AUTHORIZATION

This section authorizes the Crime Victime Assistance Program to contact the persons and organizations listed so that we may process your claim for benefits. Your application will be returned if this section is not signed and dated. You my be required to submit other authorizations that are needed to process your claim. If you have any questions about the collection and use of the information gathered by the Crime Victim Assistance Program, please contact the program at (604) 660-3888 or toll free in B.C. at 1-866-660-3888.

I _____ (please print) hereby authorize:

1. The doctor, dentist, optometrist, chiropractor, or other health care professional who treated my injuries (physical and/or psychological) to give the Crime Victim Assistance Program, on request, medical or other reports regarding my injuries, treatment or other information relevant to this application;

2. The police or other law enforcement authorities to give the Crime Victim Assistance Program, on request, a copy of police reports, statements, incident reports or other information relevant to this application;

3. The Workers' Compensation Board of BC or other authority from which the victim received or will receive or will be eligible to receive payments from provincial, federal or other jurisdictions funds to give the Crime Victim Assistance Program, on request, information relevant to this application;

4. My employer(s) or similar authority to give the Crime Victim Assistance Program, on request, information as to my employment, earnings, benefits or other information relevant to this application;

5. Any accident, disability, sickness, life insurance/assurance company or private pension scheme or extended health benefits scheme from which payments or services were received or will be received to give the Crime Victim Assistance Program, on request, information relevant to this application;

6. Human Resources and Skills Development Canada or Aboriginal Affairs and Northern Development Canada or any other authority from which payments were received or will be received to give the Crime Victim Assistance Program, on request, information relevant to this application;

7. The Canada Employment Insurance Commission or the Canada Pension Plan or similar employment insurance and pension plans from other jurisdictions, to give the Crime Victim Assistance Program, on request, information as to benefits received or to be received relevant to this application; and,

8. Canada Revenue Agency or other similar agency in any other jurisdiction, to give the Crime Victim Assistance Program, upon request, information as to my employment income.

9. The Ministry of Children and Family Development (MCFD) to give the Crime Victim Assistance Program, on request, a copy of information relevant to this application.

I understand that the Crime Victim Assistance Program may notify the above authorities that I have submitted an application for benefits pursuant to the Crime Victim Assistance Act.

Applicant Signature _____ Date _____

OPTIONAL AUTHORIZATION

CVAP staff requires your written permission to discuss the information in your file with other persons. Please complete this section if you want to allow program staff to discuss your file with another person, such as a family member or victim service worker.

This is the authorization (written permission) to discuss your file with another person.

I, _____ (please print) hereby authorize the Crime Victim Assistance Program staff to discuss my claim with _____

Name of authorized person you allow program staff to talk to (print clearly)

Authorized Person's Phone Number

Authorized person's relationship to you (applicant)

Agency Name and Address *(Street, City, Province/State, Postal/ZIP Code)*

DECLARATION

Information supplied on this form is necessary to determine your eligibility for benefits, and is collected under the authority of Section 6 of the Crime Victim Assistance Act. Any information collected will be used only for the purposes of adjudicating your claim for benefits.

By signing this section you declare that the information you have provided on this application is true and correct. It is an offence to provide false or misleading information on this application and may lead to prosecution. If it is discovered at a later time that false or misleading information has been provided on this application form, you may be required to repay to CVAP any benefits received.

I, _____ , (please print) submit this application in

support of a claim for benefits available to Victims under the Crime Victim Assistance Act, and declare the information provided in this application for benefits is true and correct.

Applicant Signature _____ Date _____
(Month/Day/Year)

OVERVIEW

This is a printed summary of the **Victim CVAP application form.**

You have indicated that you are:	**A legal representative or legal guardian completing this application on behalf of someone else.**
Legal authority that you fall under:	**Power of Attorney**
Did the crime occur in BC?	**Yes**

APPLICATION ON BEHALF OF THE VICTIM

I am	--
Full Name	--

CONTACT INFORMATION

Preferred Method of Contact	--
Phone number	--
Alternate Phone Number	--
Email Address	--

MAILING ADDRESS

Country	--
Province/State/Region	--
Mailing Address Line 1	--
Mailing Address Line 2	--
City	--
Postal/ZIP Code	--

PERSONAL INFORMATION & ADDRESS

Full Name	**Anthony Edward Stark**

OTHER NAMES USED

Full Name	**Justin Dales**
Date of Name Change	**2002-10-30**

OTHER DETAILS

Primary Phone Number	**604-734-0001**
Alternate Phone number	**604-734-0001**
Email Address	**tony.stark@gmail.com**
Birth Date	**1970-10-04**
Social Insurance Number (SIN)	**736-935-035**
Gender	**M**
Marital Status	**Single**
Occupation	**Philanthropist**

PRIMARY ADDRESS

Country	**Canada**
Province/State/Region	**British Columbia**
Mailing Address Line 1	**2154 Main Street**
Mailing Address Line 2	**Apartment 486**
City	**Vancouver**
Postal/Zip Code	**V9Z 0A9**

ALTERNATE ADDRESS

Country	**Canada**
Province/State/Region	**British Columbia**
Mailing Address Line 1	**2154 Main Street**

Mailing Address Line 2	**Apartment 486**
City	**Vancouver**
Postal/Zip Code	**V9Z 0A9**

CRIME INFORMATION

CRIME OCCURENCE

Type of Crime	--
When did the crime occur?	--
Is this application being filed within on year of the date of the crime?	--
Crime Location(s)	--

Crime Details

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POLICE INVOLVEMENT

Was the report made to the police?	--
To which police was the report made?	--
Date of report	--
Police File Number	--
Name of Investigating Officer	--
Has the alleged offender been charged?	--
Court File Number	--
Court Location	--

OFFENDER & COURT INFORMATION

Offender name --

Relationship to offender --

RESTITUTION AND CIVIL ACTION

Did you apply to the court for money from the offender? --

Have you taken, or will you be taking, legal action? --

Do you have a lawyer or law firm overseeing this case? --

LAWYER INFORMATION

Lawyer or Law Firm name --

Country --

Province/State/Region --

Mailing Address Line 1 --

Mailing Address Line 2 --

Postal/ZIP Code --

City --

MEDICAL AND DENTAL INFORMATION

COVERAGE

Do you have medical services coverage? --

Personal Health Number --

Do you have other health coverage? --

Name of provider --

Extended health plan number --

TREATMENT

Did you goto a hospital to be treated for injuries resulting from the invident?	**Yes**
Name of hospital	**Victoria General Hospital**
Is the hospital outside of BC?	**No**
Please enter the name of the hospital	--
Date of treatment	**2019-04-10**
Do you have a medical doctor/clinic who has been treating you for injuries resulting from the incident?	**Yes**
Name of Medical Doctor/Clinic	**John Tincome**
Phone Number	**250-111-2223**
Country	**Canada**
Province/State/Region	**British Columbia**
Mailing Address Line 1	**345 Fort st.**
Mailing Address Line 2	**Suite 304**
City	**Victoria**
Postal/ZIP Code	**V9Z 0A9**
Have you seen any other doctors, specialists, or counsellors who have been treating you for injuries resulting from the incident?	**Yes**

PROVIDER 1

Provder name	--
Phone number (incl. area code)	--
Type of Provider	--
Country	--
Province/State/Region	--

Mailing Address Line 1	--
Mailing Address Line 2	--
City	--
Postal/ZIP Code	--

PROVIDER 2

Provder name	--
Phone number (incl. area code)	--
Type of Provider	--
Country	--
Province/State/Region	--
Mailing Address Line 1	--
Mailing Address Line 2	--
Postal/ZIP Code	--
City	--

PROVIDER 3

Provder name	--
Phone number (incl. area code)	--
Type of Provider	--
Country	--
Province/State/Region	--
Mailing Address Line 1	--
Mailing Address Line 2	--
City	--
Postal/ZIP Code	--

EXPENSE AND LOSS

BENEFITS AVAILABLE THROUGH CVAP

Medical expenses	✔
Dental expenses	✔
Prescription drug expenses	✔
Counselling	--
Lost employment income	--
Repair or replacement costs of damaged or destroyed personal property that you were wearing at the time of the incident (e.g. eyeglasses, clothing)	--
Protective measure (e.g moving expenses, security devices)	--
Disability benefits, services or equipment	--
Crime scene cleaning	--
Other	--

OTHER BENEFITS

Disability Plan benefits	✔
Employment Insurance benefits	✔
Income Assistance	✔
Canada Pension Plan	--
Aboriginal Affairs and Northern Development Canada	--
Benefits you have received as a result of civil action	--
Other	**Veterans Benefit**
None of the above	--

EMPLOYMENT INFORMATION

INCOME LOSS INFORMATION

Were you employed when the crime occured?	**Yes**
Were you at work at the time of the incident?	**Yes**
Have you applied for Worker's Compensation benefits?	**No**
What is your Worker's Compensation Benefits claim number?	**N/A**
As a result of any crime-related injuries, did you miss any work?	**No**
Please provide days of work missed	**N/A**
As a result of any crime-related injuries, did you lose wages?	**No**

EMPLOYER INFORMATION

Are you self employed?	--
Name of Company/Organization	--
Phone number of contact person	--
Country	--
Province/State/Region	--
Mailing Address Line 1	--
Mailing Address Line 2	--
City	--
Postal/ZIP Code	--
If you are requesting benefits for lost wages, may we contact your employer?	--
Contact Name	--