LOST WAGE CLAIMS

Who may be eligible for Lost Wage Claim Reimbursements:

1. An innocent victim of violent crime who either physically or mentally is unable to return to work due to the crime. The victim must have had gainful employment immediately prior to the crime, have an offer of employment, or be a seasonal employee.

2. A parent/guardian who must miss work to take a dependent to a medical or mental health provider due to the dependent being an innocent victim of a violent crime or whose dependent was critically injured due to being an innocent victim of a violent crime and must be cared for by the parent/guardian.

The following must be included in order to receive lost wage reimbursement:

1. Employment Verification Form (filled out by employer, unless the victim is self-employed)

2. Lost Wages/Earnings Claim Form (filled out by victim/claimant)

3. Claim Form For Disability Verification
    a. Must be submitted when more than one week of work is missed
    b. Must be completed and signed by the victim's doctor
    c. Disability Dates MUST be filled in

4. Proof of income
    a. Two or three payroll check stubs for the periods immediate prior to the crime
    b. If payroll check stubs are not possible, or if the victim was self-employed, submit a copy of the previous year's federal income tax return

5. If lost wages reimbursement is being claimed to take a child to a medical or mental health provider, paperwork documenting the visit(s) must be attached along with the information above.

LOST WAGES/EARNINGS CLAIM FORM

CVR NUMBER: _____ Victim Name: _____

Claimant Name: _____

Your claim investigator is: _____ Phone #: _____

NOTE: The CVR Board does NOT guarantee full payment of your lost wages.

Who is Claiming Lost Wage Reimbursement? The Victim __ or The Parent/Guardian __ ?

STEP 1. GATHER THE FOLLOWING DOCUMENTATION TO VERIFY LOST WAGES/EARNINGS

1. Have employer complete the EMPLOYMENT VERIFICATION FORM.
2. If you missed more than one week of work, you must have your physician complete the attached DISABILITY VERIFICATION form and attach it to the claim form when complete. Otherwise, only one week can be reimbursed.
3. If you are self-employed, you must submit a copy of your tax return from the year prior to the crime incident and any contracts, bids, estimates, or other documents which might help verify your earnings and attach them to this claim form.
4. If you are not self-employed, you must also include 3-4 pay stubs or your last tax return and/or W-2 with your claim.
5. Proof of any disability income.

STEP 2. ANSWER THE FOLLOWING QUESTIONS ABOUT LOST WAGES/EARNINGS

1. Dates absent from work due to crime-related injuries:

   From ___/____/____ to ____/_____/____ = _____ Total Weeks Absent

   How many days did you work a week?_____How many hours did you work each day?_____

2. Lost Wages/Earnings lost per week = $ _____ X -----_____ = $ _____ Lost Wage Total
   Wkly Wage Wks out work

3. Did you miss more than one week of work? [ ] Yes [ ] No
   If yes, your physician MUST complete the DISABILITY VERIFICATION Form.

4. Was the loss of ANY of your wages/earnings covered in part/full by any of the following sources? _____

   If yes: Beginning Date _____ Ending Date _____

   Amounts received per week/month: _____

   [ ]Union coverage [ ]Disability insurance [ ]Workers' Compensation [ ]Sick Pay

   [ ] Vacation Pay [ ]Unemployment [ ]Other, (specify) _____

   List all insurance and/or benefits plans that might cover this loss:

   Company Name _____ Phone:_____

   Policy Number _____ Group Number _____

   Address: _____
   (Street, City, State, & Zip Code)

   NOTE: IF ANY TYPE OF COVERAGE IS AVAILABLE, YOU MUST APPLY FOR THOSE BENEFITS BEFORE FILING WITH THE CVR PROGRAM.

STEP 3. Claimant Signature: _____ Date: _____

Print Name: _____

EMPLOYMENT VERIFICATION FORM

THIS FORM IS TO BE COMPLETED BY THE VICTIM'S EMPLOYER

CVR NUMBER:

VICTIM:

VICTIM SSN:

CLAIMANT:

ADDRESS:

DATE OF CRIME:

CLAIMANT INSTRUCTIONS:
1) Ask the victim's employer to complete and return this form to you.
2) Give completed form to your claim investigator.

EMPLOYER INSTRUCTIONS:
1) A claim is being made for wages lost as a result of an injury of the victim referenced to the left, and caused by a crime on the date shown.
2) Complete this form, verifying the actual earnings lost and return to the claimant.

Name of Business: _____ Victim's Job Title: _____

Business Address:_____ Victim's Supervisor: _____

_____ Phone #.: ( ) _____

Victim employed: [ ] FULL TIME [ ] PART TIME [ ] OTHER HOW LONG EMPLOYED? _____ (Years/Months)

Days a week victim worked: [ ] Monday; [ ] Tuesday; [ ] Wednesday; [ ] Thursday; [ ] Friday; [ ] Saturday; [ ] Sunday; [ ] Schedule varies

Victim absent from work: FROM: _____/_____/_____ TO: _____/_____/_____ = _____
Total weeks out of work

Date returned to work: _____/_____/_____ [ ] Did not return to work

INCOME/EARNINGS CALCULATION

Please check one:

RATE OF PAY: $ _____ per: [ ] Hour [ ] Week [ ] Month [ ] Other _____

How many days does employee work a week?_____ How many hours does employee work each day?_____

OVERTIME/COMMISSION: $_____ per [ ] Week [ ] Month [ ] Other _____

Was employee paid for time off from work? [ ] Yes [ ] No DISABILITY INCOME : $ _____

WORKMEN'S COMP: $_____ BEGINNING DATE _____ ENDING DATE _____

LOST WAGE INCOME: $ _____ X _____ = $ _____
Wkly Income Wks/Out of Wk

($ _____) (Less: Wkrs. Comp, Social Security, etc.)

= $_____ Lost Wages (Adjusted)

VERIFYING SIGNATURE

_____
AUTHORIZED SIGNATURE

_____
DATE

_____
PRINTED NAME

(____)_____
PHONE

_____
TITLE

CVR CLAIM FORM FOR DISABILITY VERIFICATION

THIS FORM IS TO BE COMPLETED BY THE DOCTOR WHO TREATED THE VICTIM

CVR NUMBER: _____

VICTIM: _____

CLAIMANT: _____

DATE OF CRIME: _____

CLAIMANT INSTRUCTIONS:
1) Have the victim's doctor or dentist complete this form and return it to you.
2) Attach the completed form to your claim.
3) Give to your claim investigator.

PROVIDERS:
Please complete this form on behalf of victim and return to victim/claimant.

ABOUT THIS FORM

The victim has provided us with a written release to obtain and review their medical records. The information you provide will be used to verify information already provided by your patient. It will be kept confidential. (R..S. 46:1806 (c)(1).

Briefly describe the extent of injuries and treatment rendered:

_____

_____

_____

Was the treatment you provided a *direct* result of the crime? ____ No ____ Yes

Did these injuries require critical care of victim? _____Yes ____ No

Did the crime-related injury aggravate or accelerate a pre-existing condition? ____ No ____ Yes, Please explain:

_____

_____

Was the patient ABLE to return to normal job duties immediately? _____Yes ____ No

If no, was this due to injuries/emotional distress resulting from being a crime victim? _____Yes ____ No

Please list specific dates of disability: From: _____ to _____

Treatment is: (check only one) _____Completed _____ Ongoing _____ Permanent

Prognosis: Treatment plan, estimate of duration:_____

_____

_____

List medication(s) prescribed as a result of injury: _____

CERTIFICATION

I hereby certify that the above report truly and correctly sets the history, my findings, diagnosis, and opinion.

_____ _____ _____
Practitioner's Signature License Number Date

_____ _____
Printed Name Telephone Number

_____
Completed Address

Only a surgeon, medical doctor, oral surgeon, psychiatrist, or an ophthalmologist may determine disability.

Note: You may attach additional remarks or write on the back of this form.