

# crime victim assistance program

## WITNESS APPLICATION



Under the Crime Victim Assistance Act, victims injured as a result of certain crimes, immediate family members of an injured or deceased victim, and some witnesses may be eligible for financial assistance or benefits from the Crime Victim Assistance Program.

Ministry of Public Safety and Solicitor General, Victim Services Division, administers the Crime Victim Assistance Program in accordance with the Crime Victim Assistance Act and regulations.

## instructions

### WITNESS APPLICATION

#### WHICH APPLICATION FORM SHOULD YOU USE?

Under the Crime Victim Assistance Act, a WITNESS is a person who may not necessarily be related to the victim, but has strong emotional attachments to the victim *and* witnesses or comes upon the scene of a crime that caused a life-threatening injury to, or the death of, the victim.

To be eligible for benefits, a witness must have suffered diagnosed psychological harm.

As a witness, you may be eligible for counselling, prescription drug expenses and transportation and related expenses.

If this definition does not apply to you, please see the application forms for VICTIMS or IMMEDIATE FAMILY MEMBERS.

1. Please print clearly and complete all sections. Omissions may delay the processing of your application form.

2. On page W-5, please sign the Authorization and Declaration.

**Applications without the required signatures will be returned.**

3. Mail the **original application and any attachments to:**

**The Crime Victim Assistance Program  
PO Box 5550, Stn Terminal,  
Vancouver, BC V6B 1H1**

Applications by fax cannot be accepted as original signatures are required.

4. The submission of complete and accurate information will assist in processing your application.

5. Please inform the Crime Victim Assistance Program of any changes of address or telephone number.

Local victim service programs can help you complete this application. To locate a program in your community call the toll-free Victims Information Line at 1-800-563-0808.

If you have any questions, please contact The Crime Victim Assistance Program at (604) 660-3888 or toll free in B.C. at 1-866-660-3888, or visit the Government of British Columbia Web site at <http://www.gov.bc.ca>

In the search field enter "Crime Victim Assistance Program".



## section 1. witness information (applicant)

This section provides your information as a **witness** of a crime. If you are an immediate family member or legal representative applying on behalf of a witness, complete Section 5 (Application on behalf of a witness) along with the rest of this application form. *(Do not complete Section 5 if you are simply "helping" the victim complete the application.)*

If you have changed your name, provide your previous name and the date on which your name changed.

**Alternate mailing address:** provide an alternate mailing address *(e.g. the address of a family member)* in case mail sent to your **complete mailing address** is returned to us. Include postal codes.

**Telephone numbers:** provide your home telephone number and alternate numbers. Include area codes.

**Complete every section of this application carefully.**

## section 2. victim information

This section provides necessary information about the **victim**. This information is needed in order to register your application and will assist in determining your eligibility for benefits.

If you know the victim changed his or her name, please provide their previous name and the date of the name change.

**CRIME VICTIM ASSISTANCE**  
witness application for benefits

Claim # W  
CPO # W

## section 1. witness information (applicant)

|  |                        |                         |  |             |
|--|------------------------|-------------------------|--|-------------|
| Applicant's Name<br><br>(Last) (First) (Middle)              |                        |                         | <input type="checkbox"/> Female<br><input type="checkbox"/> Male |             |
| Previous Name (if applicable)<br><br>(Last) (First) (Middle) |                        |                         | Date of Name Change<br>Month / Day / Year                        |             |
| Date of Birth<br>Month / Day / Year                          | Relationship to Victim | Occupation              |  |             |
| Complete Mailing Address                                     |                        | City                    | Province   | Postal Code |
| Alternate Mailing Address                                    |                        | City                    | Province   | Postal Code |
| Home Telephone ( )   | Business Telephone ( ) | Social Insurance Number |  |             |
| Messages ( )   |                        |                         |  |             |

## section 2. victim information

|   |                        |  |  |             |
|---|------------------------|--|--|-------------|
| Victim's Name<br><br>(Last) (First) (Middle)  |                        |  | <input type="checkbox"/> Female<br><input type="checkbox"/> Male |             |
| Previous Name (if applicable)<br><br>(Last) (First) (Middle)  |                        |  | Date of Name Change<br>Month / Day / Year                        |             |
| Date of Birth<br>Month / Day / Year   | Marital Status         | Occupation                                   |  |             |
| Complete Mailing Address  |                        | City   | Province   | Postal Code |
| Home Telephone ( )  | Business Telephone ( ) | Social Insurance Number                      |  |             |
| Messages ( )  |                        |  |  |             |
| Did the injury or death occur during the course of the victim's employment, or as the result of a motor vehicle accident?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                        |  |  |             |
| Is the victim deceased as a result of the crime?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                        | If yes, date of death:<br>Month / Day / Year |  |             |

## section 3. crime information



This section provides information and details about the crime.

**Type of crime:** indicate the type of crime that occurred. It is not necessary to provide the Criminal Code section, rather *describe* the offence (*e.g. home invasion, assault*).

**Date(s) of crime:** provide the date(s) of the crime. If the crime occurred over a period of time, please provide the approximate dates (*e.g. September 2001 – December 2001*).

**Location of crime:** provide the city/town in B.C. where the crime took place. If the crime occurred over a period of time in more than one location, please provide the names of **all locations**.

**Police report:** if a complaint was filed with the police, please complete the appropriate sections. Incomplete information will result in delays in processing this application.

**Name of alleged offender:** provide the name of the person who allegedly committed the crime, if known.

**Relationship of the alleged offender to the victim (if any):** indicate the victim's relationship, if any, to the person who allegedly committed the crime (*e.g. the alleged offender is the victim's ex-husband, mother, close family friend*).

**Charges:** have the police charged the alleged offender with a crime? Check one box.

**Court file number:** if charges against the alleged offender have been approved by Crown counsel, a court file number will be assigned to the case. This is NOT the same as the police file number. If known, provide the court file number.

**Injury sustained as a result of the crime:** describe the injury you sustained as a result of witnessing the crime.

**Describe the incident in your own words:** provide a brief description of the crime.



## section 4. witness medical information

This section provides information regarding any treatment you received as a result of the crime. This will assist us in determining your entitlement to benefits.

Advise if you have medical coverage and extended health coverage. If applicable, provide your personal health care number and the name of your extended health care provider. *(For B.C. residents, your personal health care number can be found on your B.C. Care Card.)*

If you are eligible for prescription drug expenses and counselling expenses from another source, provide us with the name of the source that may provide these benefits *(e.g. employer's insurance plan)*.

**Complete all applicable sections, including addresses and phone numbers.**

## section 5. application on behalf of a witness

Complete this section only if you are an immediate family member or legal representative applying on behalf of a witness.

If you are an immediate family member applying on behalf of a witness, describe your relationship to the witness *(e.g. mother)*.

If you are a legal representative applying on behalf of the witness, describe your authority *(e.g. Public Guardian & Trustee)*.

**DO NOT complete this section if you are simply “helping” the witness to complete the application form.**

A legal representative is someone who has the legal authority to act on behalf of a victim.

Claim # \_\_\_\_\_

CPO # \_\_\_\_\_

## section 4. witness medical information

Name of counsellor/therapist who has been providing treatment (if applicable)

|  |      |                  |             |
|--|------|------------------|-------------|
| Counsellor/Therapist<br>(Last) (First) |      | Telephone<br>( ) |             |
| Complete Mailing Address               | City | Province         | Postal Code |

Name of family physician providing ongoing medical treatment for injuries received (if applicable).

|                                    |      |                  |             |
|------------------------------------|------|------------------|-------------|
| Family Physician<br>(Last) (First) |      | Telephone<br>( ) |             |
| Complete Mailing Address           | City | Province         | Postal Code |

|  |   |
|--|---|
| Do you have medical coverage?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | If yes, provide personal health number  |
| Do you have extended health coverage?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | If yes, provide the name of your extended health provider (e.g. Blue Cross) and extended health plan number |
| Are you eligible for prescription drug expenses and counselling expenses from another source (other than above)?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name of source: _____ |   |

## section 5. application on behalf of a witness

|   |   |          |                            |  |
|---|---|----------|----------------------------|--|
| Person completing the application<br>(Last) (First) (Middle)                                    |   |          | Telephone<br>( )           |  |
| Complete Mailing Address  | City  | Province | Postal Code                |  |
| Are you an immediate family member?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what is your relationship to the applicant? |          |                            |  |
| Are you a legal representative?<br><input type="checkbox"/> Yes <input type="checkbox"/> No     | If yes, what is your authority?                     |          |                            |  |
| Signature   |   |          | Date<br>Month / Day / Year |  |

## section 6. authorization



This section authorizes the Crime Victim Assistance Program to obtain information from other persons, institutions, agencies and/or organizations for use in processing your application. Fill out, sign and date this section. **Your application will be returned to you if this section is not signed and dated.**

If you have any questions about the collection and use of the information gathered by the Crime Victim Assistance Program, contact us at (604) 660-3888 or toll free in B.C. at 1-866-660-3888.

## section 7. declaration



By signing this section you declare the information provided to be true and correct. Making a false declaration may result in a denial of your application. Complete, sign and date this section. **Your application will be returned if this section is not signed and dated.**

## section 6. authorization

This authorization must be signed before the claim will be processed.

Claim # W

CPO # \_\_\_\_\_

Information supplied on this form is necessary to determine eligibility for benefits under the Crime Victim Assistance Act and is collected under the authority of s. 6 of that Act. Any information collected will be used only for the purposes of adjudicating this claim.

I, \_\_\_\_\_ hereby authorize:

please print

1. The doctor or other health care professional who treated my injuries (physical and/or psychological) to give the Crime Victim Assistance Program, on request, medical or other reports regarding my injuries, treatment or other information relevant to this application;
2. The police or other law enforcement authorities to give the Crime Victim Assistance Program, on request, a copy of police reports, statements, incident reports or other information relevant to this application;
3. The Workers' Compensation Board or other authority from which the victim received or will receive or will be eligible to receive payments from provincial, federal or other jurisdictions funds to give the Crime Victim Assistance Program, on request, information relevant to this application;
4. My employer(s) or similar authority to give the Crime Victim Assistance Program, on request, information as to my employment, earnings, benefits or other information relevant to this application;
5. Any accident, disability, sickness, life insurance/assurance company or private pension scheme or extended health benefits scheme from which payments or services were received or will be received to give the Crime Victim Assistance Program, on request, information relevant to this application;
6. Human Resources Development Canada or Indian and Northern Affairs Canada or any other authority from which payments were received or will be received to give the Crime Victim Assistance Program, on request, information relevant to this application;
7. The Employment Insurance Commission of Canada or the Canada Pension Plan or similar employment insurance and pension plans from other jurisdictions, to give the Crime Victim Assistance Program, on request, information as to benefits received or to be received relevant to this application; and
8. Canada Customs and Revenue Agency or other similar agency in any other jurisdiction, to give the Crime Victim Assistance Program, upon request, information as to my employment income.

I understand that the Crime Victim Assistance Program may notify the above authorities that I have submitted an application for benefits pursuant to the Crime Victim Assistance Act.

Applicant's Signature

Date

Month / Day / Year

## section 7. declaration

This declaration must be signed before the claim will be processed.

I am applying for benefits available to witnesses under the Crime Victim Assistance Act, and

I, \_\_\_\_\_ declare the information in this application is true and correct.

please print

Applicant's Signature

Date

Month / Day / Year



The Government of B.C. ensures the needs of victims of crime are considered in the development and implementation of legislation, policies, procedures and operations throughout the criminal justice system.

The Crime Victim Assistance Program has been implemented to assist victims, immediate family members and witnesses who have been impacted by criminal offences.

In addition, the Government also funds agencies across the province that provide services to people who have been affected by crime. These services include a provincewide toll-free Victims Information Line (1-800-563-0808) as well as victim service programs operating in non-profit agencies and local police detachments and departments throughout the province. These programs provide information about the justice system, practical help, emotional support and referrals to other appropriate programs.

Please Note: The Crime Victim Assistance Program does not cover injuries or loss sustained from motor vehicle accidents, injuries or loss sustained out of, or during the course of employment, claims for pain and suffering and/or loss of stolen personal property. Benefits provided from other sources will be deducted from benefits available under the Act.