Notarized Agreement

These terms are set forth fully in Virginia Code § 19.2-368. Your application will not be processed unless this form is signed on the signature line and witnessed by a Notary Public.

Collections

I agree that the Criminal Injuries Compensation Fund (The Virginia Victims Fund) may pay any award for my benefit directly to the person or entity to which I owe a payment as a result of the crime. I understand VVF will attempt to collect my award from the person responsible for the crime. I further agree that if I later recover money from any other source as a result of the crime, receive restitution or sue the person responsible for this crime and recover damages, I will immediately repay the VVF award. In the event I fail to repay a VVF award, I agree to be responsible for all collections costs allowed by law.

Oath

I affirm that I have reviewed this application and understand its contents. I swear it is true and complete to the best of my knowledge. I understand that if any information I submit is false, or if I have not fully cooperated with all law-enforcement agencies, including the criminal prosecution, the claim may be denied or revoked and collected upon.

Authorization:

I authorize any hospital, physician, counselor, funeral director, or other person who attended or examined

______________________________ (*the name of the victim*) and any 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 Criminal Injuries Compensation Fund (The Virginia Victims Fund), or its representative, any information requested, including tax data and prior police records, needed to complete the claimant's or victim's claim for benefits. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization is for the collection of information related only to this claim.

I further authorize the Criminal Injuries Compensation Fund (The Virginia Victims Fund) to disclose any and all information in my claim file, except those documents legally protected from dissemination, to the Victim Witness Assistance Program in the locality handling my case.

I HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS ABOVE. I swear or affirm that I am the Claimant; I have reviewed and understand all of the requirements of VVF. The information submitted is true and complete to the best of my knowledge and belief. I understand that submitting false information is a felony under 19.2-368.16 of the Code of Virginia.

______________________________ ______________________________

Print Claimant's Name — Claimant's Signature

City/County of ______________________, Commonwealth/State of ______________

Subscribed and sworn before me this ____________day of ________________, __________

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Signature of Notary Public

My commission expires the ______________day of__________________, _________

Notary Public Number: ____________________

Please note that the Criminal Injuries Compensation Fund (The Virginia Victims Fund) is a division of the Workers' Compensation Commission, which is exempt from HIPAA, and for HIPAA purposes, the Fund is a "payer" to which disclosures may be made without prior authorization.

Updated 02/12/2016