Date App. Rec'd._____
Date all Supporting Documentation Rec'd._____
ITVERP Claim Number:
_____

U.S. Department of Justice
Office of Justice Programs

OMB Number 1121-0309
Expiration: 04/30/10

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: <u>All applications</u> must include an <u>original signature</u> and <u>original receipts</u>.)***
_____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: _____ Country: _____
Telephone: _____ Fax: _____
E-mail (optional): _____
Date of Birth: _____

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

Gender: 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 E-mail (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

If Yes, please list all (additional information may be listed on the Supplemental Sheet in Section B-2):
Name: _____ Relationship: _____
Full Address: _____
Telephone: _____ Fax: _____ E-mail (optional): _____

B. Victim Information (Continued)

Check all that apply

Victim Eligibility:
____ United States Citizen/National
____ United States Government Officer
____ United States Government Employee:
____ Foreign Service National
____ Foreign Service Officer
____ Civil Servant
____ Other:_____

Is the Victim: 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: _____ Country: _____
Telephone: _____ Fax: _____ E-mail (optional): _____
Date of Birth: _____

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

Gender: Male ____ Female____ Country of Citizenship: _____

Relationship to Victim: ( ) 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
____ Other (please list):_____
_____

____ Disability Insurance
____ Vocational Rehabilitation Benefits
____ Homeowners/Renters Insurance
____ Restitution
____ Emergency Assistance Programs

Have you previously received any funds from, or have 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 it's 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: _____ Fax: _____ E-mail (optional): _____
Name of Individual Reimbursed: _____

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 _____

F. Collateral Sources (Other Sources of Financial Help) (Continued)

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: _____ E-mail (optional): _____
Type of Service Provided:_____
Cost of Service(s) Rendered $_____ Diagnosis or Condition: _____
Are services ongoing? Yes____ No____
If services are ongoing, how long will they 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/E-mail (optional)/Claim Number (if applicable)

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: _____
Telephone: _____
Email Address: _____