



## CRIMINAL INJURIES COMPENSATION APPLICATION - FORM 1

Please read the 'Guide to Lodging an Application' to assist you to complete this form. 'The Act' refers to the *Criminal Injuries Compensation Act 2003*

### PART A: APPLICANT'S DETAILS

**Note: The applicant is the person on whose behalf the application is made.**

<b>1</b> Is this application a claim for: (select more than one option if appropriate)	<input type="checkbox"/> Injury (bodily harm, mental and nervous shock or pregnancy).
	<input type="checkbox"/> Loss arising from death (funeral expenses or loss of financial support). <b>IF SO, USE FORM 2 for that claim.</b>
	<input type="checkbox"/> Neither (you are not eligible for compensation unless you were injured in the commission of an offence, or suffered loss when a close relative died).
<b>2</b> Are you making this application on behalf of: (select more than one option if appropriate)	<input type="checkbox"/> Yourself.
	<input type="checkbox"/> A parent or person in place of a parent for a child under 18 years of age.
	<input type="checkbox"/> A person with a disability as the person's guardian or administrator (provide copies of your authority).
	<input type="checkbox"/> The personal representative of a deceased person <b>IF SO, USE FORM 2 for that claim.</b>

<b>3</b> Provide the details of the applicant:			
Name	Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>		
	Surname:		
	Given Name/s:		Date of Birth:     /     /
Address			
Telephone	Home:	Mobile:	Work:
Email Address	This will be the default method of communicating with you unless otherwise requested		
Motor Vehicle Drivers Licence number	Licence No:	Occupation:	
Is there a person you authorise to speak to us on your behalf?	Name:	Relationship to you:	
	Phone:		
Email address	This will be the default method of communication unless otherwise requested		

<b>4</b> If you are making this application on behalf of the applicant, provide your details below:			
Name	Surname:		
	Given Name/s:		Date of Birth:     /     /
Address			
Telephone	Home:	Mobile:	Work:
Email Address	This will be the default method of communicating with you unless otherwise requested		
Your relationship to the applicant	<input type="checkbox"/> Parent <input type="checkbox"/> A person with a disability as the guardian or administrator (provide copies of your authority)		

<b>5</b> Are you represented by a lawyer?	Firm Name:	Practitioner Name:	Mr <input type="checkbox"/> Ms <input type="checkbox"/>
	Address:		
Lawyer's Email address	This will be the default method of communication unless otherwise requested		
Lawyer's Phone number	Lawyer's reference:		

**IMPORTANT NOTICE:** The Office of Criminal Injuries Compensation maintains records in electronic format. Please ensure you keep copies of all documents you submit, and submit only a copy of any document you need to retain. All documents submitted with your application will be destroyed when your application has been finalised.

## PART B: INCIDENT AND PROSECUTION DETAILS

**Note: For multiple incidents please complete a separate Part B for each incident.**

<b>6</b>	Please provide date of incident.		
<b>7</b>	Did the incident, or the last incident involving this offender, occur less than 3 years ago?	<input type="checkbox"/> Yes	
		<input type="checkbox"/> No: The Act states an application should be lodged within 3 years from the date of the incident or the last incident involving the same offender. Please attach a signed statement explaining why your application is lodged outside of this time.	
<b>8</b>	Where in WA did the incident occur?		
<b>9</b>	Was this a work related incident?	<input type="checkbox"/> Yes	Name of Workers' Compensation insurance provider: _____
			Claim Number: _____
<b>10</b>	Was a motor vehicle involved?	<input type="checkbox"/> Yes	Insurance Commission of WA Claim Number: _____
<b>11</b>	What was the nature of the incident?	(e.g. assault, sexual offence, murder etc.)	
<b>12</b>	Do you have a copy of the statement you made to the police?	<input type="checkbox"/> If yes: Attach a copy, you can obtain a copy of your statement from WA Police.	
		<input type="checkbox"/> No: Please attach a signed statement detailing the incident.	
<b>13</b>	Was the incident reported to Police/Public Transport Authority/Railway Police?	<input type="checkbox"/> Yes	
		<input type="checkbox"/> No: Give a statement detailing the incident and explaining why a report was not made.	
<b>14</b>	Do you know the Incident Report number?	<input type="checkbox"/> If yes: Provide the Incident Report number <input type="checkbox"/> No	
<b>15</b>	Do you know the name/s of the offender/s?	<input type="checkbox"/> Yes: Give details below	
		Surname: _____	Surname: _____
		Given Name/s: _____	Given Name/s: _____
<b>16</b>	Do you know the whereabouts of the offender/s?	<input type="checkbox"/> Yes: Please give details of the offender/s' whereabouts.	
<b>17</b>	Is the police investigation finalised?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>18</b>	Was a person charged ?	<input type="checkbox"/> Yes: What was/were the charge/s? _____	
		<input type="checkbox"/> No	
<b>19</b>	Is the matter finalised in Court?	<input type="checkbox"/> Yes	<input type="checkbox"/> No: When is the next Court date? _____
<b>20</b>	Select the court where the charge was heard	<input type="checkbox"/> Magistrates Court	<input type="checkbox"/> District Court
		<input type="checkbox"/> Supreme Court	<input type="checkbox"/> Children's Court
<b>21</b>	What was the outcome?	<input type="checkbox"/> Guilty	<input type="checkbox"/> Unknown
		<input type="checkbox"/> Not Guilty	<input type="checkbox"/> Date of the outcome: _____
<b>22</b>	Was the offender ordered to pay money to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> How much?
		Has any been received: <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, how much?    \$ _____

## PART C: CLAIMS

The maximum interim payment is \$2,250.00 for an incident after 1 January 2003.

<b>23</b> Are you making a claim for an interim payment?	Yes: Select the option/s that best describes your application for an interim payment. <input type="checkbox"/> I need treatment expenses paid <input type="checkbox"/> I need ambulance expenses paid <input type="checkbox"/> I need to obtain a report (medical, dental or psychological) <input type="checkbox"/> I need funeral expenses paid for a deceased close relative <b>IF SO, USE FORM 2 for that claim.</b>
--	---

Claims for Injury									
<b>24</b> What were your injuries?	Eg bodily harm, mental and nervous shock or pregnancy Attach a statement of the injuries you suffered and the impact of your injuries on you. Include recent photos showing any scars if appropriate.								
<b>25</b> Provide documents to demonstrate the injuries you suffered	<input type="checkbox"/> Report/s from your treating health care professional/s (attach the relevant report/s).								
	<input type="checkbox"/> Hospital/s and health care provider/s where you received treatment.								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Name of health care provider:</td> <td></td> </tr> <tr> <td>Name of hospital/practice:</td> <td></td> </tr> <tr> <td>Address of hospital/practice:</td> <td></td> </tr> <tr> <td>Contact number of practice:</td> <td></td> </tr> </table>	Name of health care provider:		Name of hospital/practice:		Address of hospital/practice:		Contact number of practice:	
	Name of health care provider:								
	Name of hospital/practice:								
	Address of hospital/practice:								
	Contact number of practice:								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Names of health care provider:</td> <td></td> </tr> <tr> <td>Names of hospital/practice:</td> <td></td> </tr> <tr> <td>Address of hospital/practice:</td> <td></td> </tr> <tr> <td>Contact number of practice:</td> <td></td> </tr> </table>	Names of health care provider:		Names of hospital/practice:		Address of hospital/practice:		Contact number of practice:	
	Names of health care provider:								
	Names of hospital/practice:								
Address of hospital/practice:									
Contact number of practice:									
<input type="checkbox"/> None of the above. If you did not have any treatment attach a signed statement explaining why.									

### Claims for Reports (medical, dental, psychological, counselling)

**26** If you are claiming the cost of reports, complete the table below and attach invoices to support your claim.

Reference number	Date	Name of the health care professional	Cost of the report provided	Has the report been paid	
				Yes	No
1.				<input type="checkbox"/>	<input type="checkbox"/>
2.				<input type="checkbox"/>	<input type="checkbox"/>
3.				<input type="checkbox"/>	<input type="checkbox"/>
4.				<input type="checkbox"/>	<input type="checkbox"/>
5.				<input type="checkbox"/>	<input type="checkbox"/>

If you want to claim an interim payment for a report you have **already obtained** complete the table below.

Include the reference number and health care professional details noted in question 26 for the report for which you wish to claim an interim payment		Select who should receive the interim payment		
Reference number	Name of the health care professional	You	Health Care Professional	Other (parent, lawyer)
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**27** If you want to claim an interim payment for a report(s) that you have **not yet obtained** complete the table below and attach quotes/invoices.

Name of the health care professional who will provide the report	Cost of the proposed report

**Claims for Travel Expenses:** You can only claim for travel expenses which were incurred to obtain treatment. These must be supported by accounts, receipts and reports.

**28** If you are claiming for travel expenses complete the table below and ensure the accounts, receipts and reports you have provided support your claim for each journey.

Date	Name of the health care professional	Starting location (provide address)	Destination (provide address)	Total number of kilometres return trip (private vehicle)	Fare (Bus, Train, Ambulance and Taxi)

**Claims for Treatment Expenses:** If you are claiming for treatment expenses, you must first claim all available private health insurance and Medicare rebates. Complete the Table below and ensure you provide copies of each invoice, receipt and rebate.

**29** Do you have private health insurance?  Yes: Provide the name of your private health insurance fund below.  No

Reference number	Date	Name of the health care professional	Service provided	Cost of the service provided	Private health insurance rebate amount received (if applicable)	Medicare rebate amount received (if applicable)	Gap (Cost less rebate amount)
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

**30** Complete the table below if you want an interim payment for a treatment expense you have *already incurred*.

Include the reference number and health care professional details noted in question 29 for treatment for which you wish to claim an interim payment.		Select who should receive the interim payment		
Reference number	Name of the health care professional	You	Health Care Professional	Other (eg parent)
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**31** Complete the table below if you want to claim an interim payment for treatment expenses you have *not yet incurred* for treatment you wish to undergo *before* your application is finalised.

Name of the health care professional who will provide the treatment	Treatment required	Cost of the proposed treatment

<b>32</b> Are you claiming for loss of <u>income</u> or loss of <u>earning capacity</u> ?	<input type="checkbox"/> Yes: Select the options that best describes your claim. <input type="checkbox"/> Loss of income: <input type="checkbox"/> Loss of earning capacity:
---	--

<b>33</b> Are you claiming for loss of earning capacity? (current and/or future)	<input type="checkbox"/> Yes: Provide a detailed statement and provide the documents requested below after question 35. Ensure the claim is supported by the reports, and briefly describe the income you are currently prevented from earning and/or are going to be prevented for earning in the future.
--	--

<b>34</b> Did you receive any income while you were unfit for work?	<input type="checkbox"/> No <input type="checkbox"/> Yes: Select the options that describe how you were paid and provide documents in support <input type="checkbox"/> Sick leave or other paid leave (e.g. annual leave) <input type="checkbox"/> Centrelink benefit <input type="checkbox"/> Workers' compensation <input type="checkbox"/> Personal accident or income protection insurance <input type="checkbox"/> Other form of income support. Please attach a signed statement giving details.
---	--

<b>35</b> How much income did you receive?	<input type="checkbox"/> Net: \$ _____ <input type="checkbox"/> Gross: \$ _____
--	---

Include copies of the following documents as part of your claim for loss of income, if relevant:

Pay slips (6 weeks before the incident and all pay slips after the incident when your income was affected)

Copies of your tax returns for the 3 years before the incident and all since the injury

Letter from your employer detailing your pre-incident average net earnings, hours worked and any paid leave

**Claims for Personal Items:** You are not entitled to compensation for the value of lost or stolen property such as jewellery, wallet, phone etc..

**36** If you want to claim for any personal items (clothing, footwear, spectacles, hearing aid, artificial limbs) which were damaged in the incident, complete the table below.

Item Damaged	Detail the damage and how it was caused	Estimated value/ replacement cost

**Claims for Provision for Future Treatment Expenses**

<b>37</b> Are you likely to incur expenses for treatment <b>after your application has been finalised</b> ? e.g. dental, counselling etc	<input type="checkbox"/> Yes: Provide details of the nature of the treatment, the expected costs and any available private health insurance or Medicare rebates and attach a letter/report from your health care professional.
---	--


## PART D: PAYMENT DETAILS

Bank Account Details				
If your claim is successful, payments can be made via electronic funds transfer (EFT) to your or your lawyer's bank account. Provide your bank details below if you wish to receive EFT payment. If you do not wish to receive funds via EFT a cheque will be sent to the address given in question 3 or 4.				
Account Name				
Account Number		BSB Number	_ _ _ _ _	
If you would like money paid to someone else (e.g. a service provider) complete the authority for the Office of Criminal Injuries Compensation to make payments to another person on your behalf from your compensation.				
Name				
Service provider/ business name				
Amount to be paid				
Address or EFT details of the person you would like to be paid.	<b>Address</b> (Cheque)			
	<b>OR</b>			
	<b>EFT Details</b>	Account Name:		
		Account Number:		
BSB Number:		_ _ _ _ _		
Signature		Date		

## PART E: DECLARATIONS

Select the section of the <i>Criminal Injuries Compensation Act 2003</i> under which your claim is made			
<b>Section 12:</b> <i>Proved offence – offender convicted</i>	<input type="checkbox"/>		
<b>Section 13:</b> <i>Alleged offence – accused acquitted, applicant claims another person committed the offence</i>	<input type="checkbox"/>		
<b>Section 14:</b> <i>Alleged offence – accused acquitted due to unsoundness of mind</i>	<input type="checkbox"/>		
<b>Section 15:</b> <i>Alleged offence – accused not mentally fit to stand trial</i>	<input type="checkbox"/>		
<b>Section 16:</b> <i>Alleged offence – charge not determined</i>	<input type="checkbox"/>		
<b>Section 17:</b> <i>Alleged offence – no person charged</i>	<input type="checkbox"/>		
Acknowledgement of Application			
If you would like the Office of Criminal Injuries Compensation to acknowledge receipt of your application, please tick the check box. Acknowledgement will be sent via your preferred method of communication (email or post). Ensure you have provided this information in part A of this application.	<input type="checkbox"/>		
<b>I understand that:</b>			
<ul style="list-style-type: none"> <li>the assessor will give written notice of the making of my application to the offender, and may if requested provide copies of supporting documents to the offender;</li> <li>the assessor may seek and receive further information and evidence from any other source/s the assessor thinks necessary;</li> <li>it is an offence knowingly to give false information in support of an application for compensation, the maximum penalty for which is a fine of \$5,000;</li> <li>the assessor may deduct from any compensation any amount I owe under a compensation reimbursement order;</li> <li>the assessor may be required to pay any debt I owe to the Fines Enforcement Registry (FER) out of any compensation awarded;</li> <li>the documents submitted with this application will be destroyed after finalisation of the application and only electronic copies will be retained;</li> <li>I must keep a copy of the documents submitted with the application.</li> </ul>			
Name		Date	
Signature			

## HOW DO I LODGE MY APPLICATION?

Email: [criminal.injuries@justice.wa.gov.au](mailto:criminal.injuries@justice.wa.gov.au)

Mail: GPO Box F317 PERTH WA 6841

In person: Level 10, Golden Square, 32 St Georges Terrace PERTH WA 6000

Application Form 150318