

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 psychological counselling support. Please note there is a maximum amount coverage. 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 **Declaration in Section 5. Applications without these signatures will be returned.**
4. 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

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 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.

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* s.33 (a) and (c). The information will be used for the purpose of verifying eligibility for the counselling program. If you have any questions about the collection of this information, you may contact the program at 780-427-7217.

Section 1 - Applicant's Personal Information

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

****You must be 18 years of age or older to be an applicant.**

*****If you are applying on behalf of minor victims or dependent adult victims, guardianship papers may be required.**

Section 2 - Dependent's or Other Impacted Family Members Requiring Counselling Support

Check which category applies (only one may be chosen)

Applicant as Victim **(Please continue to Section 3)**

If applying on behalf of a minor or dependent adult victim **(Please complete section 2 - A)**

Please note, Section 5 must be signed by the legal guardian of the minor or dependent adult victim. Documentation may be required to verify guardianship

Family group - related to a homicide victim **(Please complete section 2 - B)**

2A - Applicant on behalf of minor or dependent adult victim

Victim's First Name	Middle Name	Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Date of Birth yyyy-mm-dd	Verification ID Type (i.e. Alberta Health Care Number)	Verification ID Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Is victim's contact information same as applicant? Yes No If No, provide contact details below

Mailing Address	City/Town	Province/Territory	Postal Code
<input type="text"/>	<input type="text"/>	Alberta	<input type="text"/>
Phone Number	Alternate Phone Number	Email Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

2B - Related to a homicide victim. NOTE: if family member is 18 years or older, their signature will be required on Section 5.

Names of Family Group Members who will require counselling support

First Name of Family Member	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Relationship to Deceased Victim	Contact Number if Different from Applicant	Date of Birth yyyy-mm-dd
<input type="text"/>	<input type="text"/>	<input type="text"/>

Add Row **Remove Row**

Section 3 - Crime

Type of Crime (i.e. assault, robbery)	Date(s) of Crime dd-mmm-yyyy
<input type="text"/>	<input type="text"/>
Location of Crime (city/town)	Was Crime Reported to Police? <input type="radio"/> Yes <input type="radio"/> No
<input type="text"/>	<input type="text"/>
Police Service Crime Reported to (i.e. Edmonton Police Service, Vulcan RCMP)	Police File Number
<input type="text"/>	<input type="text"/>
Accused Name(s) (if known)	
<input type="text"/>	

Time Limitation

- Application must be submitted within forty-five (45) days of the offence taking place to be eligible for the Victims of Crime Counselling 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 - Counselling Provision

Have you been provided with contact information for a counselling provider from a Victims Services Unit, police agency or the Victims of Crime Assistance Program from where you will be receiving counselling support related to this incident?

Yes No

- **If no**, please contact the program directly at 780-427-7217 (Toll Free 310-0000) or email: victimsofcrime@gov.ab.ca
- **If yes**, what is the name of the counselling provider?

Name of Counselling Provider

o Contact information for provider:

Phone Number

Email Address

Section 5 - Declaration

I am aware that, Section 13.1 of the *Victims of Crime and Public Safety Act* authorizes the Director, or a delegated employee, to collect and use personal information about a victim to assess eligibility for the program. This includes, but is not limited to, information about treatment, care, or other similar medical services to the victim, and recommendations for further treatment, and other incidents and activities that may affect the eligibility decision or amount of assistance provided.

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

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

Applicant Full Legal Name

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

Date Signed dd-mm-yyyy

Applicant's Signature

Section 6 - OPTIONAL Consent

The *Victims of Crime and Public Safety Act* s.13.1(4)(b), allows the Director to disclose information to a parent, spouse, child or other family member of the applicant or the victim for the purposes of confirming the existence or status of an application or disclosing the amount of any award.

If you would like to limit who may discuss this application, please contact the program to indicate your preferences.