APPLICATION AND INSTRUCTIONS

HEART OF GOLD COMPENSATION PROGRAM APPLICATION CHECKLIST (PAGE 1)

INSTRUCTIONS

To ensure consideration of your application is completed, please submit the application and required supporting documentation

1

Please complete the entire application, printing clearly. Sign every place where a signature is required.

2

Provide a police or incident report that lists the victim's name, and a summary of the incident.

3

Please submit all additional documentation requested depending on the expense category you need assistance with.

4

The Heart of Gold Accounting Department will request a w-9 for new payees to verify their identity. Submitting a complete w-9 with your completed application packet will assist with processing approved payments.

5

Please mail your completed application packet to the following address:

2936 Baker Ridge Drive
Atlanta, GA 30318

Sweet Hearts, Inc. Heart of Gold program may be able to ease the financial burden incurred by the families of innocent victims who lost their life due to gun violence, where other resources are exhausted.

Eligible program applicants can receive compensation up to $15,000 to help with funeral expenses, medical and/or dental costs, loss of wages, relocation expenses due to safety reasons, crime scene sanitation, court proceedings transportation when the costs are not covered by other sources.

BENEFITS COVERED

Funeral Costs ..... UP TO $10,000
Rent & Utility Assistance ..... UP TO $5,000
Crime Scene Sanitation ..... UP TO $1,500
Court Proceedings Transportation ..... UP TO $500
Relocation Expenses due to Safety ..... UP TO $5,000
Medical and/or dental costs ..... UP TO $5,000
Loss of Wages ..... UP TO $5,000

PLEASE NOTE

- If you do not submit all required documentation, you may still submit the signed application to begin the claim process. Your claim will be incomplete until all required documentation is submitted.
- You may submit an application even if the offender is unknown. While the incident must be reported to law enforcement, arrest and/or prosecution is not a program requirement.
- Benefits are based on actual expenses backed by documentation that must be submitted with your application.

APPLICATION AND INSTRUCTIONS

HEART OF GOLD COMPENSATION PROGRAM APPLICATION CHECKLIST (PAGE 2)

Additional Support Documentation

To ensure consideration of your application is completed, please submit the application and required supporting documentation

1. Crime or Incident Report
2. Death Certificate or Authorization to communicate with the Funeral Home required for Funeral Expenses
3. Employment Verification Form for Loss of Wages and the two most recent paystubs before the crime date
4. Itemized bills (if applicable) for Rent, Utility, Medical, Dental, and/or Crime Scene Sanitation bills
5. Proof of Court Date Scheduled for Court Proceedings Transportation

Sweet Hearts, Inc. Heart of Gold program may be able to ease the financial burden incurred by innocent victims of gun violence, where other resources are exhausted.

Eligible program applicants can receive compensation up to $15,000 to help with funeral expenses, medical and/or dental costs, loss of wages, relocation expenses due to safety reasons, crime scene sanitation, court proceedings transportation when the costs are not covered by other sources.

BENEFITS COVERED

Funeral Costs	UP TO $10,000
Rent & Utility Assistance	UP TO $5,000
Counseling	UP to $5,000
Crime Scene Sanitation	UP TO $1,500
Court Proceedings Transportation	UP TO $500
Relocation Expenses due to Safety	UP TO $5,000
Medical and/or dental costs	UP TO $5,000
Loss of Wages	UP TO $5,000

PLEASE NOTE

- If you do not submit all required documentation, you may still submit the signed application to begin the claim process. Your claim will be incomplete until all required documentation is submitted.
- You may submit an application even if the offender is unknown. While the incident must be reported to law enforcement, arrest and/or prosecution is not a program requirement.
- Benefits are based on actual expenses backed by documentation that must be submitted with your application.

HEART OF GOLD COMPENSATION PROGRAM

APPLICATION (PAGE 1)

Address: 2936 Baker Ridge Drive
Atlanta, GA 30318

Phone: 404.630.2299
Website: www.sweetheartsinc.org

Section 1. VICTIM INFORMATION

Please provide information on the individual who was killed or injured as a result of a violent crime.

Victim Name (First, Middle, Last) | Gender ☐ M ☐ F ☐ LBGTQ+ ☐ NB | Date of Birth MM/DD/YYYY / / | Social Security No. XXX-XX-XXXX - -

Address (including apt #)

City | State | Zip Code

Phone Number | Alt. Phone Number | E-mail

Demographics (For Statistical Use Only)

Origin/Ethnicity

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ White/NonLatino/Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander
☐ Other _____

If 17 years or older, is the victim a veteran? ☐ Yes ☐ No Is the victim disabled? ☐ Yes ☐ No

If the above information changes, you must contact us immediately to update your application on file to still be considered for the program. You can add an additional contact name and information below.

Additional Contact Name | Phone Number | E-mail

Section 2. CLAIMANT INFORMATION

Please provide information on the individual completing this application.

Claimant Name (First, Middle, Last) | Gender ☐ M ☐ F ☐ LBGTQ+ ☐ NB | Date of Birth MM/DD/YYYY / / | Social Security No. XXX-XX-XXXX - -

Address (including apt #)

City | State | Zip Code

Phone Number | Alt. Phone Number | E-mail

Demographics (For Statistical Use Only)

Origin/Ethnicity

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ White/NonLatino/Caucasian ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander
☐ Other _____

HEART OF GOLD COMPENSATION PROGRAM

APPLICATION (PAGE 2)

Address: 2936 Baker Ridge Drive
Atlanta, GA 30318

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Section 3. BENEFITS REQUESTED

Please complete this section by checking all the benefits you are applying for and submit itemized bills for services related to the crime. Please note: A death certificate is required for funeral costs.

- ☐ Funeral Costs
- ☐ Loss of Wages
- ☐ Medical and/or Dental Costs
- ☐ Rent and/or Utility Assistance
- ☐ Crime Scene Sanitation
- ☐ Relocation Expenses for Safety Reasons
- ☐ Travel Costs for Court Proceedings
- ☐ Other

Other (Please state other assistance needed due to loss of wages)

Please note: If applying for loss of income, you cannot be reimbursed if your wages were fully covered (i.e. sick or annual leave, vacation time, disability, PTO, etc.) while you were out due to the crime. If eligible, you can only be reimbursed when you missed work and were not paid, or your wages were partially covered.

Was the victim gainfully employed before and at the time of the crime? ☐ Yes ☐ No

If yes, please provide the date(s) the victim was out of work due to the crime:

Please check if you have applied for any of the following: ☐ Restitution ☐ Worker's Compensation ☐ Law Suite/Civil Action

Section 4. MEDICAL RECORDS/INFORMATION AUTHORIZATION

Some medical and/or counseling payments may require a medical release form. While not required, submitting a medical release form can help with the decision of your application.

Please check the applicable box:

☐ I am submitting the Medical Authorization Form, along with medical/dental bills, with this application.

☐ I opt to complete the Medical Authorization Form at a later time, if needed.

Section 5. INSURANCE INFORMATION

Please provide us your insurance information, including life insurance and health insurance, including Medicaid/Medicare.

Does the victim have health insurance including Medicare/Medicaid? ☐ Yes ☐ No If yes, provide company name: _____

Does the victim have a life insurance policy? ☐ Yes ☐ No If yes, provide company name: _____

Section 6. CRIME INFORMATION

Completing the information below is optional if you include a crime or incident report with your application.

County of Crime: _____ Date of Crime: _____ Date Crime Reported: _____

Agency Crime Reported To: _____ Case Number: _____

Section 7. GOOD CAUSE INFORMATION

Please provide us information about when the crime was reported to the proper authorities and when you submitted the application.

Was the crime reported within 72 hours? In no, please explain why not. ☐ Yes ☐ No

_____

_____

_____

HEART OF GOLD COMPENSATION PROGRAM

APPLICATION (PAGE 3)

Address: 2936 Baker Ridge Drive
Atlanta, GA 30318

Phone: 404.630.2299
Website: www.sweetheartsinc.org

Section 8.
AGREEMENT ACKNOWLEDGEMENT

Please read this section carefully. The person/claimant signing this application must be at least 18 years of age.

By signing this section, I certify to date that I have not received any compensation as a result of this crime. I also acknowledge that if I recover any money by legal judgment, settlement, or restitution resulting from this crime, based on the recovery agreement, I may be responsible for repaying some or all amounts awarded to me, or on my be-half, by Sweet Hearts Inc. Heart of Gold Program. As such, I hereby agree that in consideration of an award by the Sweet Hearts, Inc Heart of Gold Program, I assign, transfer and subrogate all claims, interests and rights of action that I may have against other parties or authorities up to the amount awarded by the Program.

X_____ _____
Signature of Claimant Date

Section 9.
CRIMINAL HISTORY & MEDICAL ACKNOWLEDGEMNT

Please read this section carefully. The person/claimant signing this application must be at least 18 years of age.

A criminal history report will be completed on all claimants 18 years of age and older. I hereby authorize and understand that a criminal history report will be analyzed to determine eligibility for the Heart of Gold Compensation Program; I also authorize any hospital, physician, medical facility, insurer or any other person or law enforcement agency that has knowledge relative to my claim to furnish information to the Heart of Gold Committee.

X_____ _____
Signature of Claimant Date

Section 10.
ACKNOWLEDGEMENT OF UNDERSTANDING

Please read this section carefully. The person/claimant signing this application must be at least 18 years of age.

I hereby acknowledge that Sweet Hearts, Inc.'s Heart of Gold Program will only award compensation if all of the programs eligibility requirements are met. I also acknowledge that the Heart of Gold Program is the payor of last resort. As such, my benefits will be reduced by any monies I receive from any other source as a result of the crime, including insurance, restitution, the Georgia Victim Compensation Program, and civil suit settlements.

X_____ _____
Signature of Claimant Date

Section 11.
FOR OFFICE OFFICE USE ONLY

This section is for official Sweet Hearts, Inc. personnel only. Please do not write in the space below.

Please check the applicable box:

- ☐ APPROVED
- ☐ DENIED

Notes:

X_____ _____
Signature of Sweet Hearts, Inc. Date

HEART OF GOLD COMPENSATION PROGRAM

EMPLOYMENT VERIFICATION FORM

Address: 2936 Baker Ridge Drive
Atlanta, GA 30318

Phone: 404.630.2299
Website: www.sweetheartsinc.org

THIS SECTION IS TO BE COMPLETED BY THE CLAIMANT COMPLETING THE HEART OF GOLD PROGRAM APPLICATION

TO: Name & Address of Employer: **Date:** _____

_____

_____

_____

Employee's Name: _____ **Last (4) of SSN:** _____

I hereby authorize release of my employment records.

X_____ _____

Signature **Date**

_____

Printed Name

The individual listed above is applying for Sweet Hearts, Inc. Heart of Gold Program that helps victims of crime and their families with the financial burden of expenses directly related to the result of a crime.

_____ **Please return this form to: Sweet Hearts, Inc.**

Executive Director Name **Attn: Heart of Gold Program**
2936 Baker Ridge Drive
Atlanta, GA 30318

THIS SECTION IS TO BE COMPLETED BY THE EMPLOYER

Name of Employer: _____ **Job Title:** _____

Presently Employed: ____**Yes** **Date of First Employment:** _____ _____**No** **Last Date of employment:** _____

Current Wages/Salary: $_____ **(Check one of the following:**

☐ **hourly** ☐ **weekly** ☐ **bi-weekly** ☐ **semi monthly** ☐ **monthly** ☐ **yearly** ☐ **other:** _____

List of anticipated changes to employment and rate of pay within the next 12 months: _____

_____

_____

Effective Date: _____

Additional remarks: _____

_____

_____

X_____ _____

Employer Signature **Date**

_____

Printed Name