



## Financial Relief for Victims Emergency Fund Application

Date of Request \_\_\_\_\_ County \_\_\_\_\_

### Applicant's Information

Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
*(Full SS# is Required for Prescription Requests Only; All other requests, last 4 of SS#; If victim doesn't have SS#, leave blank)*

Sex  Male  Female

Race  Asian  African American  Caucasian  Hispanic  Other

Date of Crime \_\_\_\_\_

Was the Crime Reported? **Yes** **No** Incident Report Available? **Yes** **No**

*If "yes", please submit incident report along with this application; If "no", give description of events below. Use additional paper if necessary. **Applications submitted without description or incident report, will be denied.***

### Type of Crime: *(Please check all that apply)*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Adult Physical Assault | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Stalking              |
| <input type="checkbox"/> Adult Sexual Assault   | <input type="checkbox"/> DUI/DWI Incident  | <input type="checkbox"/> Survivors of Homicide |
| <input type="checkbox"/> Arson                  | <input type="checkbox"/> Elder Abuse       | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Burglary               | <input type="checkbox"/> Human Trafficking |  |
| <input type="checkbox"/> Child Physical Abuse   | <input type="checkbox"/> Kidnapping        |  |
| <input type="checkbox"/> Child Sexual Abuse     | <input type="checkbox"/> Robbery           |  |

### Please make sure to include number of victims below:

**TOTAL** Number of primary and secondary victims' services will assist \_\_\_\_\_

**\*\*Number of children under the age of 2** \_\_\_\_\_

### Type of Need: *(Please check all that apply)*

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Clothing   | <input type="checkbox"/> Home Repairs | <input type="checkbox"/> Medical Equipment - Other _____                                       |
| <input type="checkbox"/> Crime Scene Clean Up   | <input type="checkbox"/> Locks        |  |
| <input type="checkbox"/> Expenses to Attend Court Hearings <i>(complete additional information section below)</i> | <input type="checkbox"/> Lodging      | <input type="checkbox"/> Prescriptions <i>(complete additional information section below)</i>  |
| <input type="checkbox"/> Food <i>(complete additional information section below)</i>                              | <input type="checkbox"/> Dentures     | <input type="checkbox"/> Towing/ Storage   |
|   | <input type="checkbox"/> Glasses      | <input type="checkbox"/> Transportation <i>(complete additional information section below)</i> |



**Additional Information**

**Expenses to Attend Court Hearings**

- Lodging
- Meals
- Bus Ticket
- Other \_\_\_\_\_

**Food**

- Meals
- Groceries (choose store and include store #)
  - Bi-Lo # \_\_\_\_\_
  - Food Lion # \_\_\_\_\_

**Prescriptions** *(please attach copies of prescriptions or list names of drugs below)*

- Rite Aid # \_\_\_\_\_
- Other Pharmacy \_\_\_\_\_

List Meds Here: \_\_\_\_\_

**Transportation**

- Bus Ticket for Safety - Ticket Cost \_\_\_\_\_
- Other \_\_\_\_\_

**OPTIONAL**

The following information is needed for grant writing purposes (Please check all that apply)

- Child
- Disabled/Handicapped
- Native American
- Elderly
- Minority

Annual Household Income

- Under \$10,000
- Under \$20,000
- Under \$30,000

If this victim would like to be added to the SCVAN's Mailing List/Listserv, please include email address:

**Victim Service Provider Information**

Name \_\_\_\_\_

Agency \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email Address \_\_\_\_\_

*(required for approval notification)*

I have reviewed, signed and submitted the Emergency Fund Guidelines & Procedures and certify that this application meets the funding criteria and is not supplanting other resources. I certify that a crime was committed against this applicant (and have provided that information in writing).

Signature of Victim Service Provider: \_\_\_\_\_ Date \_\_\_\_\_

**Application Submission for Approval**

Email: [funds@scvan.org](mailto:funds@scvan.org)

Fax: 1.888.965.5634