



# CRIMINAL INJURIES COMPENSATION

Level 12, International House, 26 St George's Terrace, Perth WA 6000

Postal Address: GPO Box F317, PERTH WA 6841

Ph: (08) 9425 3250 Fax: (08) 9425 3271

Email: [criminal.injuries@justice.wa.gov.au](mailto:criminal.injuries@justice.wa.gov.au) Web address [www.justice.wa.gov.au](http://www.justice.wa.gov.au)

## APPLICATION FORM

(Please read the document 'How To Complete Your Criminal Injuries Application Form' before completing the form. If you require assistance, contact the Office of Criminal Injuries Compensation. **Please ensure you keep copies of all your documents.**

### Criminal Injuries Compensation Act 2003

#### (A): APPLICANT'S DETAILS: Please write using BLOCK LETTERS in DARK INK

1. Full Name of Applicant:	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/>		
	SURNAME:		
	GIVEN NAME(S):		
2. Capacity if claiming on behalf of applicant	SURNAME:		
	GIVEN NAME(S):		
	Relationship to Applicant (i.e. parent, guardian):		
3. Applicant's postal Address:			
4. Phone Numbers:	Home:		
	Work:		
	Mobile:		
5. Applicant's Date of Birth:		6. Applicant's Occupation:	
7. Extension of Time Required?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach a signed statement of reasons for late application.		

#### (B) ACKNOWLEDGEMENT OF APPLICATION

Please ensure you complete the following slip with your name and address so that we can acknowledge your application

NOTE: The address in the box is where the acknowledgement will be sent!

#### ACKNOWLEDGEMENT SLIP

**We will provide you with the rest of this number by mail**

Your CIC reference number is CI / \_\_\_\_\_ - \_\_\_\_\_

**This box to be completed by the applicant or representative**

Solicitor's Reference: \_\_\_\_\_

Name	_____	This is to confirm that Criminal Injuries Compensation has received your application
Address	_____	
City/Town/ Suburb	_____ P/Code _____	

<b>CHECKLIST - Have you:</b>			
1.	Attached a signed and dated request for an extension of time if required, Q7?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	Attached a signed and dated statement of the incident Q18?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Attached a signed and dated statement of the impact of the injury, Q28?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Attached a treatment plan and estimate of cost for interim payment if sought, Q30?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	Attached an account for the report cost for interim payment if sought, Q30?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	Completed Table 1 for medical expenses and attached accounts, Q31?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7.	Attached a report and quote for future treatment costs if sought, Q32?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8.	Completed Table 2 for travel expenses if sought, Q33?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9.	Attached details of personal items damaged if sought, Q34?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10.	Attached supporting documents for loss of income if sought, Q35-37?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11.	Attached details for loss of support and funeral expenses if sought, Q39&40?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12.	Ticked the section under which your claim is made, Part G?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13.	Signed and dated the application form, Part H?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14.	Filled in the acknowledgement slip, Part B?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15.	Keep a copy of the application form and all documents attached to it?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**(C) INCIDENT DETAILS: Please complete every section in BLOCK LETTERS with DARK INK**

Please note this page is scanned for office use and must include ALL details, even if they are provided elsewhere in the application.

8. Date of incident and Place of incident (suburb):	
9. Nature of Incident: i.e. Assault	
10. Incident Report or Offence Report Number(s):	(Please ensure that the whole number is included)
11. Name of Victim of Offence:	
12. Person who reported the offence (complainant):	
13. Address of complainant at date of report:	
14. Date offence reported to police:	
15. Where offence was reported:	
16. Name of Police Officer who took the complaint:	
17. Name(s) of Offender(s) if known:	
18. Statement of Events:	Please attach signed statement outlining details of the incident(s) in full.

**(D) PROSECUTION DETAILS**

19. Was a person charged?:	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please answer questions 19-27
20. What was the charge?	
21. Court where charge heard:	CPS/Magistrates Court <input type="checkbox"/> District Court <input type="checkbox"/> Supreme Court <input type="checkbox"/> Children's Court <input type="checkbox"/>
22. Date of Hearing:	
23. Outcome(s):	
24. Offender(s) address: if known:	
25. Offender(s) assets: if known:	
26. Was Restitution Ordered?	Yes <input type="checkbox"/> amount \$ No <input type="checkbox"/>
27. Has Restitution been Received?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how much has been received: \$

**(E) CLAIMS INVOLVING INJURY: PLEASE USE DARK INK**

<b>28. Injury:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> Attach signed statements of Injury & Impact, & medical reports. <b>If you answer No to this question, then you are not eligible for compensation.</b>	
<b>29. Loss:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes answer questions 30 to 37: if you leave a question unanswered it will be taken that you make no claim for that item of loss.	
<b>30. Interim Payment Claim:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, answer (i) to (iv) below to indicate payment required.	
	(i) Name of Health Professional:	
	(ii) Address:	
	(iii) Treatment Plan and Estimate:	Please attach details.
(iv) Report Cost:	Attach invoice or account.	
<b>31. Treatment and Report expenses:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete Tables 1 and 2 and attach receipts and Medicare or private insurance statement of benefits.	
<b>32. Future treatment expenses:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach detailed report and quotation.	
<b>33. Travel:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete Table 3 attached.	
<b>34. Personal Items:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach description and estimated value.	
<b>35. Loss of Earning or Earning Capacity:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach all supporting documents.	
	Centrelink:	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach details.
	Estimate of Earnings Lost:	\$                      gross                      \$                      net
<b>36. Workers Compensation:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes advise name of insurer and attach supporting documents.	
	Weekly Payments Received:	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach details.
	Expense Received:	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach details.
<b>37. Any Other Benefits, Compensation, etc:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> Provide full details.	

**(F) CLAIMS BY PERSONAL REPRESENTATIVE on behalf of DECEASED VICTIM FOR LOSS SUFFERED BY A CLOSE RELATIVE: Please use separate forms if applying under part (e) and part (f)**

<b>38. Claim by a Personal Representative of a Deceased Person:</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete questions 39 & 40.	
<b>39. Loss of Financial Support for Dependents:</b>	Please attach detailed statement.	
<b>40. Funeral Expenses:</b>	Name of person who incurred the cost.	
	Receipt or Account.	Please attach.
	Relationship to victim.	
	DCD Burial Grant.	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach details.
	Interim Payment for Funeral Cost.	Yes <input type="checkbox"/> No <input type="checkbox"/>



**PLEASE USE DARK INK**

**TABLE 2 Question 31: Treatment Expenses**

Are you a member of a Private Health Fund Yes  No

"A" DATE	"B" PROVIDER	"C" SERVICE	"D" NUMBER	"E" COST	"F" M/CARE	"G" PRIVATE	"H" GAP
<b>TOTAL:</b>							

**TABLE 3 Question 33: Travel Expenses**

DATE	NAME OF DOCTOR, DENTIST ETC	FROM (SUBURB or TOWN)	TO (SUBURB or TOWN)	TOTAL NUMBER OF KILOMETRES PER RETURN TRIP (USING PRIVATE VEHICLE ONLY)	RETURN FARE (BUS, TRAIN & TAXI ONLY)

**AUTHORITY TO PAY UNPAID ACCOUNT OR INVOICE DIRECT TO SERVICE PROVIDER**

If you would like any unpaid account for treatment, report costs or ambulance expenses paid by the Office of Criminal Injuries Compensation direct to the Service Provider from your compensation award, please complete the authority below and ensure you have enclosed a copy of the unpaid account or invoice and the address for payment.

I, \_\_\_\_\_ authorise the office of Criminal Injuries Compensation to pay the amount of  
 (Name of Applicant)  
 \$ \_\_\_\_\_ to \_\_\_\_\_ of \_\_\_\_\_

from the proceeds of any compensation award made to me on this Application.

\_\_\_\_\_  
 (Signed) (Dated)