

## Complete This Application If

If you are victim of violent crime in accordance with the *Victims of Crime and Public Safety Act*, you may be eligible for a reimbursement of related out of pocket expenses through the Emergency Crime Victim Assistance Program. Please note there is a maximum amount of reimbursement available for related out of pocket expenses. If a police agency, or Victim Service Unit, has completed a form on your behalf, you are not required to resubmit this form. If you are unsure, please contact the program.

## Instructions - What You Should Do

1. If filling in by hand, please **PRINT** clearly.
2. Complete all sections that apply to you - missing information may delay your application.
3. Ensure you sign the **Consent in Section 5** and the **Declaration in Section 6**. **Applications without these signatures will be returned.**
4. A reimbursement payment will not be issued until the damage and/or loss has been verified.
5. Mail, fax or email the application to: Victims of Crime Assistance Program  
10th Floor, 10365-97 Street  
Edmonton, Alberta T5J 3W7  
Fax: 780-422-4213  
Email: [victimsofcrime@gov.ab.ca](mailto:victimsofcrime@gov.ab.ca)

## What We Will Do

- A. We will request details of the crime from the police and verify if the eligibility criteria has been met.
- B. We will request medical information, when necessary, to verify medically required aid repair or replacement.

Your local Victim Services Unit may also assist you with completing your application. You can find your Victim Services Unit through your local police service or online at <https://www.alberta.ca/victim-services-units.aspx>.

If you have questions about your Emergency Crime Victim Assistance application, call the program at 780-427-7217 or toll-free through Service Alberta at 310-0000 and enter 780-427-7217. Additional information is also available on our website at [www.victims.alberta.ca](http://www.victims.alberta.ca).



Protected B (when completed)

Victims of Crime Assistance Program

The personal information provided on this form and attachments is collected under the authority of the *Victims of Crime and Public Safety Act* and managed in accordance with the *Freedom of Information and Protection of Privacy Act* pursuant to s.33 (a) and (c). The information will be used for the purpose of verifying eligibility for emergency assistance. If you have any questions about the collection of this information, you may contact the program at 780-427-7217.

## Section 1 - Victim's Personal Information

Mr.  Mrs.  Miss  Ms

First Name	Middle Name	Last Name	Gender <input type="radio"/> Male <input type="radio"/> Female
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other Names Used (i.e., alias, maiden name or name change)		Date of Birth dd-mmm-yyyy	Alberta Health Care Number
<input type="text"/>		<input type="text"/>	<input type="text"/>
Mailing Address	City/Town	Province/Territory	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your Preferred Phone Number	Email Address		
<input type="text"/>	<input type="text"/>		

**\*If your address or telephone number changes, advise the program as soon as possible so they are able to contact you when necessary.**

## Section 2 - Applicant's Contact Information

**You must be 18 years of age or older to be an applicant. Complete this section ONLY if the victim is under 18 years of age or is otherwise unable to apply on their own.**

- You must provide legal documentation verifying guardianship.
- If you are a single parent with custody of the victim who is under 18, documentation may be required.

Mr.  Mrs.  Miss  Ms

First Name	Middle Name	Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Mailing Address	City/Town	Province/Territory	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone	Work Phone	Cell Phone	Email Address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
What is your relationship to the victim?			
<input type="text"/>			

**Section 3 - Crime Information**

Type of Crime (i.e. assault, robbery)

Date(s) of Crime dd-mmm-yyyy

Location of Crime (city/town)

Was Crime Reported to Police?

Date Crime Reported dd-mmm-yyyy

Yes  No

Police Service Crime Reported to (i.e. Edmonton Police Service, Vulcan RCMP)

Police File Number

Accused Name(s) (if known)

**You may choose to briefly describe the crime below OR attach the statement you made to police.**

**Time Limitation**

- Application must be submitted within forty-five (45) days of the offence taking place to be eligible for the Emergency Assistance Program.

Is this application being submitted within forty-five (45) days of the date of the offence?  Yes  No

**If no**, briefly explain your reasons for the delay.

## Section 4 - Emergency Assistance Types

- A. **Out-of-pocket expenses** - a maximum total amount of \$300 may be provided for all items being requested in this category, such as:

Please note, that there may be individual expense maximum amounts noted.

**(Check all that apply)**

- Lock (damage or broken)
  - Dead bolts, bars, peepholes, etc.
  - Window contact alarms
  - Window/doorstops/guards
  - Motion sensors
  - Prepaid calling cards (maximum \$30)
  - Window/door damage
  - Meals/groceries
  - Basic necessities
  - Care for dependants or pets
- B. **Emergency Accommodation** (maximum \$600) - applicants may be eligible for funding to help cover the costs of temporary accommodation where they are unable to return to their homes following the crime for safety reasons or due to a police investigation.
- Funding covers the cost of the accommodation (e.g. hotel room charge) only, and victims/recipients are responsible for paying for any additional charges associated with the accommodation.

Accommodation required:  Yes  No      Number of Nights (1-3): \_\_\_\_\_

- C. **Replacement or Repair of Medically Required Aids** (maximum \$1000) - victims may be eligible for secondary funding to repair or replace medically required aids, such as walkers, etc., if the entire cost is not covered through another provincial or federal program.

Applications for these benefits must be submitted within six months from the date the offence occurred. The repair or replacement of the aid must be done within one year of the offence.

Medical Aid replacement/repair required:  Yes  No

I have sought and received funding from other applicable federal and provincial sources for this medically required aid:  Yes  No

**NOTE: Invoices and/or receipts will be required.**

### Section 5 - Consent to Release Personal Information

Victim's First Name

Victim's Last Name

Date of Birth dd-mmm-yyyy

Section 13.1 of the *Victims of Crime and Public Safety Act* authorizes the Director or a delegated employee (referred to here as the Director) to collect and use personal information about a victim to assess eligibility for the program. This includes, but is not limited to, information about diagnosis, treatment or care and other incidents and activities that may affect the eligibility decision or amount of assistance provided. In addition, the victim or their representative/applicant provides the following express consent.

I hereby authorize:

- (a) **Any police service, other agency or government department** involved with the investigation of the alleged crime(s) identified in this application, to disclose to the Director:
  - (i) Any information directly or indirectly related or unrelated to the alleged crime(s) identified in this application that the Director requests, and
  - (ii) Any information regarding any related or unrelated federal offence convictions and associated sentences imposed on the victim that the Director requests;
- (b) Any **medical hospital/facility and any health care professional/provider or government department** to disclose personal health records which are directly or indirectly related to the incident identified in the application to the Director;
- (c) The Director to release information, including relevant sections of the application, to police, health care facilities, treatment professionals, other agencies or government departments as may be necessary to obtain the information requested under (a) or (b) for the purpose of making a determination on the application.

I understand that I may revoke this consent at any time by advising the Director in writing.

I understand that if this consent is revoked, or if I fail to provide the information requested by the Director, it may affect the ability of the Director to assess this application.

I understand why I have been asked to consent to disclose this information and I am aware of the risks or benefits of consenting or refusing to consent to disclose this information.

**\*\*This application will be returned if this section is not completed.  
Must be over the age of 18 to sign. If you are not, please contact the program.**

Name of Victim/Applicant

Date Signed dd-mmm-yyyy

Victim's/Applicant's Signature

**Note to custodians of health information:** Section 34 of the *Health Information Act* authorizes a custodian to disclose health information with the consent of the individual concerned. Section 35(1)(p) authorizes a custodian to disclose health information where the disclosure is authorized or required by another enactment, which includes the *Victims of Crime and Pubic Safety Act*.

[Empty box]

**Section 6 - Declaration**

I am applying for assistance under the *Victims of Crime and Public Safety Act*, and

I, \_\_\_\_\_, declare the information in this application is true and correct.  
Victim/Applicant Name

**\*\*This application will be returned if this section is not signed and dated.**

Date Signed dd-mmm-yyyy  
[Empty box]

Victim's/Applicant's Signature  
[Empty box]

**Section 7 - OPTIONAL Consent**

**Would you like the program to be able to discuss your application with another person?**

Privacy legislation does not allow us to speak to anyone but the victim or applicant about an application without written authorization being provided.

**Consent to discuss your application with another person.**

I, \_\_\_\_\_, authorize the Emergency Crime Victim Assistance Program  
Victim/Applicant Name

to discuss my application with \_\_\_\_\_.  
Name of the Person you are giving Authorization to

**This consent can be revoked at any time by the victim/applicant.**

Phone  
[Empty box]

Relationship to Victim  
[Empty box]

Date Signed dd-mmm-yyyy  
[Empty box]

Victim's/Applicant's Signature  
[Empty box]