Office of the Attorney General

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Emergency Responder Death Benefit Claim Form

INSTRUCTIONS: The department shall award up to a maximum of $50,000 to the surviving spouse, children, parents or guardian, or siblings of a deceased emergency responder who is killed answering a call for service in the line of duty. Fill out the form completely, attach all required documentation, and submit to the address shown above. Failure to submit the necessary documentation will result in a denial of benefits.

SECTION ONE. VICTIM INFORMATION

Please provide the emergency responder's information. (please print)

Victim's Name (last, first, middle)

Date of Birth	Social Security Number

This information is collected for federal reporting purposes and is optional.

Race/Ethnicity (circle one) American Indian/Alaska Native | Asian | Black/African American | Hispanic/Latino | Native Hawaiian or Other Pacific Islander | White Non-Latino/Caucasian | Other | Multiple Races

Gender (circle one) Male Female

National Origin _____

SECTION TWO. APPLICANT AND DEPENDENT INFORMATION

To be completed by the spouse, adult child, parent or guardian of a minor child, or adult sibling. (please print)

Applicant's Name (last, first, middle)

Date of Birth	Social Security Number		
Email Address	Would you like all correspondence sent by email? Yes No		
Address	City	State	Zip code
Telephone Number (area code first)	Alternate Phone Number (area code first)		
Relationship to Victim / Occupation	Is the application and law enforcement report being submitted within one year from the date of crime? (circle one) Yes No *(if no, explain)*		

Are you the parent or guardian of a minor child or sibling of the deceased? Yes No (if no, skip to the next row)

List all minor dependents below.

Name (last, first, middle)	Date of Birth	Relationship to Victim

Review and initial each of the following verifications.

_____ I acknowledge understanding that if two or more persons are entitled to the benefit, the award will be distributed among all eligible applicants at the time the award is processed, and at the discretion and direction of the department.

_____ I agree that the department may deny, reduce, or withdraw any award if the department has previously approved or paid out for the same incident.

_____ I affirm that I have reviewed the qualifications and disclosures section below, and understand that additional qualification criteria, deadlines, and exceptions not listed may apply.

The applicant must sign and date their signature to acknowledge understanding that under penalty of perjury or fraud, the information provided is true and correct to the best of their knowledge.

Applicant Signature _____ **Date**_____

SECTION THREE. LINE OF DUTY VERIFICATION

To be completed by an individual has the appropriate authority given by the victim's employer to verify the qualifications of eligibility. (please print)

Name of Person Verifying (last, first, middle)

Name of Agency/Organization	Telephone Number (area code first)	Email Address	
Address	City	State	Zip code

Identify the role in which the victim identified in section one was employed. (circle one)

Emergency Medical Technician Paramedic Firefighter Law Enforcement Officer

Type of Crime (attach acceptable proof of crime)	Law Enforcement Agency
Date of Crime	Name of Offender (if known)

Review and initial each of the following verifications.

_____ The victim was actively answering a call for service in an official capacity, meaning they were actively performing official duties, including the identification, prevention, or enforcement of the penal, traffic, or highway laws of this state, traveling to the scene of an emergency situation, and performing those functions for which the emergency responder has been trained and certified to perform.

_____ The victim was in the line of duty as an emergency medical technician (s. 401.23, Fla. Stat.), paramedic (s. 401.23, Fla. Stat.), firefighter (s. 633.102, Fla. Stat.), or law enforcement officer (s. 943.10, Fla. Stat.), at the time of crime.

_____ The applicant/dependent(s) identified in section two is the surviving family member of the victim according to personnel records or documentation managed and maintained by the victim's current employer.

_____ Acceptable proof of crime is attached to the application. The incident was identified by the proper authorities as a compensable crime.

The application assistant delegated by the victim's employer must sign and date their signature to acknowledge understanding that under penalty of perjury or fraud, the information provided is true and correct to the best of their knowledge.

Delegate Signature _____ **Date**_____

Qualifications and Disclosures

SOCIAL SECURITY NUMBER DISCLOSURE: The Bureau of Victim Compensation collects and uses Social Security numbers for the purpose of performing imperative duties and responsibilities which may include the following: searching criminal history records, identity management, billing and payments, benefit processing, and reporting to authorized state and federal government agencies. Failure to provide this optional information may delay the processing of your application or benefits. Federal and State laws require the Bureau to protect Social Security numbers from disclosure to unauthorized parties. Absent a waiver from you or your legal representative, Social Security numbers will be redacted, unless the agency receives a court order to turn over a nonredacted file.

CRIMINAL HISTORY RECORD CHECK: In order for compensation to be considered, the victim or applicant must not have been confined or in custody in a county or municipal facility; a state or federal correctional facility; or a juvenile detention commitment, or assessment facility; adjudicated as a habitual felony offender, habitual violent offender, or violent career criminal; or adjudicated of a forcible felony offense.

ACCEPTABLE PROOF OF CRIME: The Bureau of Victim Compensation does not make an independent judgment on whether a compensable crime occurred, but instead relies on proof of crime from the proper authorities. Failure to provide acceptable documentation proving that a compensable crime occurred shall result in your application not being processed or your claim being denied. Acceptable documentation includes: a law enforcement report or charging affidavit from a child protection team, law enforcement agency, state or prosecuting attorney, or the Department of Children and Families that affirms a compensable crime occurred; an indictment by a grand jury; an indictment by a prosecutor from a court of competent jurisdiction; a report from any Federal Law Enforcement agency; or a Florida Department of Law Enforcement cybercrime investigator certification of a crime for purposes of Section 960.197, F.S.

COMPLETE APPLICATION PACKAGE: It is the victim/applicant's responsibility to provide a complete application package which includes acceptable documentation proving that a crime occurred. If the department receives a report which is insufficient for proving that a compensable crime occurred, the application will be assigned a claim number and denied. Claim numbers assigned are not indicative of eligibility or denial. For assistance with collecting acceptable documentation, please contact your local law enforcement agency, the agency where the crime was reported, the referral source, or your local State Attorney's Office.

NOTICE OF PAYMENT LIMITATIONS: Limits below the maximum may apply and may be reduced without prior notice to the award recipient based on the availability of funding. The payment shall be processed upon receipt of the first eligible application.

RELEASE OF INFORMATION: I give permission to any hospital, doctor, dentist, mental health counselor, or other treatment provider, banking institution, social service agency, law enforcement agency, corrections agency, state attorney's office, insurance carrier, attorney or employer to give out information that is requested concerning any treatment rendered, employment, insurance, third-party payer, or law enforcement investigative information to the Department of Legal Affairs for use in processing my claim. I give permission to the Department to release information about the status of my claim to any treatment provider, law enforcement agency, or state attorney's office.

Victim:	Claim Number:
BVC Claims Analyst:	Crime Date: