INTERNATIONAL TERRORISM VICTIM EXPENSE REIMBURSEMENT PROGRAM (ITVERP)

ITVERP APPLICATION

ELIGIBILITY: Before you complete the ITVERP application, please consider whether you or the victim are eligible for the program by answering the following questions:

1) Is the victim a U.S. Citizen or a Foreign Service National who was an employee of (or contractor with) the U.S. Government at the time of the incident?

2) Did the incident occur outside the United States?

If you answered NO to either of these questions, you are not eligible for ITVERP and should not complete this application. If you answered YES to *both* of these questions, please complete the application. Be aware, the application requires a considerable amount of detail and may take a significant amount of time to complete.

GENERAL INSTRUCTIONS

Please type or print clearly and do not use any correction fluid on this application. Attach additional supplemental sheets as needed for each expense category. If you have questions or would like assistance in completing this application, contact an ITVERP case manager by phone at 1–800–363–0441or by email at itverp@ojp.usdoj.gov. Please be sure to include all supporting documentation with your application.

Note: ITVERP does not cover attorney's fees, lost wages, or noneconomic losses, such as pain and suffering, loss of enjoyment of life, etc.

A. APPLICATION TYPE

The type of application you submit depends on the kind of reimbursement you are requesting. Each type of application requires specific information. Please review the application options below to determine which type of application is appropriate for your situation. Choose only one.

☐ **Itemized Application**	☐ **Supplemental Application**	☐ **Interim Emergency Application (Conditional)**
This is the most common ITVERP application. If this is your first time filing an ITVERP claim, and you are not asserting a substantial financial hardship, please check this box.	This is for ITVERP claimants who have a prior ITVERP application and are now submitting additional expenses for reimbursement. Please include your previous claim number here: _____	This is for immediate financial hardship *only*. If you check this box, you must describe the reason for your substantial financial hardship. This type of application is limited to: **medical care, funeral and burial costs, short-term lodging, and emergency transportation.**

For assistance contact:
810 Seventh Street, NW • Washington, DC 20531 • 1–800–363–0441 • ITVERP@usdoj.gov
www.ovc.gov

For Interim Emergency Applicants Only: Please provide a detailed statement below about the substantial financial hardship you will incur if your ITVERP application is not processed as an Interim Emergency Application. *(Attach additional paper if necessary.)*

_____

_____

_____

B. REQUEST FOR EXTENSION OF FILING DEADLINE

Generally, the filing deadline for an ITVERP claim is 3 years from the date of the international terrorist incident; however, ITVERP regulations allow the Director discretion to waive this deadline upon a showing of good cause. If you are a new claimant and are submitting this application more than 3 years after the date of the incident, you must state the reason you missed the program's filing deadline.

Are you filing the application within 3 years of the date of the terrorist incident?

☐ Yes ☐ No (*If you checked "no," please complete the information below.*)

_____

_____

_____

_____

C. CLAIMANT AND VICTIM INFORMATION

There is only one ITVERP claim per victim. The victim is the person who was injured or killed as a result of the incident and is often also the claimant for the purpose of submitting an application. Sometimes the claimant is not the direct victim, but rather a surviving family member or representative of the victim who submits the application on behalf of the victim.

The only exception to the one claim per victim rule is when the victim is deceased and surviving family members apply for mental health expense reimbursement. In those cases, each family member would file their own claim for mental health reimbursement.

What is your relationship to the *victim*?

☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Other _____

REQUIRED DOCUMENTS

Please include all of the information requested below.

Victim Identification: A copy of a valid, government-issued photo ID.

Certificate of Death: If the victim is deceased, a copy of a death certificate or other official recognition of death.

Claimant Identification: A copy of a valid, government-issued photo ID.

Claimant & Victim Relationship Verification: A copy of a legal document substantiating the relationship between the victim and claimant, such as a marriage certificate, birth certificate, power of attorney, will, health care directive, etc.

CLAIMANT INFORMATION:

The claimant is the person other than the victim who is completing the application. If you are the victim, please skip this section and go to the Victim Information section below.

Claimant First Name	Claimant Last Name	Middle Initial	Date of Birth
Street Address	City	State	Zip Code
Country of Citizenship	Telephone	Gender ☐ Male ☐ Female	Email
Social Security Number/Employee Identification Number/Other Identification Number *(Please identify the type of number used.)*			

VICTIM INFORMATION:

All ITVERP applications must include complete information about the victim. If you are the claimant, you must complete this section.

Victim First Name	Victim Last Name	Middle Initial	Date of Birth	Place of Birth
Street Address	City	State/Country	Zip Code	
Country of Citizenship	Telephone	Gender ☐ Male ☐ Female	Email	
Social Security Number/Employee Identification Number/Other Identification Number *(Please identify the type of number used.)*				
Is the victim a veteran? ☐ Yes ☐ No				
Victim's Employer (If victim was working abroad or for the U.S. Government.)		Victim's Employer's Address		
Victim's Supervisor/Contact Person – Name (if known)		Victim's Supervisor/Contact Person – Email and Phone (if known)		

D. INTERNATIONAL INCIDENT INFORMATION

The incident must have occurred outside the United States.

Date of Incident	Location of Incident (City, Country)	Lead Investigative Agency
Brief Description of Incident		
Brief Description of Injuries		

REQUIRED DOCUMENTS

Please include any and all supporting documents related to the incident, such as a police report, news articles, photographs, etc.

E. OUT-OF-POCKET EXPENSE INFORMATION

Please read the following information carefully as it may impact your reimbursement request. If you have any questions, please contact us.

1. Collateral Sources: ITVERP is a payer of last resort. This means that ITVERP will only provide reimbursement for out-of-pocket expenses that are *not* covered by some other source, like an employer or insurance company. ITVERP will contact all other potential collateral sources to verify whether they covered the expense (in whole or in part) for which you are requesting reimbursement.

2. Service Providers: ITVERP will contact relevant service providers to verify receipt of services, the cost incurred, and if the service(s) were linked to the incident. If the services were not linked to the incident, the reimbursement request for that expense will be denied.

3. Third Party Contributions: If you are submitting expenses that another person(s) may have contributed to paying, such as family members or friends, these expenses are considered out-of-pocket expenses incurred by a third party. ITVERP regulations require that each claimant (the person filing the application) obtain approval from the people who contributed to paying those expenses in order for ITVERP to reimburse the claimant on behalf of those third parties.

4. Currency Type: Please state all payment amounts in the same currency in which the out-of-pocket expense was incurred.

REQUIRED DOCUMENTS
In the appropriate expense categories, you must include as much detail as possible (with supporting documentation) in order for ITVERP to contact your service providers. When possible, you must submit copies of original receipts and copies of any documentation that you have to help substantiate your expenses.

F. MEDICAL EXPENSES

Are you requesting reimbursement for out-of-pocket medical expenses?

No ☐ Go to the Mental Health Expense section.

Yes ☐ What is the total out-of-pocket expense in this category? _____

Have any other sources or person(s) covered these medical expenses?

No ☐ Go to the Service Provider section below.

Yes ☐ Complete the chart below for *each* medical expense.

Applicable sources of coverage (or financial assistance) for each expense could include private, group, employer, or union health insurance providers; veteran's and military benefits; workers' compensation; proceeds from civil litigation; state compensation; FBI emergency assistance; Medicare, SSI, and SSDI.

You must attach copies of supporting documentation for *each* expense.

Medical Expense *Please list each medical expense for which you are seeking reimbursement.*

Describe the Medical Expense	What was the out-of-pocket cost? *(If not in U.S. Dollars [USD], please identify the currency.)*	Date Medical Expense was Incurred	
Name of Service Provider	Contact Person's Name	Email	Telephone
Provider's Address	City	State	Zip Code

Medical Coverage *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

Coverage Source's Name	Policy # – Acct # – Claim #	Contact Person's Name
Coverage Source's Address	Source's Telephone	Source's Email/Fax

For additional expenses, please refer to **Supplemental Sheet F: MEDICAL EXPENSES.**

G. MENTAL HEALTH EXPENSES

Are you requesting reimbursement for out-of-pocket mental health expenses?

No ☐ Go to the Property Loss Expense section.
Yes ☐ What is the total out-of-pocket expense in this category? _____

Have any other sources or person(s) covered these mental health expenses?

No ☐ Go to the Service Provider section below.
Yes ☐ Complete the chart below for each mental health expense.

Applicable sources of coverage (or financial assistance) for each expense could include private, group, employer, or union health insurance providers; veteran's and military benefits; workers' compensation; proceeds from civil litigation; state compensation; FBI emergency assistance; Medicare, SSI, and SSDI.

You must attach copies of supporting documentation for *each* expense.

Mental Health Expense *Please list each mental health expense for which you are seeking reimbursement.*

Describe the Mental Health Expense	What was the out-of-pocket cost? *(If not in USD, please identify the currency.)*	Date Mental Health Expense was Incurred	
Name of Service Provider	Contact Person's Name	Email	Telephone
Provider's Address	City	State	Zip Code

Mental Health Coverage *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

Coverage Source's Name	Policy # – Acct # – Claim #	Contact Person's Name
Coverage Source's Address	Source's Telephone	Source's Email/Fax

For additional expenses, please refer to **Supplemental Sheet G: MENTAL HEALTH EXPENSES**.

H. PROPERTY LOSS EXPENSES

Are you requesting reimbursement for out-of-pocket property loss expenses?

No ☐ Go to the Funeral and Burial Expense section.

Yes ☐ What is the total out-of-pocket expense in this category?_____

Required Supporting Documentation**:** For property loss, you must provide supporting documentation of the cost you incurred, such as copies of receipts, photographs, credit card statements, or other documentation that shows the cost of the property at the time it was purchased.

Detailed Itemized List: If you do not have any documentation to support your property loss claim, you must submit an itemized statement with specific details about the item and attest, under penalty of perjury, that the information provided is true and correct to the best of your knowledge. Itemized lists without specific details will not be accepted for property loss verification.

Please list a detailed description of your specific items below.

Item Name	Detailed Description	Cost at Time of Purchase *(if not in USD, please identify the currency)*	Was the Item Insured?	Attached Supporting Documentation
Example: Digital Camera	*1 Canon PowerShot S95 Camera with 10 megapixels, 4x zoom, 3" LCD display and SD memory card slot*	*988 AED*	*No*	*Receipt*
1.				
2.				
3.				

You must attach copies of supporting documentation for each expense. For additional items, please refer to **Supplemental Sheet H: PROPERTY LOSS**.

CERTIFICATION

I certify that the information provided on this itemized list of property loss (and the attached Supplemental Sheet H: Property Loss) is true and correct to the best of my knowledge.

Signature: _____ Date: _____
Claimant's Signature

I. FUNERAL AND BURIAL EXPENSES

Are you requesting reimbursement for out-of-pocket funeral and/or burial expenses?

No ☐ Go to the Miscellaneous Expense section.

Yes ☐ What is the total out-of-pocket expense in this category? _____

You must attach copies of supporting documentation for *each* expense.

Please list a detailed description of your requested expenses below.

Type of Expense	Detailed Description	Total Cost at Time of Purchase *(If not in USD, please identify the currency)*	Amount Covered by Other Sources	Purpose of Expense	Attached Supporting Documentation
Example: *Airfare*	*Roundtrip airline ticket—San Diego, CA, to Fort Knox, TN, for John Smith*	*$498.00*	*0*	*Attending induction ceremony*	*Bank statement*
1.					
2.					
3.					

Third Party Contributions: Has any other person(s), such as a family member or friend, paid for part of the out-of-pocket funeral and/or burial expenses for which you are seeking reimbursement?

No ☐ Go to the Miscellaneous Expense section.

Yes ☐ Complete the chart below.

Person(s) Who Paid	Contact Information for Person(s) Who Paid	Relationship	Amount Paid *(If not in USD, please identify the currency.)*	For What Expense
Name	Address, email, and telephone			
Name	Address, e-mail, and telephone			

For additional items, please refer to **Supplemental Sheet I: FUNERAL & BURIAL**.

J. MISCELLANEOUS EXPENSES

Are you requesting reimbursement for out-of-pocket miscellaneous expenses?

No ☐ Go to page 11.

Yes ☐ What is your total out-of-pocket expense in this category? _____

You must attach copies of supporting documentation for *each* expense.

Please list your specific expenses below.

Type of Expense	Detailed Description	Cost at Time Expense was Incurred *(If not USD, please identify the currency.)*	Amount Covered by Other Sources	Purpose of Expense	Attached Supporting Documentation
Example: Phone charges from Mumbai, India, to Oakland, CA	*Incurred expense while in Mumbai attending to victim's affairs, June 2004*	*$384.28*	*No*	*Putting victim's affairs in order*	*Phone bill*

Third Party Contributions: Has any other person(s), such as a family member or friend, paid for part of the out-of-pocket miscellaneous expenses for which you are seeking reimbursement?

No ☐ Proceed to page 11.

Yes ☐ Complete the chart below.

Person(s) Who Paid	Contact Information for Person(s) Who Paid	Relationship	Amount Paid *(If not in USD, please identify the currency.)*	For What Expense
Name	Address, email, telephone			
Name	Address, email, telephone:			

For additional items, please refer to **Supplemental Sheet J: MISCELLANEOUS**.

Instructions: Please read each statement below. Your signature at the bottom indicates your agreement with the terms of the program and certification that all statements and information provided in this application are true and correct to the best of your knowledge.

K. CONSENT AND CERTIFICATION

This release must be signed and dated before your application can be considered for expense reimbursement.

I hereby agree to contact and repay ITVERP if I receive any payments from the person or governments responsible for the act of international terrorism, a civil lawsuit, an insurance policy, a debt waiver, or any other government or private agency to cover expenses for which I have already received payment from this program.

Any unsatisfied judgment against a foreign government will be considered a collateral source of financial help, and your ITVERP reimbursement will be reduced accordingly, unless you agree to **NOT** sue the United States Government for satisfaction of that judgment by signing and dating the following:

I waive any right I may have to sue the United States Government for satisfaction and enforcement of my unsatisfied judgment against the foreign government for the act of terrorism for which I am claiming reimbursement from ITVERP.

I hereby certify, subject to penalty of fine or imprisonment or both, that below I have listed all names and addresses of all other individuals who may be eligible to receive expense reimbursement in relation to the victim in this claim.

_____

_____

_____

_____

I hereby certify, subject to penalty of fine or imprisonment or both, that I am neither directly nor indirectly responsible for the incident for which I am seeking expense reimbursement.

I hereby certify, subject to penalty of fine or imprisonment or both, that the information contained in this application for the International Terrorism Victim Expense Reimbursement Program (ITVERP) is true and correct to the best of my knowledge.

_____

Victim/Claimant Signature Date

_____

Representative's Signature *(or signature of individual who assisted in the preparation of this application)* Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA Compliance)

This release must be signed and dated before your application can be considered for expense reimbursement.

I hereby authorize my health care provider to disclose my protected health information, described below, to ITVERP. You may disclose this information to: ITVERP Resource Center, Office for Victims of Crime, 810 Seventh Street NW, Washington DC, 20531; by fax: 202–514–6383; or by e-mail: itverp@usdoj.gov.

I hereby authorize any physicians, clinics, psychologists, dentists, chiropractors, nursing homes, pharmacies, acupuncturists, or naturopaths to furnish ITVERP program representatives with any information requested, including medical records, diagnostic assessments, and mental health evaluations, needed to complete my claim for expense reimbursement. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby authorize any health insurance companies, HMOs, employer health plans, and government programs—such as Medicare, Medicaid, and military and veterans' health care programs—to furnish to ITVERP program representatives with any information requested, including medical records, diagnostic assessments, and mental health evaluations, needed to complete my claim for expense reimbursement. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby authorize a funeral director; municipal authority; employer or union; insurance company; social service bureau; Social Security office; or any other person, firm, agency, or organization to furnish ITVERP program representatives with any information requested to complete my claim for expense reimbursement. A photocopy of this authorization shall be considered as effective and valid as the original.

This authorization expires when ITVERP completes verification of my claimed expenses.

Revocation: I understand that if I revoke this authorization, the ITVERP expense verification process cannot be completed. I understand that to revoke this authorization I must submit a written letter to ITVERP stating authorization is revoked, or I may contact the ITVERP program representative and verbally revoke authorization. I understand revocation is only effective after it is received and recorded by ITVERP. Any use or disclosure made prior to revocation will not be affected as part of this revocation.

_____

Victim/Claimant Printed Name Date

_____

Victim/Claimant Signature Date

_____

Representative's Printed Name Date

_____

Representative's Signature *(or signature of individual who assisted in the preparation of this application)* Date