# GEORGIA CRIME VICTIMS COMPENSATION PROGRAM

CRIMINAL JUSTICE COORDINATING COUNCIL

## GEORGIA MASS CASUALTY APPLICATION

**Apalachee High School 9/4/2024**

104 Marietta Street, Suite 440 - Atlanta, GA 30303
Office (404) 657-2222 - Fax (404) 463-7652

### SECTION 1. VICTIM/WITNESS INFORMATION

Please provide information on the individual who was killed or injured as a result of a violent crime, or who witnessed a violent crime.

| Victim/Witness Name (First, Middle, Last.) | Gender<br>☐ Male ☐ Female | Date of Birth (MM/DD/YY)<br>/ / | Social Security Number (or TIN) |
|---|---|---|---|
| | | | |

**Demographic Data (For Statistical Use Only)**

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian and Other Pacific Islander
☐ White/Non-Latino/Caucasian ☐ Hispanic/Latino ☐ Other Race_____

**If 17 or older, is the victim a veteran?** ☐ Yes ☐ No **Is the victim disabled?** ☐ Yes ☐ No **If yes, is the disability a result of the crime?** ☐ Yes ☐ No

| Street Address (including apartment #) | City | State | Zip Code | Best Contact Phone Number |
|---|---|---|---|---|
| | | | | |

Email Address:

| Does the victim have health insurance, including Medicaid/Medicare?<br>☐ Yes ☐ No | If yes, name of Insurance Company. |
|---|---|

### SECTION 2. CLAIMANT INFORMATION

Complete this section if you are filing on behalf of a deceased victim, minor victim, incapacitated adult victim, or if you are not the victim, but are paying bills on behalf of the victim.

| Claimant Name (First, Middle, Last) | Date of Birth (MM/DD/YY)<br>/ / | Gender<br>☐ Male ☐ Female | Social Security Number (or TIN) |
|---|---|---|---|
| | | | |

**Demographic Data (For Statistical Use Only)**

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian and Other Pacific Islander
☐ White/Non-Latino/Caucasian ☐ Hispanic/Latino ☐ Other Race_____

**Are you a veteran?** ☐ Yes ☐ No **Are you disabled?** ☐ Yes ☐ No

| Street Address (including apartment #) | City | State | Zip Code | Best Contact Number |
|---|---|---|---|---|
| | | | | |

| Relationship to Victim/Witness | Email Address |
|---|---|
| | |

### SECTION 3. SECONDARY CONTACT INFORMATION

If your contact information changes, please provide information for a person we can contact to reach you about your claim. We will not disclose claim information to your secondary contact.

| Secondary Contact Name (First, Middle, Last.) | Best Contact Phone Number |
|---|---|
| | |

### SECTION 4. SUBROGATION AGREEMENT ACKNOWLEDGEMENT

**Please read this section carefully.** The person who is signing this application, either as the victim/witness or the claimant, **must be at least 18 years of age.**

By signing this section, I certify to date that I have not received any compensation as a result of this crime. I also acknowledge that if I recover any money by legal judgment, settlement, or restitution resulting from this crime, based on the recovery agreement, I may be responsible for repaying some or all amounts awarded to me, or on my behalf, by the Georgia Crime Victims Compensation Program. As such, I hereby agree that in consideration of an award by the Georgia Crime Victims Compensation Program, I assign, transfer and subrogate all claims, interests and rights of action that I may have against other parties or authorities up to the amount awarded by the Program.

X _____ _____
**Victim/Witness/Claimant Signature** (Original Signature Required) **Date**

### SECTION 5. CRIMINAL HISTORY & MEDICAL ACKNOWLEDGEMENT

**Please read this section carefully.** The person who is signing this application, either as the victim/witness or the claimant, **must be at least 18 years of age.**

A criminal history report will be completed on all victims/witnesses and claimants 18 years of age and older. I hereby authorize and understand that a criminal history report will be analyzed to determine eligibility for the Georgia Crime Victims Compensation Program; I also authorize any hospital, physician, medical facility, insurer or any other person or law enforcement agency that has knowledge relative to my claim to furnish information to the Georgia Crime Victims Compensation Board. If psychiatric assistance is requested, a separate authorization form may be required.

X _____ _____
**Victim/Witness/Claimant Signature** (Original Signature Required) **Date**

### SECTION 6. ACKNOWLEDGEMENT OF UNDERSTANDING

**Please read this section carefully.** The person who is signing this application, either as the victim/witness or the claimant, **must be at least 18 years of age.**

I hereby acknowledge that the Georgia Crime Victims Compensation Program will only award compensation if all of the programs eligibility requirements are met. I also acknowledge that the Georgia Crime Victims Compensation Program is the payor of last resort. As such, my benefits will be reduced by any monies I receive from any other source as a result of the crime, including insurance, restitution and civil suit settlements.

X _____ _____
**Victim/Witness/Claimant Signature** (Original Signature Required) **Date**