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: FL 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:FL 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: _____

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