

**LOUISIANA CRIME VICTIMS REPARATIONS BOARD
APPLICATION FOR HEALTHCARE PROVIDERS OF SERVICES
TO VICTIMS OF SEXUALLY-ORIENTED CRIMINAL OFFENSES**

Office: (225) 342-1749 Nationwide Toll-Free (888) 6-VICTIM www.lcle.la.gov/cvr

Date Application Received _____ CVR # _____

THIS BOX IS TO BE COMPLETED BY THE CVR OFFICE

This application must be completely filled out and signed by an authorized representative of the healthcare provider.
PLEASE PRINT! You have one year from the date of the crime to file this application.

VICTIM INFORMATION

Name: (First, Middle, Maiden and Last) _____

Complete Mailing Address: _____

Date of Birth: _____ Social Security #: _____ Date of Crime: _____

Did the alleged offense occur in Louisiana? _____ What Parish did the offense occur in? _____

If you are unsure what Parish the offense occurred in, please provide the name of the city. _____

STATISTICAL INFORMATION

Sex (Please circle.)		Victim's Age at Time of Crime	Ethnic Background (Please circle.)					
Male	Female	_____	Black	American Indian	Asian	White	Hispanic	Alaskan Native

If the victim chose to file with his/her insurance company, please complete the following insurance information:

Did the victim file with his/her insurance company? Yes No The victim has no insurance.

Company Name _____ Phone _____

Policy Number _____ Group Number _____

Address _____

(Street, City, State, & Zip Code)

If the victim is a minor, was the sexual assault reported to law enforcement? Yes No

If yes, what specific agency was the sexual assault reported to? _____

LIST ALL EXPENSES. Attach current itemized bills, and EOBs if applicable, for each charge listed below.

Provider Name	Total Charge +	Collateral Payments -	Paid by Claimant -	Owed to Providers =

On behalf of the healthcare provider, I authorize the Crime Victims Reparations Board to review this application in accordance with R.S. 46:1802. I agree and certify that no person shall incur any legal liability to me by releasing any information pursuant to this authorization. A photocopy or exact reproduction of this signed release shall have the same force and effect as the original. I understand that willfully and knowingly providing false information could result in a fine or imprisonment. I certify subject to penalty of law that all information submitted with this application is correct and true to the best of my knowledge and that losses to be claimed are a direct result of the crime.

Healthcare Provider Name: (Hospital, Clinic, etc.) Name: _____

Complete Mailing Address: _____ FEI #: _____

Contact Name: _____ Phone #: _____ Fax #: _____

E-Mail Address: _____ Job Title: _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE HEALTHCARE PROVIDER:

_____ Date: _____

**PLEASE SEND THIS FORM AND REQUIRED ATTACHMENTS TO THE CRIME VICTIMS REPARATIONS BOARD OFFICE:
LCLE/CVR, P.O. Box 3133, Baton Rouge, LA 70821**