PROPERTY LOSS DISABILITY VERIFICATION FORM

INSTRUCTIONS TO VICTIM/APPLICANT: PLEASE DO NOT WRITE ON THIS FORM. To be considered for property loss benefits, the victim must be over the age of 60, or have a pre-existing permanent physical or mental impairment. You may forward this form to your medical physician to document your disability.

INSTRUCTIONS FOR PHYSICIAN: If your patient suffers from a permanent whole body disability which pre-existed the crime, please complete and sign this form. Return the form directly to the Office of the Attorney General, Bureau of Victim Compensation, PL-01, The Capitol, Tallahassee, FL 32399-1050, or by facsimile to (850) 414-6197 or (850) 414-5779, or email to VCIntake@MyFloridaLegal.com. Please provide a copy of this information to your patient.

SECTION ONE: VICTIM'S INFORMATION (please print)

1. Name: (last, first, middle) ____________________

2. Date of Birth: ____/____/______ 3. Last Four Social Security Number: XXX-XX- ______

4. Mailing Address: ______________ 5. City: __________ 6. State: ______ 7. Zip Code: ______

8. Telephone Number: (______) ____________ 9. Email Address: ____________________

SECTION TWO: DISABILITY INFORMATION (please print)

10. Does the patient suffer from a permanent physical impairment which substantially limits their ability to perform normal daily living activities? (circle one) No Yes If yes, please explain: ____________________
____

11. Did the patient's permanent disability exist prior to the date of crime? (circle one) No Yes

SECTION THREE: PHYSICIAN INFORMATION (please print)

12. Name of Attending Physician (last, first, middle): ____________________

13. Primary Location Facility Name: ____________________

14. Street Address: ______________ City: __________ State: ______ Zip Code: ______

15. Telephone Number: (______) ____________ 16. Facsimile Number: (______) ____________

17. Federal Identification Number: ____________ 18. State Medical License Number: ____________

BY SIGNING THIS FORM, I AFFIRM THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

19. Physician's Signature: ____________________ 20. Date: ______________

The Office of the Attorney General, Bureau of Victim Compensation is an equal opportunity provider and employer.

BVC410 10/20 Rule 2A-2.2002(3)(a)(2), F.A.C.