROVIDER			
STREET ADDRESS			
CITY	STATE	ZIP	COUNTRY
TELEPHONE	FAX	EMAIL (optional)	

Type of Assistance Provided: ____

Cost of Service(s) Rendered $_________________ Diagnosis or Condition: ________________________________

Are services ongoing? ❑ Yes ❑ No If Yes, how long will service continue? _____________________

Were you billed for the cost of the services? ❑ Yes ❑ No

Were the costs paid in full? ❑ Yes ❑ No If "yes", full amount paid $_____________________________

Were the costs paid in part? ❑ Yes ❑ No If "yes", partial amount paid $___________________________

By whom were either the full or partial payments made? Name/Telephone/Fax/Email (optional)/Claim Number (if applicable) ____

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H. Authorization, Consents, and Certifications

This release must be signed and dated before your application can be considered for expense reimbursement.

I agree to contact and repay ITVERP if I receive any payments from the persons or governments responsible for the act of international terrorism, a civil lawsuit, an insurance policy, or any other government or private agency to cover expenses for which I have already received payment from this program.

I hereby authorize any hospital, physician, funeral director, municipal authority, employer or union, insurance company, social service bureau, Social Security office, or any other person, firm, agency, or organization to furnish to the Office for Victims of Crime, ITVERP, or its representatives, any information requested, including medical records, diagnostic assessments, and mental health evaluations, needed to complete my claim for expense reimbursement. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby certify, subject to the penalty of fine or imprisonment or both, that I have provided all names and addresses of all other individuals who may be eligible to receive expense reimbursement in relation to the victim in this case, and I further certify that I have notified these individuals in writing, either by certified mail or hand delivery, that I have filed a claim for expense reimbursement in relation to the victim.

I hereby certify, subject to the penalty of fine or imprisonment or both, that I am neither directly nor indirectly responsible for the terrorist act for which I am seeking expense reimbursement.

I hereby certify, subject to the penalty of fine and imprisonment, that the information contained in the application for terrorism victim expense reimbursement is true and correct to the best of my knowledge.

____ _________________________

Victim/Claimant's Signature Date

____ _________________________

Representative's Signature (or signature of individual who assisted in the preparation of this application) Date

STREET ADDRESS		
CITY	STATE	ZIP
EMAIL		TELEPHONE