Ontario

Ministry of Attorney General

Victim and Vulnerable Persons Division
Victim Quick Response Program

Victim Quick Response Program (VQRP) – Referral Form

Instructions

- Send application to VQRP office by Ontario's Enterprise Attachment Transfer Service (EATS).
- Keep signed copy of application on file.
- After EATS application is processed by VQRP, delete electronic file from agency's computer.

Fields marked with an red asterisk (*) must be completed where applicable.

VQRP File Number	
Date Received (yyyy/mm/dd)	

A Applicant Information

* ☐ Victim ☐ Witness **OR** Apply on behalf of ▼ ☐ A child under 16 ☐ Incapacitated Victim ☐ A Deceased Person

Last Name*	First Name*	Middle Initial

Relationship to Victim*	Gender* ☐ Male ☐ Female ☐ Transgender	Date of Birth (yyyy/mm/dd)* !

Unit/Apt. Number	Street Number*	Street Name (PO Box/Postal Station/Rural Station)*

City/Town*	Province*	Postal Code*

Is it safe to send correspondence to the above address?* ☐ Yes ☐ No

B Victim Information (Must Reside in Ontario)

(Only required if completing on behalf of a child under 16, incapacitated victim or a deceased person)

Last Name*	First Name*	Middle Initial

Gender* ☐ Male ☐ Female ☐ Transgender	Date of Birth (yyyy/mm/dd)*	☐ Child (under 16) ☐ Elder (65 or over)

Unit/Apt. Number	Street Number*	Street Name (PO Box/Postal Station/Rural Station)*

City/Town*	Province*	Postal Code*

Is it safe to send correspondence to the above address?* ☐ Yes ☐ No

C Crime Information

Type of Crime*

- ☐ Homicide
- ☐ Human Trafficking ▶
- ☐ Serious Assault
- ☐ Domestic Violence ▶
- ☐ Attempt Murder
- ☐ Sexual Assault ▶
- ☐ Hate Crime ▶

Note: If the crime has not been reported to a Police Service, please identify the Domestic Violence Shelter, Sexual Assault Centre, Hospital or other community agency where the crime was reported.

Date of Crime (latest incident) (yyyy/mm/dd)*	Date Reported (yyyy/mm/dd)*

Police Service or Community Agency Where The Crime Was Reported*

D Type of Service(s) Required*

Services must be accessed and funding for services must be expended within the Province of Ontario

- ☐ Funeral expenses
- ☐ Counselling
- ☐ Crime scene cleanup
- ☐ Transportation to counselling
- ☐ Expense for victim with a disability
- ☐ Emergency child and dependant care
- ☐ Emergency home safety expenses
- ☐ Emergency transportation
- ☐ Emergency accommodation/meals
- ☐ Personal care items
- ☐ Cellular phone
- ☐ Emergency vision care
- ☐ Other service(s) – special circumstances information attached

Name of Applicant/Victim (Last Name, First Name)

Funeral Expense (Funeral Home/Mosque/Cremation Centre Information)

Name of Facility(s) Selected by the Applicant*

Unit Number	Street Number*	Street Name (PO Box/Postal Station/Rural Station)*	
City/Town*		Province ON	Postal Code*
Telephone Number*		Fax Number*	

Counselling (Counsellor Information)

Name of Counselling Agency Selected by the Applicant/Crime Victim (if applicable)*

Name of Counsellor (Last Name) (if applicable)*		(First Name) (if applicable)*	
Unit Number	Street Number*	Street Name (PO Box/Postal Station/Rural Station)*	
City/Town*		Province ON	Postal Code*
Telephone Number*	Fax Number*	Is group counselling requested?* ☐ Yes ☐ No	

E Notice of Collection of Personal Information (Please Read Carefully)

Personal information contained in or required by this form will be collected and used by the Ministry of the Attorney General, the Victims and Vulnerable Persons Division, the Service Delivery Organization and their authorized representatives or as otherwise required by law, to administer the Victim Quick Response Program (VQRP), including processing, assessing and verifying the information provided. Please be advised that the VQRP may contact the signatory or the Service Delivery Organization, the referral source or other government programs for the purpose of completing, clarifying or verifying information on this Referral Form.

Personal information is being collected for the proper administration of a lawful activity authorized under section 5(4) of the *Victims' Bill of Rights, 1995* and section 5 of the *Ministry of the Attorney General Act.* If you have any questions about the collection and use of your information, please contact the Victim Quick Response Program Coordinator, Victims and Vulnerable Persons Division, 31 Adelaide St E, PO Box 456, Toronto ON M5C 2J5. Telephone 416 326-2546 or toll free at 1 866 320-3350.

F Declaration and Consent (Please Read Carefully) !

I hereby consent to the collection and sharing of the information provided in this Referral Form for the administration of the Victim Quick Response Program. I understand that, except as required by law, personal information will be disclosed only for the purposes of administering the program, as described above, or for the administration of other government programs, such as Ontario Works, the Ontario Disability Support Program or the Criminal Injuries Compensation Board.

I hereby declare that I will not be receiving financial assistance that duplicates this request from any of the following sources

- Private Insurance Plan
- Criminal Injuries Compensation Board
- Ontario Disability Support Program
- Insurance Plan through place of employment
- Workplace Safety and Insurance Board
- Ontario Works
- Other Publicly-funded Services

I hereby declare that I have no other recourse or financial resource to address this immediate need.

I hereby agree that, if I am approved for the program, I will follow the program restrictions.

I hereby declare that I have read the completed application and to the best of my information and belief, all my answers are true, correct and complete. I hereby declare that the service provider is selected by me and I therefore release the Ministry of the Attorney General and the Service Delivery Organization from any quality of service guarantee.

Signature of Applicant*	Date (yyyy/mm/dd)*

Do you consent to participate in a client satisfaction survey?*

☐ Yes ☐ No (**Note:** Declining to consent will not affect eligibility for the Victim Quick Response Program.)

Name of Applicant/Victim (Last Name, First Name)

G Service Delivery Organization (SDO)

Agency Name*			Region*
Unit Number	Street Number*	Street Name (PO Box/Postal Station/Rural Station)*	
City/Town*		Province ON	Postal Code*
Telephone Number*	Fax Number*	Email Address*	

☐ Completed referral signed by both applicant and SDO on file* !

☐ Special circumstance information is attached

Note: If request falls outside the guidelines, a special circumstance letter must be attached.

Please attach the following with the referral form:

i) Appendix A

ii) Special circumstances request, where applicable

Authorized SDO Representative (Last Name, First Name)*	Signature* !	Date (yyyy/mm/dd)

H VQRP Approval (Internal Use Only)

Meets Eligibility	Signature	Date (yyyy/mm/dd)
☐ Yes ☐ No		