

## INTERNATIONAL TERRORISM VICTIM EXPENSE REIMBURSEMENT PROGRAM (ITVERP) ITVERP APPLICATION

**ELIGIBILITY:** Before you complete the ITVERP application, please consider whether you or the victim is eligible for the program, by answering the following questions:

- 1) Is the victim either a U.S. Citizen or a Foreign Service National who was an employee (or contractor with) the U.S. Government at the time of the incident?
- 2) Did the incident occur outside the United States?

If you answered no to one of the questions, you are not eligible for ITVERP and should not complete this application. If you answered YES to *both* questions, please proceed with completing the application. Please be aware the application requires considerable detail and make take significant time to fully complete.

### GENERAL INSTRUCTIONS

Please type or print clearly. Please do not use *any* white-out on this application. Attach additional supplemental sheets as needed for each expense category. If you have questions or would like assistance in completing this application, please contact an ITVERP case manager at 1-800-363-0441 or [itverp@ojp.usdoj.gov](mailto:itverp@ojp.usdoj.gov). Please include all supporting documentation with your application.

**Note:** ITVERP does not cover attorney's fees, lost wages, or non-economic losses such as pain and suffering, and loss of enjoyment of life, etc.

### A. APPLICATION TYPE

There is only one ITVERP application. However the type of application you submit depends on the kind of reimbursement you are requesting. Each type of application requires additional and/or different information. Please review the application types below to determine the type of application you are submitting. Choose only one.

|  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>Itemized Application</b><br><br>This is the most commonly used ITVERP application. If you have never filed an ITVERP claim, and are not asserting a substantial financial hardship, please check this box. | <input type="checkbox"/> <b>Supplemental Application</b><br><br>This is for ITVERP claimants who have already submitted an ITVERP application and now are submitting additional expenses for reimbursement that have not been previously submitted. Please include your claim number here:<br><br>_____ | <input type="checkbox"/> <b>Interim Emergency Application (Conditional)</b><br><br>This is for imminent financial hardship <i>only</i> . If you check this box, you must state a reason describing your substantial financial hardship. This type of application is limited to: <b>medical care, funeral and burial costs, and short-term lodging and emergency transportation.</b> |
|--|---|---|

**For Interim Emergency Applicants Only:** Please provide a detailed statement below about the substantial financial hardship you will incur if your ITVERP application is not processed as an Interim Emergency application. *(Attach additional paper if necessary).*

---

---

---

### **B. REQUEST FOR EXTENSION OF FILING DEADLINE**

Generally the filing deadline for an ITVERP claim is 3 years from the date of the terrorist incident. However, ITVERP regulations allow the Director discretion to waive this deadline, upon a showing of good cause. If you are a new claimant and are submitting this application 3 years after the date of the incident, please request a waiver and state the reason you missed the program's filing deadline.

---

---

---

### **C. CLAIMANT AND VICTIM INFORMATION**

There is only one claim per victim. The victim is the person who was injured or killed as a result of the incident and is often also the claimant for the purpose of submitting an application. However, sometimes the claimant is not the direct victim, but a family member or representative of the victim, who submits the application on behalf of the victim. The only exception to one claim per victim rule is when the victim is deceased and different family members apply for mental health expense reimbursement. In those cases, each family member would file their own claim for mental health reimbursement.

What is your relationship to the *victim*?

Self  Spouse  Child  Parent  Sibling  Other \_\_\_\_\_

#### **REQUIRED DOCUMENTS**

Please include all of the information requested below.

Victim Identification: A copy of a valid, government issued photo I.D.

Certificate of Death: A copy of a death certificate or some other official recognition of death, *if the victim is deceased.*

Claimant Identification: A copy of a valid, government issued photo I.D.

Claimant & Victim Relationship Verification: A copy of a legal document substantiating the relationship between the victim and claimant, such as a marriage certificate, birth certificate, power of attorney, will, health care directive, etc.

**CLAIMANT INFORMATION:**

The claimant is the person other than the victim, completing the application. If you are the victim, skip this section and go to Victim Information below.

|   |                    |  |               |  |
|---|--------------------|--|---------------|--|
| Claimant First Name   | Claimant Last Name | Middle Initial   | Date of Birth |  |
| Street Address  | City               | State  | Zip Code      |  |
| Country of Citizenship  | Telephone          | Sex:<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | E-mail        |  |
| Social Security Number/ Employee Identification Number/Other Identification Number: |                    |  |               |  |

**VICTIM INFORMATION:**

All ITVERP applications must include complete information about the victim. If you are the claimant, you must complete this section.

|   |                  |  |                |                 |
|---|------------------|--|----------------|-----------------|
| Victim First Name   | Victim Last Name | Middle Initial   | Date of Birth: | Place of Birth: |
| Street Address  | City             | State/<br>Country  | Zip Code       |                 |
| Country of Citizenship  | Telephone        | Sex:<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | E-mail         |                 |
| Social Security Number/ Employee Identification Number/Other Identification Number: |                  |  |                |                 |
| Victim's Employer (If victim was working abroad or for the U.S. Government)         |                  | Victim's Employer's Address  |                |                 |
| Victim's Supervisor/Contact Person - Name (If Known)                                |                  | Victim's Supervisor/Contact Person - Email and Phone (If Known)          |                |                 |

|  |  |
|--|--|
|  |  |
|--|--|

**D. INTERNATIONAL INCIDENT INFORMATION**

The incident must have occurred outside the United States.

|                               |                                      |                           |
|-------------------------------|--------------------------------------|---------------------------|
| Date of Incident              | Location of Incident (City, Country) | Lead Investigative Agency |
| Brief Description of Incident |                                      |                           |
| Brief Description of Injuries |                                      |                           |

**REQUIRED DOCUMENTS**  
 Please include any and all supporting documents related to the incident, such as a police report, news articles, pictures, etc.

**E. OUT OF POCKET EXPENSES**

1. Collateral Sources: ITVERP is a payer of last resort. This means that ITVERP will only provide reimbursement for out-of-pocket expenses that are *not* covered by some other source like an employer or insurance company. ITVERP will contact all other potential collateral sources to verify whether they covered the expense (in whole or in part) for which you are requesting reimbursement.
2. Service Providers: ITVERP will contact relevant service providers. ITVERP will verify receipt of services, the cost incurred, and if the service(s) were linked to the incident. If the services are not linked to the incident, the reimbursement request for that expense will be denied.
3. Third Party Contributions: If you are submitting expenses that another person(s) may have contributed to paying, such as other family members or relatives, these expenses are considered Third Party expenses. ITVERP regulations require that each claimant (the person filing the application) obtain third party approval from people who contributed to paying, in order for ITVERP to reimburse the claimant, on behalf of the third parties, for those expenses.
4. Currency Type: Please state all currency amounts in the same currency in which the out-of-pocket expense was incurred.

**REQUIRED DOCUMENTS**

In the appropriate expense categories below – you must include as much detail as possible (with supporting documentation) in order for ITVERP to contact your service providers. When

possible, you must submit copies of original receipts and copies of any documentation that you have, to help substantiate your expenses.

## F. MEDICAL EXPENSES

### Are you requesting reimbursement for out-of-pocket medical expenses?

No  Go to the Mental Health Expense section.

Yes  What is the total out-of-pocket expense in this category? \_\_\_\_\_

### Have any other sources or person(s) covered these medical expenses?

No  Go to the service provider section below.

Yes  Complete the chart below for *each* medical expense.

Applicable sources of coverage (or financial assistance) for each expense could include: private, group, employer or union health insurance providers, veteran's and/or military benefits, workers compensation, proceeds from civil litigation, state compensation, FBI emergency assistance, Medicare, SSI or SSDI.

For *each* expense you must attach copies of supporting documentation.

### Medical Expense *Please list each medical expense for which you are seeking reimbursement*

|                              |                                  |                                   |            |
|------------------------------|----------------------------------|-----------------------------------|------------|
| Describe the Medical Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred |            |
| Name of Service Provider     | Contact Person's Name:           | E-mail                            | Telephone: |
| Provider's Address           | City                             | State                             | Zip Code   |

### Medical Coverage *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

|                           |                             |                        |
|---------------------------|-----------------------------|------------------------|
| Coverage Source's Name    | Policy # - Acct # - Claim # | Contact Person's Name: |
| Coverage Source's Address | Source's Telephone          | Source's E-mail/Fax    |

For additional expenses, please refer to **Supplemental Sheet F: MEDICAL EXPENSES**

## G. Mental Health Expenses

**Are you requesting reimbursement for out-of-pocket mental health expenses?**

No  Go to the Property Loss Expense section.

Yes  What is the total out-of-pocket expense in this category? \_\_\_\_\_

**Have any other sources or person(s) covered these mental health expenses?**

No  Go to the service provider section below.

Yes  Complete the chart below for each mental health expense.

Applicable sources of coverage (or financial assistance) for each expense could include: private, group, employer or union health insurance providers, veteran's and/or military benefits, workers compensation, proceeds from civil litigation, state compensation, FBI emergency assistance, Medicare, SSI or SSDI.

For *each* expense you must attach copies of supporting documentation.

**Mental Health Expense** *Please list each medical expense for which you are seeking reimbursement*

|                                    |                                  |                                   |            |
|------------------------------------|----------------------------------|-----------------------------------|------------|
| Describe the Mental Health Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred |            |
| Name of Service Provider           | Contact Person's Name:           | E-mail                            | Telephone: |
| Provider's Address                 | City                             | State                             | Zip Code   |

**Mental Health Coverage** *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

|                           |                             |                        |
|---------------------------|-----------------------------|------------------------|
| Coverage Source's Name    | Policy # - Acct # - Claim # | Contact Person's Name: |
| Coverage Source's Address | Source's Telephone          | Source's E-mail/Fax    |

For additional expenses, please refer to **Supplemental Sheet G: MENTAL HEALTH EXPENSES**

## H. PROPERTY LOSS EXPENSES

**Are you requesting reimbursement for out-of-pocket property loss expenses?**

No  Go to the Funeral and Burial Expense section.

Yes  What is the total out-of-pocket expense in this category? \_\_\_\_\_

Required Supporting Documentation: For property loss, you must provide supporting documentation of the cost you incurred, such as copies of receipts, photographs, credit card statements or other documentation that shows the cost of the property at the time it was purchased.

Detailed Itemized List: If you do not have any documentation to support your property loss claim, you must submit an itemized statement with specific detail about the item, and attest, under penalty of perjury, that the information provided is true and correct to the best of your knowledge. Itemized lists without specific detail will not be accepted for property loss verification.

*Please list in detail, your specific items below.*

| Item Name                         | Detailed Description   | Cost at time of purchase | Was the item insured? | Attached Supporting Documentation |
|-----------------------------------|--|--------------------------|-----------------------|-----------------------------------|
| <i>Example:</i><br>Digital Camera | <i>1 Canon PowerShot S95 Camera with 10 megapixels, 4x zoom, 3" LCD display and SD memory card slot.</i> | <i>\$865.00USD</i>       | <i>No</i>             | <i>Receipt</i>                    |
| 1.                                |  |                          |                       |                                   |
| 2.                                |  |                          |                       |                                   |
| 3.                                |  |                          |                       |                                   |
| 4.                                |  |                          |                       |                                   |
| 5.                                |  |                          |                       |                                   |

For each expense you must attach copies of supporting documentation. For additional items, please refer to **Supplemental Sheet H: PROPERTY LOSS**

### CERTIFICATION

I certify that the information provided in this itemized list of property loss (and the attached Supplemental Sheet H: Property Loss) is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Claimant's Signature

## I. FUNERAL AND BURIAL EXPENSES

**Are you requesting reimbursement for out-of-pocket funeral and/or burial expenses?**

No  Go to the Miscellaneous Expense section.

Yes  What is the total out-of-pocket expense in this category? \_\_\_\_\_

For each expense you must attach copies of supporting documentation.

*Please list in detail, your requested expenses below:*

| Type of Expense            | Detailed Description  | Total Cost at time of purchase | Amount covered by other sources | Purpose of Expense                  | Attached Supporting Documentation |
|----------------------------|---|--------------------------------|---------------------------------|-------------------------------------|-----------------------------------|
| <i>Example:</i><br>Airfare | <i>Roundtrip airline ticket -San Diego, CA to Fort Knox, TN. for John Smith</i> | <i>\$498.00</i>                | <i>no</i>                       | <i>Attending induction ceremony</i> | <i>Bank statement</i>             |
| 1.                         |   |                                |                                 |                                     |                                   |
| 2.                         |   |                                |                                 |                                     |                                   |
| 3.                         |   |                                |                                 |                                     |                                   |
| 4.                         |   |                                |                                 |                                     |                                   |
| 5.                         |   |                                |                                 |                                     |                                   |

**Third Party Contributions:** Has any other person(s), such as a family member or friend paid for part of the out-of-pocket funeral and/or burial expenses for which you are seeking reimbursement?

No  Go to the Miscellaneous Expense section.

Yes  Complete the chart below.

| Person Who Paid | Contact Information for Person(s) Who Paid | Relationship | Amount Paid | For What Expense |
|-----------------|--|--------------|-------------|------------------|
| Name            | Address, e-mail and telephone              |              |             |                  |
| Name            | Address e-mail and telephone               |              |             |                  |

For additional items, please refer to **Supplemental Sheet I: FUNERAL & BURIAL**



## J. MISCELLANEOUS EXPENSES

**Are you requesting reimbursement for out-of-pocket miscellaneous expenses?**

No  Go to page 10.

Yes  What is your total out-of-pocket expense in this category? \_\_\_\_\_

For *each* expense you must attach copies of supporting documentation.

*Please list your specific expenses below.*

| Type of Expense   | Detailed Description   | Cost at time expense was incurred | Amount covered by other sources | Purpose of Expense                       | Attached Supporting Documentation |
|---|--|-----------------------------------|---------------------------------|--|-----------------------------------|
| <i>Example:<br/>Phone charges from Mumbai, India to Oakland, CA</i> | <i>Incurred expense while in Mumbai attending to victim's affairs, June 2004</i> | <i>\$384.28USD</i>                | <i>no</i>                       | <i>Putting victim's affairs in order</i> | <i>Phone bill</i>                 |
|   |  |                                   |                                 |  |                                   |
|   |  |                                   |                                 |  |                                   |
|   |  |                                   |                                 |  |                                   |
|   |  |                                   |                                 |  |                                   |

**Third Party Contributions:** Has any other person(s) such as a family member or friend paid for part of the out-of-pocket miscellaneous expenses for which you are seeking reimbursement?

No  Proceed to page 10.

Yes  Complete the chart below.

| Person Who Paid | Contact Information for Person(s) Who Paid | Relationship Between Claimant and Who Paid | Amount Paid | For What Expense? |
|-----------------|--|--|-------------|-------------------|
| Name      E-mai | Address, e-mail, telephone                 |  |             |                   |
| Name      AA A  | Address, e-mail, telephone                 |  |             |                   |

For additional items, please refer to **Supplemental Sheet J: MISCELLANEOUS**

DRAFT

**Instructions:** Please read each statement below. Your signature at the bottom indicates your agreement with the terms of the program and certification that all statements and information provided in this application are true and correct to the best of your knowledge.

**K. CONSENT**

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

**L. CERTIFICATION**

I hereby certify, subject to penalty of fine or imprisonment or both, that below I have listed all names and addresses of all other individuals who may be eligible to receive expenses reimbursement in relation to the victim in this claim.

---

---

---

---

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

I hereby certify, subject to penalty of fine or imprisonment or both, that the information contained in this application for the International Terrorism Victim Expense Reimbursement Program (ITVERP), is true and correct to the best of my knowledge.

---

Victim/Claimant Signature Date

---

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

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA Compliance)

I hereby authorize my health care provider to disclose my protected health information described below, to ITVERP. You may disclose this information to: ITVERP Resource Center, Office for Victims of Crime, 810 Seventh St. NW, Washington DC, 20531; fax: 202-514-6383 or by e-mail: [itverp@usdoj.gov](mailto:itverp@usdoj.gov).

I hereby authorize any physicians, clinics, psychologists, dentists, chiropractors, nursing homes, pharmacies, acupuncturists, naturopaths, to furnish ITVERP program 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 authorize any health insurance companies, HMO's, employer health plans, and government programs such as Medicare, Medicaid, and military and veterans' health care programs to furnish to ITVERP program 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 authorize 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 ITVERP program representatives, any information requested, to complete my claim for expense reimbursement. A photocopy of this authorization shall be considered as effective and valid as the original.

This authorization expires when ITVERP completes verification of my claimed expenses.

**Revocation:** I understand if I revoke this authorization the ITVERP expense verification process cannot be completed. I understand that to revoke this authorization I must submit a written letter to ITVERP stating authorization is revoked, or I may contact the ITVERP program representative and verbally revoke authorization. I understand revocation is only effective after it is received and recorded by ITVERP. Any use or disclosure made prior to revocation will not be affected as part of this revocation.

Once protected health information is disclosed to others, it may be re-disclosed to persons or entities that are not subject to privacy regulations. Therefore the protected health information may no longer be protected by federal privacy regulations.

---

Victim/Claimant Signature

Date

---

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

Date