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Transforming Violence Recovery Through Crime Victim Compensation

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ABSTRACT

Crime victim compensation (CVC) is intended to reimburse victims of violent crime for expenses such as medical bills and lost wages incurred from their victimization. Today, all 50 states operate CVC programs, overseeing the allocation of state and federal funds. CVC has the potential to significantly support violent crime victims during their recovery, but research has shown that few people successfully access CVC. Hospitals are often the first and only access portal violent crime victims have within the healthcare system. Hospital-based violence intervention programs (HVIPs) are uniquely positioned to support patients' comprehensive injury recovery and assist them access social benefits, like CVC. Conducting a mixed-methods study, I quantitatively described the extent of CVC underutilization in Illinois, comparing number of CVC claims to total reported incidents of violent crime, showing low application rates and high denial rates particularly for victims of assault, sexual assault and domestic violence. Circulating a survey to HVIPs nationwide and conducting qualitative interviews with HVIP workers, it became clear that they are often the most likely members of the trauma care team to assist patients with the CVC application process. Complicated application requirements, and stringent eligibility criteria were identified by HVIP workers as significant barriers for their patients trying to access CVC. While impactful when efficiently awarded, HVIP workers often describe how CVC is currently inadequate at substantively addressing their patient's recovery needs. Informed by HVIP workers' insights, this study offers several policy recommendations to transform CVC into a reparative policy tool to aid violence recovery.

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INTRODUCTION

Crime victim compensation (CVC) programs are intended to provide victims of violent crime with financial reimbursement, covering eligible expenses resulting from their victimization and acknowledging the harm done to them. However, only 4% of victims of violent crime nationally ever file a CVC claim, with claim rates being lowest for young minority men and female victims of interpersonal violence. (Crime Survivors Speak, 2022; Rutledge, 2011). The harm caused by violent victimization and the associated costs are multifactorial — medical bills, lost wages, funeral costs, damaged property, legal fees, and decreased overall well-being (Kirkner & Houston-Kolnik, 2019). CVC could be especially helpful to those most in need in under resourced communities, with the potential to act as a form of structural reparations or distributive justice for victims of violent crime (Kirkner & Houston-Kolnik, 2019; Sonnenberg et al., 2024).

CVC functions as a reimbursement program of last resort, only used to cover eligible expenses once other sources of compensation have been exhausted. In Illinois crime-related expenses qualifying for CVC reimbursement include funeral and burial costs, lost wages, loss of dependent support, crime scene clean up, tattoo removal, medical/hospital/dental/counseling fees, transportation/relocation/accessibility costs, among others (The Crime Victims Compensation Program Fact Sheet, Illinois Attorney General, n.a.). Until 2022, the maximum payout claimants could receive in Illinois was $27,000; since 2022, claimants can receive up to $45,000. Reimbursable expenses, eligibility criteria, and maximum payout each vary widely by state.

This study explores the uptake of CVC, with a particular focus on the role hospital-based violence intervention programs (HVIPs) and trauma healthcare providers play in helping their patients access CVC after presenting to the hospital. I was particularly interested in better understanding the factors that contribute to the underutilization of CVC by victims of violent crimes. I hypothesized HVIPs play a critical role in helping patients access CVC, and that violence recovery specialists therefore possess lived expertise on how best to improve CVC programs to better assist victims recover. To date, nationally I am the first to draw on this professional population's expertise pertaining to CVC, and among the first to quantitatively describe the scope of CVC underutilization in Illinois.

To test this theory, I conducted a mixed-methods study, combining quantitative and qualitative data. Novel analysis of geographic distribution of CVC claims in Illinois and rate of CVC application following major violent crime categories was conducted using a dataset previously compiled with several Freedom of Information Act Requests from the Illinois Secretary of State's office. I then circulated a survey nationally to several HVIPs associated with the Health Alliance for Violence Intervention (HAVI) Research and Evaluation Workgroup. Qualitative interviews were then conducted with respondents who expressed willingness to participate. Both survey and interview questions were designed to investigate the level of awareness HVIP staff have of the CVC eligibility and application requirements, how much support they receive from their institutions, whose responsibility it is to inform patients of the program, and other factors that may prevent patients from accessing CVC. Interviews provided another level of nuance and detail that supported survey findings, elaborating on many similar themes. Quantitative analysis showed the extent of CVC underutilization in Illinois, survey

findings explored barriers from the perspective of HVIP workers, and interviews sought to comprehensively understand HVIP workers beliefs about CVC's efficacy.

How healthcare providers and hospital-based systems can assist victims in accessing compensation is a nascent area of research. Emergency rooms and trauma centers are uniquely positioned to initiate comprehensive services for their patients that could help them access CVC and other social benefits following violent crime victimization, as this may be the only point of contact victims of violent crime have within the healthcare system. Lack of awareness and application assistance pose significant challenges to victims who may otherwise be eligible for reimbursement, so it is essential that healthcare professionals, HVIP workers, and social workers inform patients about the program. By drawing on HVIP workers' experience with CVC, I hope to better understand the barriers claimants face, and suggest impactful policy interventions to improve the program's efficacy.

Following this introduction, I provide necessary background information about CVC and HVIP programs. I subsequently summarize existing literature and provide my methodology. Finally, I recount my findings and offer a set of policy recommendations supported by responses from surveys and interviews with HVIPs. Increasing the resources and support HVIP workers have at their disposal to assist their patients access CVC is just one example of how the goals of modern medical care should become more comprehensive. There is a need to pair application support with institutional changes to the program itself. Lifting law enforcement cooperation requirements and replacing the need to file a police report with a medical report are recommended to make reimbursement more accessible. It is suggested that trauma centers and HVIPs implement specific protocols and guidelines to screen new patients for potential CVC eligibility and eventually to assist them with the often complex application process. The

American College of Surgeons (ACS-COT) requires all Level I and II trauma centers to possess a "comprehensive quality assessment program" (American Trauma Society, n.a.). Ultimately, it would be beneficial to incorporate the rate of CVC claims submitted into trauma center quality assessment programs, linking an institution's success in referring patients to CVC to their certification and allocated funding.

BACKGROUND

In 1984, the Victims of Crime Act was signed into law by President Ronald Reagan, establishing the Crime Victims Fund. The Victims of Crime Act was the culmination of the work by President Reagan's Task Force on Victims of Crime, that spent two years travelling to six cities, and meeting with over 1,000 people to assess the national needs of crime victims (Ames, 2024). Prior to this point, the criminal justice system did little to support the financial, personal, and emotional recovery of victims (Ames, 2024).

Today, all 50 states operate CVC programs to financially compensate victims of violent crime, and the Crime Victims Fund contains over $3.2 billion, primarily collected from fines and penalties after convictions in federal cases (Kirkner & Houston-Kolnik, 2019; Office for Victims of Crime, Victims of Crime Act Administrators, n.a.). Since 1988, the Office for Victims of Crime has overseen the allocation of the federal fund to state victim compensation and assistance programs (Office for Victims of Crime, Victims of Crime Act Administrators, n.a.). States are allocated funding from the Crime Victims Fund based on the amount the state paid out in compensation two years prior to the current grant year, following a 'pay-for-performance' model (Formula Grants OVC, n.a.).

Individual states are responsible for operating their own CVC program. Victim compensation is an example of a true state-federal partnership, whereby the federal government provides about 30% of the funding for each state's victim compensation program through the Victims of Crime Act, with states providing the remaining funding themselves and overseeing the program's allocation (Victim Compensation in America: The State-Federal Partnership, 2023). In Illinois, an online CVC application is available in English, Spanish and Polish. Alternatively, it can be printed, filled out by hand, and mailed to the Office of the Illinois Attorney General. A police report showing that a crime occurred, and that the victim was not involved, must be included with documentation confirming pecuniary loss. A completed application is then reviewed by the Illinois Attorney General's Office CVC Bureau, and additional documentation may be requested. A determination is made regarding a claimant's eligibility for reimbursement and what sum will be paid out. (The Crime Victims Compensation Program Fact Sheet, Illinois Attorney General, n.a.).

Although there is a burgeoning literature describing the uptake of CVC, it still remains limited. The ways in which healthcare providers and hospital-based systems can assist victims of violent crime access compensation is an emerging area of research and practice. The first HVIP was established in 1994 in Oakland, California, embedding a violence recovery program in a hospital to specifically assist victims of violence (The HAVI — Our History | Health Alliance For Violence Intervention, n.d.). HVIPs deliver trauma-informed care to patients' bedsides while they are in the hospital, a critical moment in an individual's recovery trajectory where they may be particularly receptive to implementing positive behavioral changes and accessing social benefits. These interdisciplinary teams bridge gaps in trust between violently injured patients and healthcare systems. HVIPs are typically paid for by a combination of federal and state funding

and grants ("Hospital-Based Intervention Programs Reduce Violence and Save Money," 2022). Since 2023, Connecticut, Oregon, Illinois, California and Maryland have allowed Medicaid reimbursement for violence prevention services (The HAVI — For Lawmakers | Health Alliance For Violence Intervention, n.d.). Many people presenting to the hospital following violent injury in under resourced communities are particularly distrustful of healthcare and criminal justice institutions (The HAVI — What Is an HVIP?, n.d.). Bringing together medical care teams and community partners, training and integrating community members to serve as violence prevention professionals, HVIPs assist patients form a recovery plan to meet their own unique post-discharge needs — from safe relocation to meeting return to normal function goals. HVIP workflow typically consists of four steps: initial intervention in the emergency department or hospital bedside; comprehensive care; follow up service with community partners; and, addressing social determinants of health to decrease rates of violent injury and recidivism (Figure 1) (The HAVI — What Is an HVIP?, n.d.). Physicians, nurses, and other healthcare providers in the emergency room and trauma center identify patients and flag them for a visit from a hospital's HVIP workers. Initial intervention then consists of an HVIP worker coming to the patient's bedside and discussing with them their violence recovery needs. HVIPs can assist patients access housing, seek employment opportunities, address substance misuse, find social support, and obtain other social benefits they may be entitled to, reducing risk factors for recidivism and addressing upstream social determinants of health (The HAVI — What Is an HVIP?, n.d.). CVC can play a critical role in supporting victims' recovery needs and should thus be a point of focus for HVIPs when they initially aid patients.

Figure 1: Typical hospital-based violence intervention program workflow — intervention (initial bedside or emergency room visit), care (case management connecting patients with community organization and services), follow-up services (visiting patients in their

home and continuing to assist them with long-term recovery needs) and address social determinants of health (improving patients housing, employment, education, and safety) (figure courtesy of The HAVI — What Is an HVIP? | Health Alliance For Violence Intervention, n.d.).

The HAVI is a national organization that coordinates and advances HVIPs with the goal of reducing violence, particularly in communities of color (The HAVI | Health Alliance For Violence Intervention, n.d.). Created in 2009, under the name National Network of Hospital-Based Violence Intervention Programs, it included seven HVIPs nationwide and 30 experts on how to maximize their impact (The HAVI — Our History | Health Alliance For Violence Intervention, n.d.). The organization was renamed the HAVI in 2018, now including more than 50 programs in over 85 cities and continuing to grow (The HAVI — Our History | Health Alliance For Violence Intervention, n.d.). The HAVI has created a national network of HVIPs, helping build new programs while offering training and technical assistance to existing HVIPs.

The HAVI is also engaged with research that supports HVIPs, recently publishing a report detailing their efficacy in New Jersey, while also being deeply involved in advocacy at the federal and state levels, successfully petitioning for violence prevention professionals to be eligible for reimbursement through Medicaid and consistently securing increased funding for HVIPs (The HAVI — Advocacy | Health Alliance For Violence Intervention, n.d.). The HAVI plays a critical role in reducing violence and serves as an invaluable resource for exploring the role HVIPs play in CVC uptake.

Today, there is an ongoing effort to expand the scope of patient care, moving to create a workforce of socially conscious physicians who engage in both acute surgical intervention while working to longitudinally address the social and structural determinants of health. Physicians should be aware of CVC, while actively working with HVIPs to ensure that potentially eligible patients receive the assistance they may need. Social and structural determinants of health describe environmental and systemic factors that impact health, which are especially important to consider given decreases in average life expectancy following the COVID pandemic and widening Black / White disparities in morbidity and mortality (Lipshutz et al., 2022). CVC awareness and uptake is a crucial step in this evolution.

The ACS-COT is responsible for reviewing, validating, and verifying the trauma care resources at trauma centers (ACS, n.a.). There are three distinct levels of ACS trauma center verification. To qualify as a Level I trauma center, a hospital must be equipped to treat all forms of injury with 24-hour immediate coverage from general surgeons and subspecialists in neurosurgery, orthopedics, anesthesiology, emergency medicine, and critical care (American Trauma Society, n.a.) Additionally, a Level I trauma center must possess programs for substance abuse, and meet a minimum annual patient volume (American Trauma Society, n.a.). Critically,

recognizing prevention as an essential aspect of injury, Level I trauma centers must include injury prevention efforts in the communities they serve (American Trauma Society, n.a.). The integration of preventative efforts and HVIPs into trauma centers expands the scope of advocacy and treatment offered to patients, further supporting the notion that trauma healthcare providers should be advocating for patients along the entire continuum of care.

LITERATURE REVIEW

The U.S. Department of Justice Federal Bureau of Investigation (FBI) defines violent crime in their Uniform Crime Reporting (UCR) Program as murder or non-negligent manslaughter, forcible rape, robbery, and aggravated assault (FBI Crime in the United States, n.a.). In 2023, it was estimated that there were approximately 22.5 violent victimizations in the U.S. per 1,000 people aged 12 or older (Tapp & Coen, 2024). Victims of intentional, interpersonal violence represent an important patient population treated at trauma centers. While not every victim of violent crime will present to the hospital, a significant proportion do — in 2021 alone over 1.4 million people went to the emergency room following assault (CDC, 2021). Crime-related trauma leads to increased healthcare utilization (Robinson & Keithley, 2000).

Presenting to the hospital following intentional interpersonal violence can be extremely costly. The average charge for admission to the hospital through the emergency room following a gunshot wound is $95,887 (Amnesty International, 2019). The median cost of a tier I trauma activation (full activation) is $9,500 (Zitek et al., 2023). Costs associated with traumatic injury extend far beyond the immediate impacts of a visit to the emergency room or trauma center, with recovery unfolding over months and medical expenses continuing to balloon. While the cost incurred by the patient will depend largely on their insurance status, these financial burdens can

prove ruinous for uninsured individuals, and even high out-of-pocket costs from deductibles and co-pays can become significant sources of stress for insured patients. The combination of objective financial burden and subjective financial distress can have a direct impact on a patient's health, a phenomenon called financial toxicity (Zafar & Abernathy, 2015). One study of financial toxicity found that 75.7% of patients enrolled in a hospital's HVIP following firearm related injury reported assistance with CVC application as one of their financial needs (Reyes et al., 2025). Efficient and proportionate allocation of CVC could alleviate financial toxicity, directly improving trauma patients' injury recoveries. Debt is a strong predictor of recidivism following violent injury, further underpinning CVC's utility in addressing victims' financial needs as a key part of global injury recovery (van Beek et al., 2023).

Several reasons for the apparent underuse of CVC have been posited by scholars. In every state, there are strict eligibility requirements that must be met for claims to be successfully awarded. While these requirements vary by state, typically, victims must report crimes to law enforcement (or complete a sexual assault evidence kit in instances of sexual violence) within a specified timeframe, cooperate with criminal and legal proceedings, not be implicated in the crime, and have exhausted other funding sources like insurance and public benefits (Kirkner & Houston-Kolnik, 2019). In Illinois specifically, victims have 72 hours to report the crime (7 days for sexual assault) and must file a CVC application within 2 years of the crime or 1 year of criminal charges being filed (Kirkner & Houston-Kolnik, 2019). Scholars have indicated that these stringent eligibility criteria represent a significant hurdle to accessing CVC, and that possible claimants will often self-screen. For example, one study suggests reporting and cooperation requirements could immediately prevent over half of victims of violent crime from successfully receiving CVC (Felson & Lantz, 2014). In 2020, this was the case as only about

40% of violent victimizations were reported to law enforcement, precluding over half of victims from ever receiving CVC (Morgan, 2020).

Even if a victim meets the eligibility requirements, several other factors may prevent them from accessing compensation. CVC currently functions as a reimbursement program, requiring victims to pay upfront costs (such as medical bills, funeral expenses, relocation costs, etc.) themselves and hope to be reimbursed afterwards. This reimbursement model poses a significant challenge for resource-depleted communities that may be unable to afford expenses, amplifying the risk of repeat violence (van Beek et al., 2023). Claims in Illinois still typically take up to a year to be fully processed and paid out, posing yet another challenge to those who need immediate assistance or who pay with the expectation of being promptly reimbursed (Kirkner & Houston-Kolnik, 2019). Compiling the necessary documentation and records can be time consuming, presenting another roadblock to victims. Patton et al. (2019) identified assistance with financial paperwork as a significant need for traumatically injured hospital patients' post-discharge. In a qualitative study of victims of gun violence at a Midwestern university hospital, difficulties accessing CVC funds were reported (Patton et al., 2019).

A paper by Moos et al. (2025) uses the same dataset employed for this project, obtained via several Freedom of Information Act requests filed with the Illinois Secretary of State's Office, to investigate CVC uptake by victims of sexual assault and domestic violence in Illinois. Consistent with my findings, they reveal that between January 2012 and July 2024, 46,792 CVC claims were filed in Illinois. The most common crimes for which a CVC claim was filed were assault/battery (45.1% of claims) and homicide (21.8% of claims). Over this period, females filed 18,657 claims (40% of all claims), of which significantly more were for sexual assault and

domestic violence, and males filed 27,991 claims (60% of all claims), of which significantly more were for assault and homicide.

Table 1: Illinois Crime Victim Compensation Claims by Gender From 2012 to 2024 (table courtesy of Moos et al., 2025)

Type of Claim	Female	Male	All
Assault / Battery	5,805 (27.6)	15,247 (72.4)	21,052
Murder	2,125 (20.9)	8,030 (79.1)	10,155
Other	3,489 (54.4)	2,927 (45.6)	6,416
Domestic Violence	3,500 (84.7)	633 (15.3)	4,133
Child / sex abuse	1,922 (78.0)	541 (22.0)	2,463
Rape / sexual assault	1,270 (92.0)	110 (8.0)	1,380
Driving Under the Influence	450 (51.4)	426 (48.6)	876
Child physical abuse	66 (49.2)	68 (50.8)	134
Child pornography	30 (70.9)	9 (23.1)	39
Total	18,657 (40)	27,991 (60)	46,648

In 2019, Amnesty International declared firearm violence in the United States a human rights crisis. On July 19th, 2024, the 19th (2015-2017) and 21st (2021-2025) US Surgeon General Vivek Murthy declared firearm violence a public health crisis (Abbasi & Hswen, 2024). In March 2025, this advisory was removed from the Health & Human Services website (Kekatos, 2025). Despite the particular threat firearm violence poses to public health, the literature shows that there is a lack of support for victims seeking compensation following violent injury. HVIPs offer one way that victims can receive assistance accessing social benefit programs during their hospital stay. One study found that 48% of patients enrolled in an HVIP cited a need for assistance with CVC (Juillard et al., 2016). HVIPs have also been shown to be an effective intervention for decreasing recidivism of violent criminal activity and are promising interventions for decreasing reinjury rates for trauma patients (Cooper, Eslinger & Stolley, 2006; Kirkner & Houston-Kolnik, 2019). This decrease in recidivism means that HVIPs have the

potential to save significant amounts of money for their hospitals, with one study indicating that their HVIP reduced net cost by $5,892 per patient (Juillard et al., 2015). 75% of over 6,000 patients enrolled in one Chicago-based HVIP expressed a social determinant of health need, and HVIP workers showed great utility in strengthening doctor-patient relationships, particularly in an under-resourced community (Cosey-Gay et al., 2023). Yet, as of 2019, only 25 registered trauma centers in the United States had a functioning HVIP (Coupet Jr., Huang & Delgado, 2019). It remains unclear exactly how well HVIPs can fulfill patients' needs, with one study showing that it is often difficult for HVIPs to meet the mental health and time-intensive long-term needs of their patients (Jang et al., 2023). Proper implementation of HVIPs requires thorough collaboration between healthcare systems and community partners to establish sustained, multidisciplinary programs (Mueller et al., 2022). It is crucial that HVIPs not only assist patients while they remain in the hospital, but also longitudinally following discharge (Mancini et al., 2023). One study estimates that it costs approximately $1.1 million annually to operate an HVIP out of a mid-sized city's hospital, serving approximately 100 violently injured patients annually (O'Toole et al., 2025).When implemented effectively, specifically in under-resourced communities of color, HVIPs have the potential to directly address anti-Black racism and historical trauma, combatting the root causes of inequities in violence (Woods-Jaeger et al., 2023).

Sonnenberg et al. (2024) show that healthcare providers indicate that difficulty accessing CVC is one of the most frequently identified health-harming legal needs trauma patients experience. Furthermore, Alvidrez et al. (2008) identified lack of assistance and lack of awareness as the two primary challenges trauma patients faced accessing CVC. Medical-legal partnerships or health-justice partnerships, collaborations between medical teams and legal

professionals, have shown efficacy in increasing uptake of social welfare programs (Beardon et al., 2021). The potential benefits medical-legal partnerships provide their patients are wide ranging, from improved physical and mental health outcomes to increased knowledge about legal rights and systems (Johnson et al., 2024). The addition of medical-legal partnerships into the trauma care setting is a relatively new development. Research indicates the utility of having HVIPs and other comprehensive services embedded directly into trauma care to support violently injured patients' recoveries (Rucha et al., 2024). This is facilitated by integrating violence recovery specialists, who can understand and relate to patients' sociocultural contexts, into the trauma care team (Decker et al., 2020).

It remains unclear how informed trauma healthcare providers themselves are about CVC. While trauma healthcare providers are increasingly stretched thin when patients present following a violent crime, it is paramount that patients are made aware of opportunities for compensation and allowed to take the necessary, time-sensitive steps needed to access CVC. HVIPs are uniquely positioned in the moments immediately following victimization to make their patients aware of CVC and initiate the application process, but this is impossible if they themselves lack the necessary knowledge and support to assist patients. Sonnenberg et al. (2024) employed similar methods to those I use, surveying and interviewing trauma healthcare providers about the health-harming legal needs their patients face. In 2016, it was shown that when Illinois residents were asked if crime victims were eligible to receive compensation, 22% of residents responded no, and 66% responded that they did not know (Hahn, 2017). This underscores the critical role HVIPs can play in promoting CVC uptake, informing and supporting their patients.

The present study is among the first to quantitatively assess the underutilization of CVC following violent crime in Illinois. The body of literature describing the role HVIPs play in promoting CVC uptake is extremely limited. To my knowledge, I am the first to explore the crucial role HVIPs nationwide play in assisting their patients access CVC and center the voices of HVIP workers themselves to assess how best to transform CVC into a truly reparative policy tool.

METHODS

I conducted a mixed-methods analysis, using a previously compiled novel database of CVC claims in Illinois from 2012 to 2024 to describe CVC underutilization in Illinois quantitatively, also circulating an online survey to HVIPs and conducting qualitative interviews to better understand the barriers applicants face from the perspective of HVIP workers. The study was deemed exempt by the University of Chicago Institutional Review Board office (protocol IRB24-1912).

Survey respondents were contacted via email through the HAVI Research and Evaluation Workgroup. This is one of the eight HAVI Workgroups, as each focuses on a different domain related to the work of HVIPs. The Research and Evaluation Workgroup is focused on conducting novel research with HVIPs, while implementing standardized data collection protocols to evaluate HVIP performance (The HAVI — Working Groups | Health Alliance For Violence Intervention, n.d.). The Research and Evaluation Workgroup email list had 85 individuals, excluding HAVI and Kaiser Permanente staff, associated with 12 to 15 different HVIPs across the nation. I requested that individuals disseminate the survey to HVIP staff at their respective hospitals. I specifically targeted violence recovery/intervention workers, and HVIP affiliated

social workers, as they were hypothesized to be patients' primary point of contact for CVC application assistance in the healthcare setting. All respondents were asked to specify the hospital at which they work, otherwise responses were anonymous. The 20-question survey designed using Survey Monkey, opened on February 5th, 2025, and responses were collected through February 28th, 2025. After initial notification was sent, follow-up reminders were sent one and two weeks after the survey opened. Initially, respondents were awarded a $10 gift card for survey completion. When the first reminder was sent, award amount was increased to $20. All survey responses were stored in an encrypted UChicago Box folder and analyzed with descriptive statistics.

Circulating a survey had some limitations that must be considered. Of the 14 people who started to fill out the survey, only 11 people completed it (78.6%). This attrition, along with the significant portion of contacted participants who never responded, introduce response bias, as the HVIP workers taking the time to complete the survey may not be representative of the general HVIP workforce. Respondents may have only responded if they had some underlying knowledge or specific experience with their state's CVC program. They also may have felt compelled to give socially desirable answers and thus overstate their respective knowledge of the CVC application process and eligibility criteria. I attempted to keep the survey as brief as possible, sacrificing some depth for additional data points. Average response time was 6m:17s, with time taken by respondents varying from 3m:48s to 22m:38s, potentially indicating survey fatigue in some participants. Survey responses merit consideration alongside the other sources of data used in this study and continue to add depth to the findings describing HVIP workers' opinions of CVC program efficacy.

If survey respondents expressed interest in being contacted for participation in a 30-minute, qualitative interview, they were contacted via their preferred method of communication to schedule an interview over Zoom. No additional compensation was offered to interview participants. All interviewees underwent a full consent process. A loose question script was followed, with different follow-up questions asked depending on respondents' answers. Interviews were recorded and transcribed to text using OtterAI, a program that converts audio recordings into written transcriptions. Transcripts were then reviewed for accuracy. I analyzed the data using content analysis, rather than a particular coding method, giving particular emphasis to individual experiences.

Working with qualitative data potentially introduces bias into the analysis. The results of this study are limited by the number of interview participants. It is also subject to response bias, given that the HVIP workers willing to take part in an undergraduate research project about CVC may not be a representative sample of HVIP workers nationwide. However, the opportunity to combine qualitative interview with quantitative analysis of survey responses and CVC data in Illinois gives additional insight into the lived expertise of HVIP workers pertaining to CVC, not described elsewhere in the literature. Despite certain limitations, these findings are worth considering given the transformative impact CVC could have assisting victims in their global injury recovery, alleviating financial toxicity and serving as a form of structural reparations.

For the quantitative analysis, I used two main datasets: CVC claims in Illinois and Illinois uniform crime reporting data. I had access to a dataset previously obtained by filing several Freedom of Information Acts with the Illinois Secretary of State's office, requesting and obtaining data on CVC claims filed in Illinois from January 2012 through July 2024. This included anonymized individual-level records pertaining to CVC applications, including

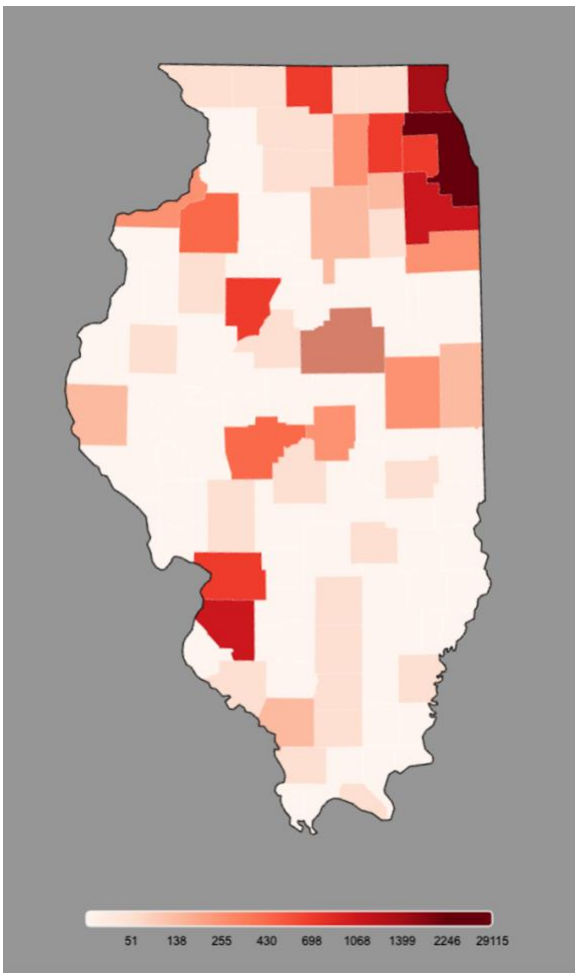
demographic information (race, gender, age) and claim details (associated crime, date filed and closed, reason for denial, total payout). I compared the number of claims filed and paid out to total crimes committed annually in Illinois in a novel analysis. Publicly available data collected by the Illinois state police's uniform crime reporting program was used to obtain the total number of violent crimes reported to police annually from 2012 to 2020 in the state. Finally, I compared number of claims filed by county across Illinois. All statistical analyses were completed in R (R Core Team, 2023).

The CVC data compiled originated from four distinct Freedom of Information Act requests for CVC claims in Illinois from 2012 to 2024. Some of the information requested in the Freedom of Information Act, such as the type of expense, was not provided. The Illinois Secretary of State does not collect data on the initial amount requested by CVC claimants, making it impossible to know if the compensation amount awarded adequately fulfilled the applicant's need. Gender was limited to binary categorizations due to state limitations in data collection, eliminating any possibility of analyzing how CVC may be used by transgender and gender diverse individuals, who are disproportionately victims of violent crime and sexual violence. The publicly available data used for this study, collected by the Illinois state police's Illinois uniform crime reporting program for the annual crime in Illinois publication, was only available until 2020, preventing analysis of years since. Publicly available data only described total annual reported violent crimes in Illinois with no description of the number of victims who present to the hospital. This precluded analysis of CVC uptake in the hospital setting specifically. Each state operates its own CVC program, with significant variability in eligibility criteria. My study's quantitative portion focuses exclusively on Illinois and can serve to help publicize CVC programs available in other states or regions.

FINDINGS AND DISCUSSION

Quantitative Analysis

Figure 2: A map of the geographic distribution of crime victim compenstion claims by county filed in Illinois from 2012 to 2024.



Using data previously compiled with several Freedom of Information Act Requests from the Illinois Secretary of State's office, I conducted a novel analysis of the geographic breakdown of Illinois CVC claims from January 2012 to July 2024. Of the 46,792 CVC claims filed in Illinois during this period, 24,404 (52.2%) were filed in the City of Chicago, and an additional 4,711 (10.1%) were filed in greater Cook County (Figure 2). This is consistent with crime trends

in Illinois, which show the vast majority of crime in the state concentrated in Chicago and Cook County, the most populous areas (Andriesen, 2025). Neighboring suburban counties of Lake, Will and Kane, as well as counties near St. Louis and the Missouri border, such as St. Clair, also filed many CVC claims during the study period. From 2012 to 2024, 75 of the 105 counties and cities listed filed fewer than 100 CVC claims. There is a clear divide between urban and rural counties both in rates of violent crime and CVC applications filed. Large, urban, tertiary care hospitals are where the most seriously injured patients are transferred, and also the most likely to be located in densely populated areas with high burdens of violent crime, but local community hospitals should also be equipped to help their patients access CVC. Further research should investigate how community hospitals without the resources or patient volume needed to operate an HVIP, can still sufficiently support violently injured patients access CVC.

Using publicly available data collected by the Illinois state police's uniform crime reporting program, I obtained the total number of violent crimes reported to police annually from 2012 to 2020 in Illinois. Data was not publicly available past 2020. During this 8-year period, there were 268,377 assaults, 7,651 homicides, 932,595 domestic violence incidents, and 43,194 sexual assaults reported to Illinois law enforcement.

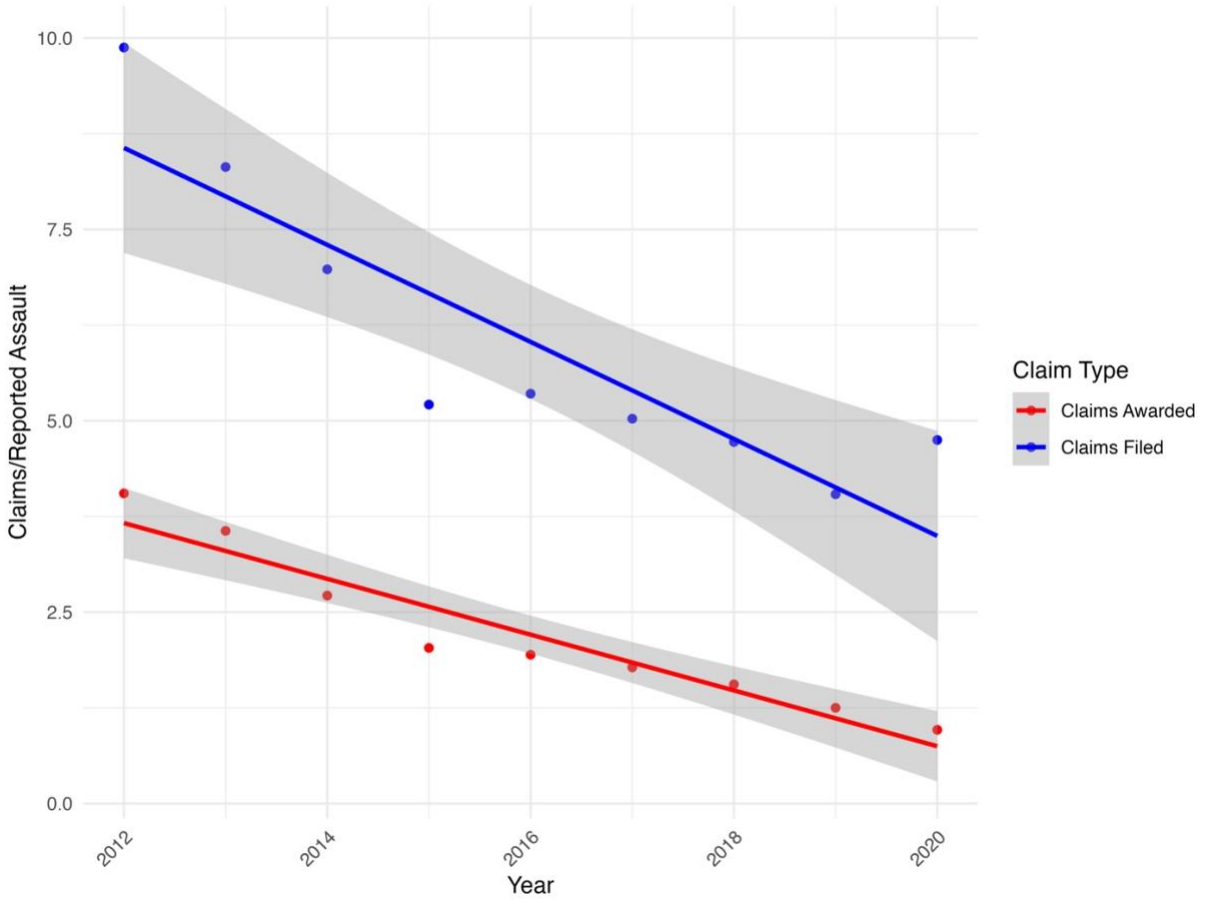
Despite more than 250,000 reported incidents of assault over this 8-year period, only 15,984 CVC claims were filed (6.0% of total reported victimizations). Only 5,796 of claims were successfully paid out (2.2% of total reported victimizations), with 63.7% of assault-related claims denied. Despite relatively constant rates of reported assaults, the rate at which CVC claims were filed and awarded both decreased significantly from 2012 to 2020 (both $p<0.01$). In 2012 2,862 claims were filed (9.9% of total reported victimizations) and 1,174 were successfully paid out (4.1% of total reported victimizations). By 2020 only 1,559 claims were filed (4.7% of

total reported victimizations) with just 316 successfully paid out (0.96% of total reported victimizations), with a denial rate of 79.7% that year. It appears that CVC following assault may be becoming more difficult to access, with denial rates climbing between 2012 and 2020. Costs associated with assault can be wide-ranging and difficult for victims to track, underpinning the importance of having early awareness of CVC.

Table 2: Reported assaults in Illinois and assault-related crime victim compensation claims filed and paid out from 2012 to 2020.

Year	Reported Assaults	CVC Claims Filed (N%)	CVC Claims Awarded (N%)
2012	28,981	2,862 (9.9)	1,174 (4.1)
2013	27,626	2,297 (8.3)	984 (3.6)
2014	26,655	1,860 (7.0)	724 (2.7)
2015	28,343	1,477 (5.2)	576 (2.0)
2016	31,234	1,672 (5.4)	607 (1.9)
2017	31,212	1,569 (5.0)	555 (1.8)
2018	29,810	1,408 (4.7)	464 (1.6)
2019	31,688	1,280 (4.0)	396 (1.2)
2020	32,828	1,559 (4.7)	316 (0.96)
Total	26,8377	15,984 (6.0)	5,796 (2.2)

Figure 3: Trends in rate of crime victim compensation claims filed and awarded from 2012 to 2020 following assault in Illinois.



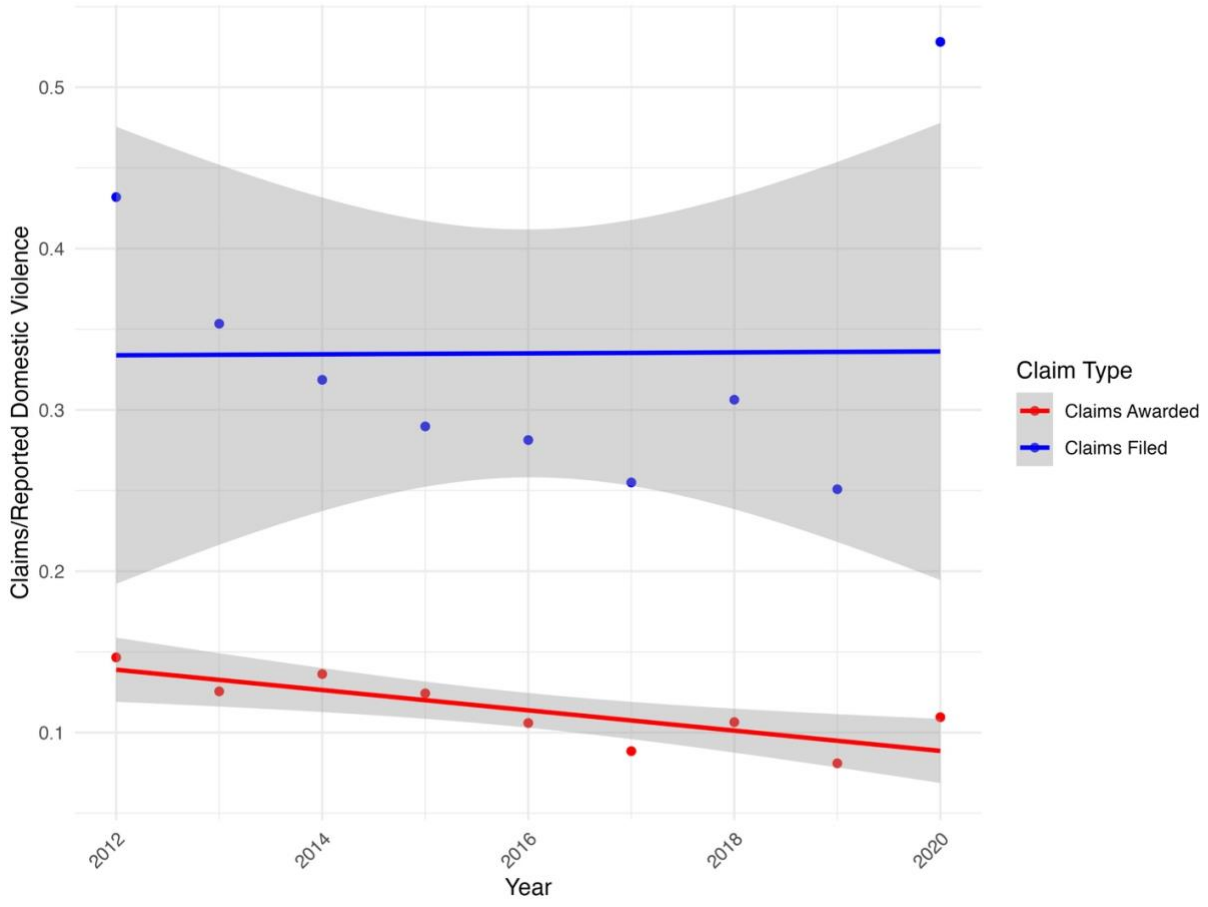
The underutilization of CVC appears even more drastic for victims of domestic violence. With nearly one million reported incidents of domestic violence from 2012 to 2020, only 3,024 domestic violence-related CVC claims were filed (0.32% of total reportedvictimizations) with only 1,054 succesfully awarded (0.11% of total reported victimizations). Domestic violence victims were the least likely to apply for and succesfully receive CVC. On average over the study period, 65.2% of claimants were denied CVC. In 2019, just 92 of the 113,618 reported victims (0.08%) succesfully received CVC. There was no statistically significant decrease in the rate at which CVC claims were filed ($p=0.92$), but there was a statistically significant decrease in the proportion of claims succesfully awarded ($p<0.01$). In 2020, just 73 domestic violence-related CVC claims were awarded (0.11% of total reported victimizations), with 79.3% of claims denied that year. As elaborated in subsequent qualitative interviews, victims who know their

assailant are perhaps more hesitant to cooperate with law enforcement, potentially contributing to low rates of CVC application and high denial rates for this subset of victims. CVC administrators can also reject a claim if they believe it will enrich the victims assailant, which may be another reason for domestic violence-related claim denial if a victim continues to live with their assailant. Restrictive eligibility requirements in Illinois likley preclude many victims of domestic violence from succesfully accessing CVC.

Table 3: Reported domestic violence in Illinois and domestic violence-related crime victim compensation claims filed and paid out from 2012 to 2020.

Year	Reported Domestic Violence	CVC Claims Filed (N%)	CVC Claims Awarded (N%)
2012	101638	439 (0.43)	149 (0.15)
2013	103552	366 (0.35)	130 (0.13)
2014	99795	318 (0.32)	136 (0.14)
2015	106978	310 (0.29)	133 (0.12)
2016	118014	332 (0.28)	125 (0.11)
2017	115275	294 (0.26)	102 (0.9)
2018	107075	328 (0.31)	114 (0.11)
2019	113618	285 (0.25)	92 (0.08
2020	66650	352 (0.53)	73 (0.11)
Total	932595	3024 (0.32)	1054 (0.11)

Figure 4: Trends in rate of crime victim compensation claims filed and awarded from 2012 to 2020 following domestic violence in Illinois.



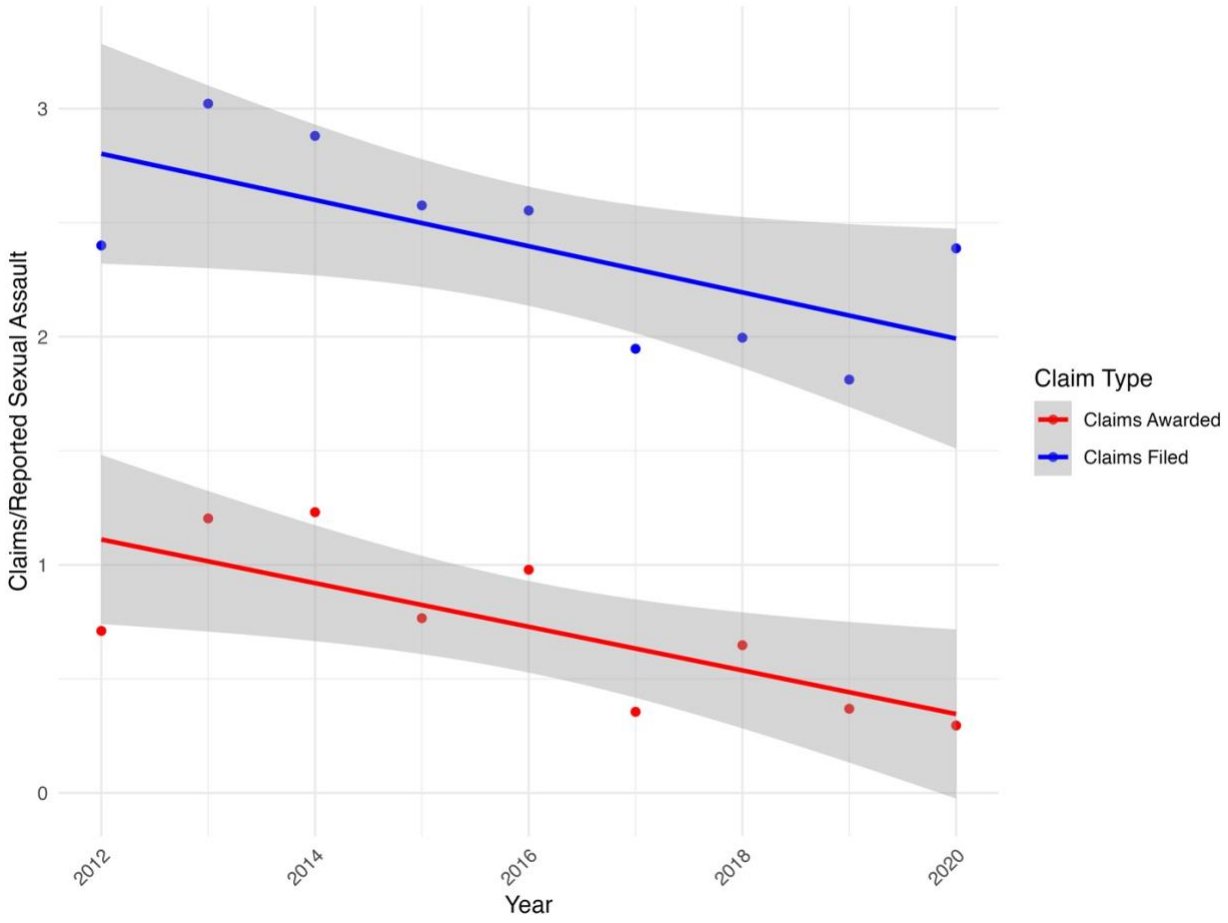
Despite over 43,000 incidents of sexual assault reported to law enforcement, just 1,013 sexual assault-related CVC claims were filed (2.3% of total reported victimizations) with 300 succesfully paid out (0.69% of total reported victimizations). Of all violent crime victims in Illinois, victims of sexual assault were the most likely to have their CVC claims denied, with 70.4% of claims denied during the study period. There was a statistically significant decrease in both the proportion of CVC claims filed and awarded following sexual assault from 2012 to 2020 (both $p<0.05$). By 2020, only 14 sexual assault-related CVC claims were paid out in Illinois, representing just 0.30% of total reported victimizations, with 87.6% of all sexual assault-related CVC claims denied that year. In Illinois, to be eligible for CVC victims of sexual assault must notify law enforcement within 7 days, obtain an Order of Protection, or undergo sexual assault evidence collection within 7 days (Kirkner & Houston-Kolnik, 2019). These eligibility

criteria may preclude many victims from ever seeking compensation, but for those who do present to the hospital, it is paramount that they are informed of the criteria, and initiate steps to fulfill them. While HVIPs have historically focused their efforts on community violence, they are now expanding care to patients affected by sexual assault (Aboutanos et al., 2019). In the same way healthcare providers and Sexual Assault Nurse Examiners would spend time addressing patients' immediate medical needs, it is critical that HVIP workers help patients to incorporate CVC awareness and application assistance into their trauma care workflow.

Table 4: Reported sexual assault in Illinois and sexual assault-related crime victim compensation claims filed and paid out from 2012 to 2020.

Year	Reported Sexual Assault	CVC Claims Filed (N%)	CVC Claims Awarded (N%)
2012	4083	98 (2.4)	29 (0.7)
2013	3905	118 (3.0)	47 (1.2)
2014	4062	117 (2.9)	50 (1.2)
2015	4698	121 (2.6)	36 (0.77)
2016	4700	120 (2.6)	46 (0.98)
2017	5341	104 (1.9)	19 (0.36)
2018	5712	114 (2.0)	37 (0.65)
2019	5960	108 (1.8)	22 (0.37)
2020	4733	113 (2.4)	14 (0.30)
Total	43194	1013 (2.3)	300 (0.69)

Figure 5: Trends in rate of crime victim compensation claims filed and awarded from 2012 to 2020 following sexual assault in Illinois.



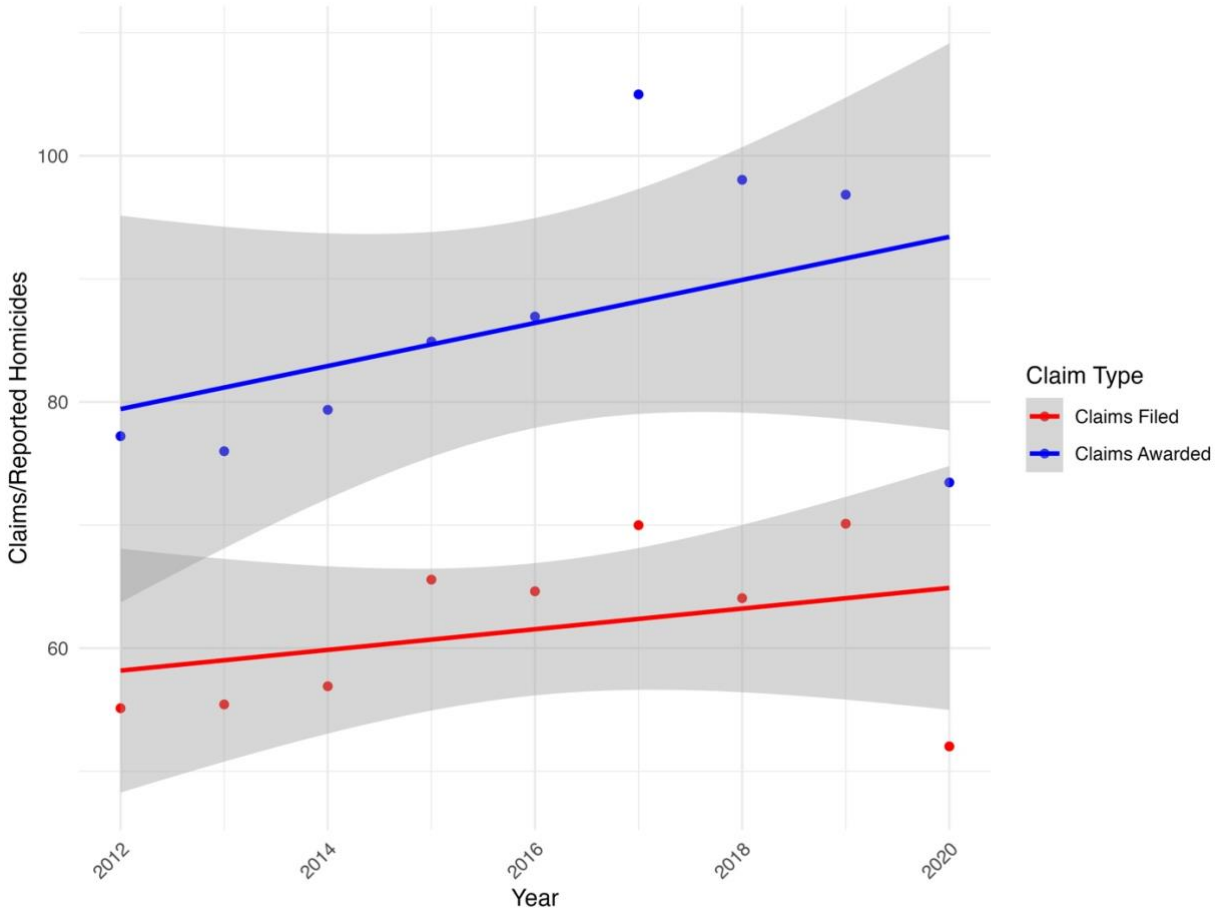
Compared to other violent crimes, CVC functions most effectively following homicide. From 2012 to 2020, 7,651 homicides were reported to Illinois law enforcement. In this same period, 6,637 CVC claims were filed (86.7% of total reported victimizations), with 4,714 claims succesfully awarded (61.6% of total reported victimizations). CVC claims were by far most likely to be filed following homicide victimization. Notably in 2017, the number of CVC claims filed actually exceeded the number of reported homicides (105.0% of total reported victimizations). This is likely because multiple family members and dependents can file separate claims following a homicide. Homicide-related claims were also the most likely to be paid out, with 71.0% of claims awarded. While it is also important to consider how long applicants waited for claims to be processed, as well as the size of the final award sum, the likelihood of having a

homicide-related claim paid out was significantly higher compared to other types of violent crime. Unlike the trends observed for CVC claim and award rates following other types of violent crime in Illinois, from 2012 to 2020 there was no statistically significant decrease in the proportion of CVC claims filed or awarded following homicide (p=0.25, p=0.37 respectively). Rather, there is a non-significant upward trend in both. The costs associated with a homicide, such as funeral expenses and medical bills, are easily substantiated, compared to the diverse physical and mental recovery needs associated with a crime like sexual assault, which may explain why claim rates are significantly higher following homicides than other major type of violent crime. Further investigation is needed to determine how long claimants wait for applications to be processed, as well as if any disparities exist across races in claim delays, award rates, and award amounts. Homicide victims are also the most likely of all groups to present to the hospital, and thus it is critical that HVIPs continue to work with victims families to assist them access reimbursement.

Table 5: Reported homicides in Illinois and homicide-related crime victim compensation claims filed and paid out from 2012 to 2020.

Year	Reported Sexual Assault	CVC Claims Filed (N%)	CVC Claims Awarded (N%)
2012	742	573 (77.2)	409 (55.1)
2013	700	532 (76.0)	388 (55.4)
2014	659	523 (79.4)	375 (56.9)
2015	729	619 (84.9)	478 (65.6)
2016	1026	892 (86.9)	663 (64.6)
2017	963	1011 (105.0)	674 (70.0)
2018	871	854 (98.0)	558 (64.1)
2019	823	797 (96.8)	577 (70.1)
2020	1138	836 (73.5)	592 (52.0)
Total	7651	6637 (86.7)	4714 (61.6)

Figure 6: Trends in rate of crime victim compensation claims filed and awarded from 2012 to 2020 following homicide in Illinois.



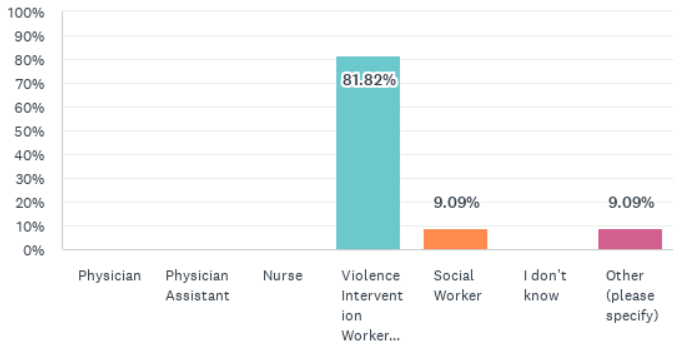
Quantitative findings indicate that CVC claims in Illinois are concentrated around large, urban city centers. CVC appears to function most effectively following homicide, where expenses such as funeral costs are easily substantiated. Compared to the total reported incidents of violent crime in the state, particularly following assault, domestic violence and sexual assaults, few victims ever end up applying for CVC, and those who do remain unlikely to have a claim successfully awarded. From 2012 to 2020, there was typically a significant decrease in the proportion of victims who applied for and successfully received CVC following these kinds of crime.

Survey Responses

From February 5th, 2025, to February 28th, 2025, I collected 14 survey responses from individuals associated with HVIPs contacted through the HAVI's Research and Evaluation Workgroup. A complete list of interview questions can be found in the Appendix. 11 of the 14 respondents (78.6%) successfully completed the entire survey; the other three did not respond beyond the initial consent page. Of the 11 complete responses collected, the sample consisted of four violence intervention workers, four social workers, one community health worker, one HVIP director, and one county-wide case manager. I collected responses from individuals in Delaware, California, Ohio, Minnesota, Pennsylvania and South Carolina, allowing for comparisons to be drawn between how different states administer their respective CVC programs. Many respondents (9/11, 81.8%) agreed that HVIP workers would be the most likely people in their hospital to assist victims of intentional, interpersonal violence with the CVC application process (Figure 7). Additionally, eight respondents (72.7%) had assisted a patient apply for CVC within the last month. This supported my hypothesis that HVIP workers play an essential role in the uptake of CVC in the healthcare setting. Note that one respondent replied "Other" and specified that the "Trauma Recovery Center" at their hospital would be responsible for assisting patients with the CVC application process. While no further information was provided regarding their specific Trauma Recovery Center, programs by the same name have been adopted at other hospitals nationwide. Trauma Recovery Center's typically focus specifically on addressing patients' mental health recovery needs and often work alongside HVIPs ("Trauma Recovery Center," n.d.).

Figure 7

Q4 Who in your hospital might be the most likely to help patients following intentional interpersonal violence access crime victim compensation (CVC)?



All but two respondents (9/11, 81.8%) were aware that their patients who were victims of violent crime could potentially receive CVC as a benefit from the Victims of Crime Act. One respondent was unaware, and another responded that they did not know. In this sample, HVIP employees were generally well informed of CVC and its potential utility for their patients. However, when asked how well informed they considered themselves about CVC eligibility requirements and application processes, only two respondents (18.2%) considered themselves "completely informed." On average, from a scale of 1 being completely unaware, and 10 being completely informed, respondents considered themselves to be a 7/10 when it came to both eligibility criteria and application processes. Further described during qualitative interviews, in certain states it seemed that information about eligibility criteria is intentionally guarded by program administrators. Interviewees mentioned their experience encountering hidden eligibility criteria, that do not appear in writing but are cited as reasons for their patients being denied. This makes it especially difficult for HVIP workers and case managers to access this information and provide proper guidance.

Lack of transparency during the application and claim review process is another factor that makes CVC especially tedious and challenging to navigate for HVIP workers and their patients. Described in further detail during qualitative interviews, training provided to HVIP workers at their respective institutions about the details of their state's CVC program is inconsistent. Often knowledge of the intricacies of the process was accrued through lived experience assisting patients. Lack of training is one factor contributing to a lack of awareness in these areas. When asked in the survey if their respective hospital had specific guidelines or resources to assist patients access CVC, only two said yes (18.2%), with nine stating either no or that they did not know (81.8%). Furthermore, when asked if their hospital provides them with specific trainings related to the Victims of Crime Act and the CVC application process, only two responded yes (18.2%), with seven responding no (63.6%), and two responding that they did not know (18.2%). Respondents learned about CVC in diverse ways: one knew about it from a prior workplace, another was informed about it during their onboarding process, and another stated they "received brief explanations of how to complete the application from a member of the National Crime Victim's Center but did not receive formal training." The one respondent who received official Victims of Crime Act trainings considered themselves well informed of both CVC application and eligibility criteria, suggesting potential utility of adopting these trainings more widely. It is clear that some hospitals lack sufficient support to help patients access CVC, often relying exclusively on HVIP workers, who are increasingly stretched thin, especially in under-resourced states and healthcare systems, to be the sole resource for patients to gain assistance accessing CVC.

Despite typically lacking specific guidelines, resources, or trainings related to CVC, 10 respondents (90.9%) indicated that their HVIP was responsible for directly assisting patients

apply for CVC, with one respondent (9.1%) citing that their HVIP outsources this function to a community partner organization. Further research should investigate which HVIP model is more effective at helping patients access CVC. Given that admittance to the hospital may be a violently injured patient's only interaction with the healthcare system, it appears to be the opportune moment to connect them with social programs, rather than relying on follow-up with a community organization post-discharge. When respondents were asked their opinion about the statement "CVC helps my violently injured trauma patients," four respondents indicated they strongly agree (36.4%), one respondent agreed (9.1%), four were neutral (39.4%) and two disagreed (18.2%). The diversity of opinions regarding the efficacy of CVC is indicative of the significant state-by-state differences that exist in the program. Some, more financially robust states like California, have committed the resources and funding to make CVC efficient and impactful for victims, while other less financially robust states like South Carolina operate programs that struggle to sufficiently address patients' needs. California, with a maximum CVC reimbursement of $70,000, was allocated over $23 million from the Office for Victims of Crime in the 2024 fiscal year. By comparison, South Carolina, with a maximum CVC reimbursement of $15,000, was allocated just over $3 million. This disparity was described in detail during qualitative interviews.

The three most common barriers respondents indicated preventing their patients from accessing CVC were 1) difficulty with the application itself, 2) lack of awareness, 3) failure to cooperate with law enforcement (Figure 8). This is consistent with previous findings outlined in the literature review, revealing that most people are unaware of the social benefits they may be entitled to, and that the cumbersome paperwork and burden of substantiating pecuniary losses with receipts is a significant hurdle for victims of crime seeking reimbursement. HVIP workers

are in a privileged position, visiting a patient early in the trajectory of their care, capable of initially promoting awareness of the program, and subsequently encouraging patients to keep track of their expenses.

Figure 8

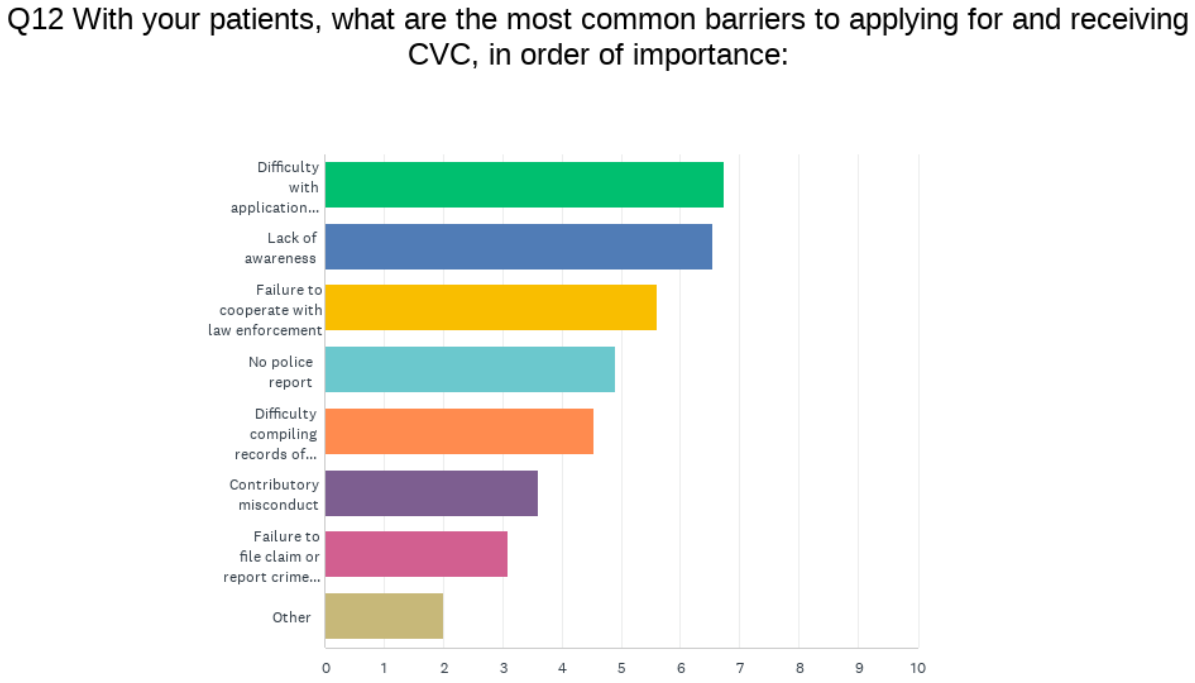


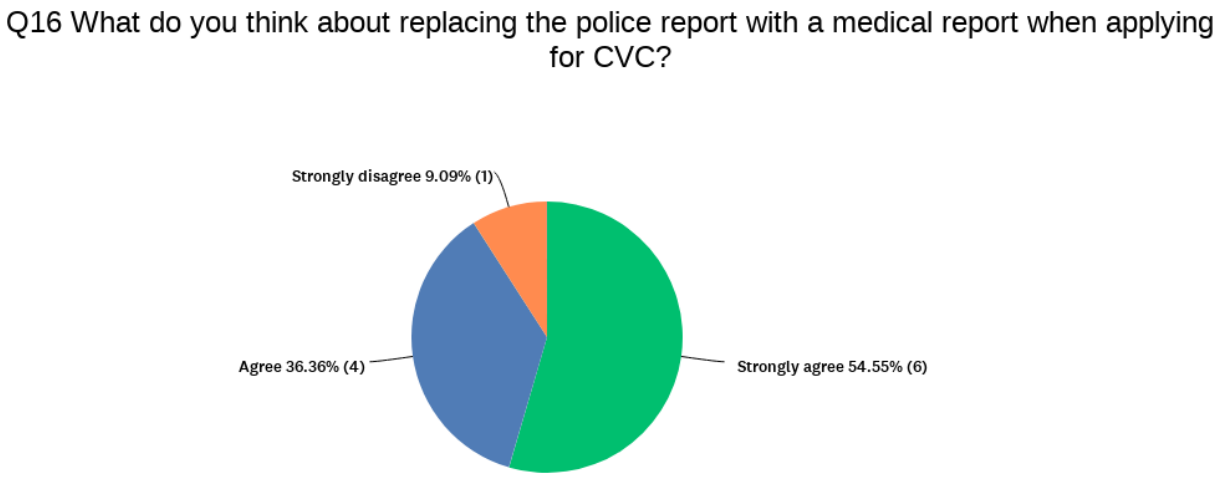
Table 6: Respondents rank order responses when asked what the most common barriers their patients encountered applying for and receiving crime victim compensation.

	1	2	3	4	5	6	7	8	I DON'T KNOW	TOTAL	SCORE
Difficulty with application itself	36.36% 4	27.27% 3	9.09% 1	27.27% 3	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	11	6.73
Lack of awareness	45.45% 5	9.09% 1	27.27% 3	9.09% 1	0.00% 0	0.00% 0	9.09% 1	0.00% 0	0.00% 0	11	6.55
Failure to cooperate with law enforcement	9.09% 1	36.36% 4	9.09% 1	9.09% 1	9.09% 1	9.09% 1	9.09% 1	0.00% 0	9.09% 1	11	5.60
No police report	0.00% 0	0.00% 0	36.36% 4	27.27% 3	18.18% 2	0.00% 0	9.09% 1	0.00% 0	9.09% 1	11	4.90
Difficulty compiling records of expenses	9.09% 1	9.09% 1	9.09% 1	18.18% 2	18.18% 2	27.27% 3	9.09% 1	0.00% 0	0.00% 0	11	4.55
Contributory misconduct	0.00% 0	9.09% 1	0.00% 0	9.09% 1	36.36% 4	9.09% 1	18.18% 2	9.09% 1	9.09% 1	11	3.60
Failure to file claim or report crime in time	0.00% 0	9.09% 1	0.00% 0	0.00% 0	9.09% 1	45.45% 5	18.18% 2	9.09% 1	9.09% 1	11	3.10
Other	0.00% 0	0.00% 0	9.09% 1	0.00% 0	0.00% 0	0.00% 0	18.18% 2	36.36% 4	36.36% 4	11	2.00

Other barriers frequently cited were lack of a police report and difficulty compiling records of expenses. 10 of the 11 respondents (90.9%) either agreed or strongly agreed that replacing the requirement of a police report with a medical report would be beneficial for their patients (Figure 9). This opinion, widely shared by HVIP workers nationwide, is reflective of the fact that mandating victims of violent crime, disproportionately in under-resourced communities, approach law enforcement following a violent crime can prevent access to reimbursement for those who may benefit from it most. Especially in communities with tense relationships with law enforcement and high levels of distrust, requiring cooperation and only accepting a police report as proof of victimization fails to offer inclusive paths to legitimizing victimization and can compound historical trauma in marginalized communities. Fear of retaliation for cooperating with police was mentioned in interviews as a reason why some victims may be hesitant to approach law enforcement following their victimization. It is also possible that certain populations, such as young, Black, male victims of physical assault or firearm violence, face

greater barriers to compensation and elevated scrutiny regarding 'victim misconduct' determinations compared to other victim populations. 'Victim misconduct' or 'contributory misconduct' are cited as cause for a claim denial if law enforcement or CVC administrators believe a victim either directly contributed to their victimization or was engaged in illegal activity at the time of their victimization (Hurdles to Healing, 2021). However, there is no unified definition of what constitutes misconduct, and decisions are largely left to law enforcement and administrator discretion. In some states like Mississippi, claimants can be denied for illegal activity or delinquent acts completely unrelated to the claimant's own victimization (Hurdles to Healing, 2021). Gang affiliation, or the perception of gang affiliation, was cited in interviews as one such disqualifier for CVC in some states.

Figure 9



Respondents on average estimated that 25.5% of their patients who apply for CVC are denied. Three respondents stated that as few as 10% of their patients are denied CVC, and three respondents indicated that 40% of their patients are denied, the largest percentage cited by all respondents. This is particularly interesting because quantitative analysis of CVC in Illinois

shows average denial rates of 70.4% for sexual assault-related claims, 65.1% for domestic violence-related claims, 63.7% for assault-related claims and 29.0% for homicide-related claims. Assuming that CVC in Illinois is relatively representative of other states, two plausible explanations emerge. It could be that HVIP workers are only working with patients who present to the hospital, likely the most seriously injured crime victims, with the most tangible expenses incurred because of their injury. This could mean that HVIP workers are primarily working with families of homicide victims who are more likely to receive reimbursement for funeral expenses and medical bills than other victims with less tangible costs. It could also be that HVIP workers are very effective at assisting their patients access CVC. Many victims of assault, sexual assault and domestic violence will still present to the hospital, and low denial rates cited by HVIP workers could indicate that when HVIP workers assist patients assemble their CVC application, they are far more likely to successfully receive reimbursement than the average claimant in Illinois.

A majority of respondents (6/11, 54.6%) agreed that trust patients place in HVIPs decreases after being denied CVC, and that trust in HVIPs increases after successfully receiving CVC (8/11, 72.7%). CVC has the potential to play a reparative role, healing deep distrust between communities affected by violence and government programs, extending to healthcare institutions in underserved areas. Rifts resulting from decades of systemic disinvestment and discrimination, may in part be overcome through CVC. However, delays in CVC awards and low success rates reinforce skepticism and erode trust in HVIPs, representing a severe problem as the entire HVIP ecosystem model hinges on the trust-based credibility of community messengers.

Respondents were asked for their conception of an ideal victim compensation program in a final open response question, with full answers included in the Appendix. Themes consistent

with those that arose during qualitative interviews were cited by survey respondents. Several respondents indicated a desire to transition towards a direct payment model opposed to a reimbursement model, whereby patients could receive services upfront, particularly in emergency situations, rather than paying out of pocket and then waiting to be reimbursed. Cooperation with law enforcement was frequently cited as a problem with the current CVC status quo, specifically because respondents' patients "are targeted by retaliation if they collaborate with law enforcement" or because interactions with law enforcement can be "re-traumatizing for families." Bureaucratic barriers and a general lack of transparency was another frequently cited issue, with respondents expressing a desire for a program that was more user friendly and required less documentation. More efficient claim review and staffing a representative of victim services offices in the hospital itself were other aspects of an ideal victim compensation program that respondents listed. Given these responses, and subsequent data from qualitative interviews, the ideal CVC program, from the perspective of HVIP workers, is one that compensates patients directly for the services they need following their injury, decreases the burden of law enforcement cooperation by making eligibility criteria more flexible, and allowing for a medical report in lieu of a police report. Additionally, expedited processing times, a more transparent application process with clear instructions and limits of required documentation, and staffing a victim services office representative in the hospital itself to help patients navigate the CVC application process are cited criteria for an ideal CVC model.

Qualitative Interviews

Table 7: Key Themes and Representative Quotes

Theme	Description	Representative Quotes

1. Cooperation with Law Enforcement	Stringent requirements to obtain a police report and cooperate with law enforcement were frequently cited as barriers to accessing CVC	"Victim compensation, requires you to participate with law enforcement, which I think is such a barrier." "Our families are afraid, sometimes even to go to the police that if the medical record can help, in lieu of a police report to help with the victim compensation rather than get a police report, if the medical record that will help … because, you know, sad to say, and especially … right now, people are afraid to go to the police." "I've often times found that some are little iffy about it, because it does require talking to, you know, detectives on their caseload about what may have happened to them, and there is a certain level of comfortability surrounding that, especially if they know who their assailant was, and answering those questions, they just rather not even get into it and kind of just deal with the bills after the fact." "Lack of trust in the system as well, because I've had patients who because a police report was worded in a way that maybe my patient wasn't engaged in criminal behavior, but someone that the patient was with was perhaps engaging in criminal adjacent behavior, right? They're no longer eligible for the compensation, and so if a police report has something in it that is not true or paints the victim in a negative light, that is a huge barrier." "Another huge barrier is cooperation with law enforcement, I'm dealing with 16-year-olds in Charleston who have targets on their back right like there's a kid that I work with. He's 15, and he's been shot three times in the past two years. And so these are kids who, quite literally, their lives are at risk if they speak to the cops. You know if, if they are outed as a rat, their life is over." "The problem sometimes is that man, they just got shot, and they're, you know what I'm saying, you're trying to, our doctors are trying to save their life. You're trying to, you know, and they don't feel like talking to nobody."
2. Issues with Reimbursement	Dissatisfaction with the current reimbursement model of CVC was widely expressed, particularly because members of impoverished, under resourced communities most at risk of violent crime victimization lack the ability to pay up front costs with hopes of being reimbursed later on	"The issue, I would say, generally, is that a lot of this is reimbursement … They need to be reimbursed, meaning that they have to show receipts that they've already paid them, which is often the barrier for people accessing those resources. Whereas, same thing, even with like funeral and burial costs, sometimes that could be difficult because it has to be reimbursed." "I think, for maybe folks who are a little more affluent, who can cover initial costs and then wait a year to two years to get reimbursed, sure, but most of the folks that I'm working with do not have the means, right, … Folks don't have the means to pay upfront for these resources and then wait for however long." "It does kind of run through their health insurance first, and then Crime Victim Compensation picks up after the fact, and it covers them for their employment and also like housing and relocation if necessary." "The information that I was given at the start of my training was, if a patient has Medicaid, don't fill out this form for them, because Medicaid will take care of it. And that's sort of the mindset that I've had, but I know my patients with Medicaid are really, really, really struggling." "I would love to see, … maybe just us being a satellite, you know, so that we're directly dealing with it, we could, you know, get those funds to help support our patients"
3. Inconsistent Training Procedures	HVIP workers in different hospitals across the county received various levels of	"So, I just feel like at this point, like we're just not trained well, of you know, depending on someone's documentation status, can they qualify? Still, a lot of it seems very unclear."

	formal training related to the CVC application process, with most expressing dissatisfaction with either their initial training or lack of ongoing learning opportunities	"When I initially got the position, I found out by working with the patient's bedside how they were able to apply for it." "In the beginning, when I first started in my role, there was a lot of training up front on how to fill out the application. Who is eligible, who is not eligible, special considerations, right? If someone was engaging in criminal behavior at the time of their violent injury, things like that, and then over time, there's not as many refreshers. The State offers us very little as far as training or ongoing learning opportunities. So I really just wish there was more." "The great thing is, when I did begin, … we have an amazing supervisor, … and he gave us, you know, a full on rundown, and we went through as a collective, what resources like we have, and, you know, amongst each other, and so that's how, you know, we became aware of that. So that was definitely part of onboarding, and then just ongoing, like if we didn't have resources, it's always great to go to him, and you know, he guides us through some stuff"
4. Processing Delays and Lack of Transparency	Lengthy delays in claim decisions and lack of transparency during the review process was a source of frustration for HVIP workers and their patients; maintaining a victim services office representative in-house at the hospital was cited as a potential solution	"I mean, processing alone could take up to six months once you've applied for some of these resources. And people don't have six months to wait to get money back, to be relocated, you know, because someone tried to kill them, right?" "It's interesting, because it's such a bureaucratic process, meaning they're so like, we can inform people that there are these services. However, the issue is, most people don't get those services because of X, Y and Z." "Really the best that I can do for them is assist them with the application, send it off to my point of contact and then say, hey, did you get a letter in the mail with your claim number yet? Like, yeah, I basically have as much access to the Department of crime victim compensation as they do." "We're not going to leave this pregnant mom and or two kids that just got GSW out on the dang streets, like we're not going to do that, and reason why they can't go back to their home, because that's where the crime happened, and the suspect is still out. Like these are real, what I shared is a real case, but, you know, in those effects, so I think more clear communication" "Again, I think the program is great, … As soon as we scan and send the applications over … there's a fast response, you know, of approval or no approval … majority of time there's approval unless something was off or and then … they're always answering the phone." "I would love to see that there was actual staff from these Victim Services present for like, asking a lot of these questions, being able to help problem solve" "I think one of the things that I see that we need to have is at the hospital, is somebody already from the violence compensation board in the hospital. They're outside, so sometimes it's harder, but if the person was there at the hospital to help right away navigate, I think that would help a lot."
5. Other Opinions and Obstacles	- Probation, parole, and gang affiliation as unjust reasons for claim denial - Lack of awareness of CVC as the first barrier victims must overcome	"I think, for the application, I think we should do away with whether or not someone was on probation or parole like I think it should not matter whether someone's legal status." "I think for us over here, and I think the little change that to broaden up the victim, because there is we deal with a lot of gang shootings also. So sometimes, if there's an affiliation of any gang sort, sometimes they get disqualified. So it's just, I think, is brought in a more the perspective of what is actually a victim.

	- Severe state level cuts to victim compensation programs and victim services in general - Insignificant award amounts compared to severity of crimes - Poor engagement from local Attorney General's offices	Because, you know, for some of our families, they feel they are, but they don't qualify, because it wasn't a, like, a big, big crime." "First of all, knowledge. They don't know that this exists until I tell them, they have no idea. And I think another barrier is, um, soft skills, ability to, like, tolerate the frustration of filling out a form and mailing it in." "I know that our state, unfortunately has made some pretty significant cuts to crime victim funds and just victim service provider networks in general." "Just that it needs so much more money, money, money, money … we just need more funds to be brought to our victims. So I just think more, more victim service providers in general too. Like just building up the coalition of support for survivors … would be huge, but we really need money to back that." "Every aspect of her life will be different because she is now paralyzed and wheelchair bound, and so Crime Victim Compensation is never going to make that better, right? Like no amount of money will ever change the fact that she can no longer walk, and at the same time, it helps her parents and herself pay." "I would love to see more participation from our local AGs office."

Of the 11 respondents who successfully completed the survey, nine indicated a willingness to be contacted about potentially participating in a qualitative interview over Zoom and five were subsequently willing to be interviewed. A complete list of interview questions can be found in the Appendix.

The most widely discussed themes that emerged across interviews were issues with law enforcement as a mandatory criterion for CVC eligibility, which arose in all five interviews, problems with the reimbursement model of CVC, insufficient training, and processing delays combined with a lack of transparency, that were each cited in four of the interviews. Another major theme that emerged during interviews was a lack of knowledge and assistance patients received with the application process, with HVIP workers often having to go above and beyond to help their patients access reimbursement. Staffing a representative from the state's respective victim services office within the hospital itself was mentioned as a potential solution.

The requirement that victims cooperate with law enforcement and obtain a police report came up in every interview that I conducted. Opinions of the relative efficacy of local police

forces varied interview by interview, with some interviewees expressing positive attitudes towards law enforcement. Consistent with previous findings, cooperation with law enforcement was a universal requirement for CVC eligibility among interview participants. Generally, interviewees agreed that cooperating with law enforcement presented a significant barrier for many of their patients trying to access CVC. One participant stated: “there's very specific eligibility requirements, like victim compensation, requires you to participate with law enforcement, which I think is such a barrier.” Cooperation with law enforcement precluded patients from receiving CVC in two primary ways: challenges with police interactions themselves, and fear of retribution from being perceived as complying with law enforcement. It may be difficult for a victim to cooperate with police, especially immediately upon arriving at the hospital following a violent injury, when healthcare providers are treating them. One participant stated: “the problem sometimes is that man, they just got shot, and they're, you know what I'm saying, you're trying to, our doctors are trying to save their life … and they don't feel like talking to nobody.” A persistent lack of trust between communities and law enforcement further prevents victims from readily cooperating, with one interviewee stating:

> Lack of trust in the system as well, because I've had patients who because a police report was worded in a way that maybe my patient wasn't engaged in criminal behavior, but someone that the patient was with was perhaps engaging in criminal adjacent behavior, right? They're no longer eligible for the compensation, and so if a police report has something in it that is not true or paints the victim in a negative light, that is a huge barrier.

Because there is no clear definition of what constitutes ‘cooperation’ or ‘contributory misconduct,’ law enforcement has the capacity to exert considerable discretion in making these determinations. Another complicating factor is that victims may personally know their assailants

or face high risk of retaliation if they are caught cooperating with law enforcement. One HVIP worker told me:

> Another huge barrier is cooperation with law enforcement, I'm dealing with 16-year-olds in Charleston who have targets on their back right, like there's a kid that I work with. He's 15, and he's been shot three times in the past two years. And so, these are kids who, quite literally, their lives are at risk if they speak to the cops. You know if, if they are outed as a rat, their life is over.

One solution that could eliminate this barrier would be to allow for a medical report to substantiate victimization instead of a police report. One interview participant referenced this themselves: "I think it will benefit a lot, because our families are afraid, sometimes even to go to the police, that if the medical record can help, in lieu of a police report."

Another common opinion held by interview subjects was that the reimbursement model of CVC was inadequate at addressing the needs of their patients. One interviewee directly referenced this: "the issue, I would say, generally, is that a lot of this is reimbursement … They need to be reimbursed, meaning that they have to show receipts that they've already paid them, which is often the barrier for people accessing those resources." Even in cases where CVC is used to cover funeral and burial expenses, the family must first pay the costs themselves and hope to be reimbursed afterwards. This is a significant hurdle for people living in poverty, who could benefit from CVC most. An interviewee pointed out that "some medical bills are over $100,000 or $200,000," a significant sum to expect victims to cover upfront prior to reimbursement. Another interview participant stated: "I think, for maybe folks who are a little more affluent, who can cover initial costs and then wait a year to two years to get reimbursed, sure, but most of the folks that I'm working with do not have the means … to pay upfront for these resources and then wait for however long." Perhaps more affluent victims can bear large

initial expenses, but the reimbursement model fails those who lack the means to pay up-front. CVC functions as a reimbursor of last resort, meaning that victims must first exhaust all other avenues of funding, like their own health insurance, before being reimbursed for additional expenses. This means that some HVIP workers have been instructed to not even bother filling out a CVC application for patients who have Medicaid: "the information that I was given at the start of my training was, if a patient has Medicaid, don't fill out this form for them, because Medicaid will take care of it." Even if Medicaid sufficiently covers medical expenses, victims may still be eligible to be reimbursed for other costs, such as lost wages or counselling. This supports quantitative findings that CVC is more effective at addressing tangible costs like funeral and medical expenses, but in its current form fails to appropriately compensate victims for other costs incurred as a result of their victimization, particularly those associated with long term mental and emotional recovery.

Sharing their experiences first learning about CVC, it became clear that HVIP workers received inconsistent training regarding CVC. One interview participant explicitly stated: "I just feel like at this point, like we're just not trained well, of you know, depending on someone's documentation status, can they qualify? Still, a lot of it seems very unclear." The application process is intricate and nuanced, a detail like one's immigration status can determine if a victim is eligible or not, and it seems that many HVIP workers are not being given sufficient instruction enabling them to fully assist their patients. There was considerable variation in how participants were trained. Some learned through direct experience on the job, without formal guidance: "when I initially got the position, I found out by working with the patient's bedside how they were able to apply for it." Others did receive formal training but expressed a desire for refresher

courses and ongoing learning opportunities, especially as eligibility criteria and program details change. One interview participant stated:

> In the beginning, when I first started in my role, there was a lot of training up front on how to fill out the application. Who is eligible, who is not eligible, special considerations, … and then over time, there's not as many refreshers. The State offers us very little as far as training or ongoing learning opportunities. So, I really just wish there was more.

Another interview participant reflected positively on the way they were trained:

> We have an amazing supervisor … he gave us, you know, a full-on rundown, and we went through as a collective, what resources like we have, … So that was definitely part of onboarding, and then just ongoing, like if we didn't have resources, it's always great to go to him, and you know, he guides us through some stuff.

This affirms the importance of having administrators leading HVIPs who are well informed about CVC and focused on increasing its uptake. Further research should investigate how to implement training protocols across HVIPs nationwide so that all violence prevention workers receive sufficient CVC training.

Delays in processing claims and a lack of transparency throughout the claim review process also emerged as important themes during interviews. Several participants cited several months passing between when a claim was filed to when a determination about its status was eventually made: “I mean, processing alone could take up to six months once you've applied for some of these resources. And people don't have six months to wait to get money back, to be relocated, you know, because someone tried to kill them, right?” This finding is consistent with previous work done by Moos et al. (2025) describing CVC claim processing taking on average

more than eight months for victims of sexual assault in Illinois. For CVC to function in its current reimbursement form, claimants cannot be forced to wait months before having their clams processed. Quantitative analysis shows that in Illinois, many claimants remain highly unlikely to have claims awarded even after waiting months. This was echoed during an interview, when a participant stated: “very few people get accepted … there's just so many barriers. I just have had so many people get denied. I have had to submit so many appeals. Like, it is, it is really ridiculous.” Another said: “we can inform people that there are these services. However, the issue is, most people don't get those services because of X, Y and Z.” When a claim is unsuccessful, but can be appealed, the appeal queue can be exceedingly long. One interviewee retold a story where a patient was initially denied because their primary care provider was a nurse practitioner rather than an MD, and that when they went to file an appeal, they were told it could take up to seven years before their appeal was processed: “two to seven years to even just open back up the case, when all it was because their primary care was not an MD and that person didn't have a cosigner.” Throughout the review process, applicants can spend years waiting for a decision to be made, without receiving any updates about their claim’s status, and HVIP workers are typically unable to expedite the process. One interviewee stated: “really the best that I can do for them is assist them with the application, send it off to my point of contact and then say, hey, did you get a letter in the mail with your claim number yet?” Long waits, opaque review processes, and low acceptance rates each serve to disincentivize patients from applying for CVC. When HVIP workers spend time encouraging patients and helping them fill out a CVC application, just for it to be delayed several months and then denied for an obscure reason, it can erode trust between HVIPs and the people they serve, consistent with survey findings.

Several other important points were mentioned during interviews that merit consideration alongside other data. Two interviewees indicated issues surrounding restrictive victim misconduct categorizations, that immediately preclude victims on probation, parole, or with any gang affiliation from receiving CVC. Another participant told me that lack of awareness of CVC is the first barrier victims their patients face in accessing CVC, a finding echoed in survey responses. This same respondent cited state-level cuts to CVC in South Carolina and victim services programs as major problems for their patients, expressing a dire need for more money to support victims' recoveries. Furthermore, the local Attorney General's office remained uninvolved in helping make CVC more accessible.

Qualitative data collected in this study largely indicates that HVIP workers nationwide feel that CVC must be greatly improved before it can sufficiently support the diverse recovery needs of their patients. While this may appear to be a daunting task, interviewees laid out several clear steps that must be taken, and one participant reflected positively on their CVC program, showing us there is hope. In an interview with an HVIP worker in California, they reflected on the efficient, effective functioning of their CVC program. They spoke of the substantial positive effect CVC can have on their patient's recovery. They stated that the program is "great, … as soon as we scan and send the applications over … there's a fast response, you know, of approval or no approval," and that the "majority of time there's approval unless something was off … in my experience, … they're always answering the phone." An efficient and responsive CVC program, reaching as many victims as possible, can serve as a model to other programs and states nationwide, a testament to the transformative effect HVIP workers can have on their patient's recovery when CVC is made clearly accessible to them.

POLICY RECOMMENDATIONS

This study suggests important policy implications, reconceptualizing violence recovery as a complex, multifaceted and holistic process, one where patients receive support in the hospital, but also longitudinally following their discharge. HVIPs and CVC play significant roles along this continuum of recovery. Survey responses confirmed that HVIP workers are the most likely individuals to assist hospital patients with CVC applications. Difficulty with the application itself, lack of awareness of the program, and failure to cooperate with law enforcement were cited as the three most frequent reasons for failure to access CVC. Survey respondents also indicated a strong desire to allow a medical report to be used in lieu of a police report to verify victimization. Follow-up qualitative interviews confirmed issues with law enforcement, unclear application and claim review processes, inconsistent HVIP worker CVC training, and problems with the reimbursement model of CVC. Policy recommendations are made based on these findings.

First, CVC must be designed to more substantively and efficiently address the needs of victims. CVC should be reframed as a reparative policy tool, aligning with transitional justice principles with the potential to address public health inequities and racial disparities (Bassett & Galea, 2020; Himmelstein et al., 2022). Transitioning from a reimbursement model to a direct payment model is a first step. Then expanding eligibility criteria to allow for multiple pathways to verify victimization, namely allowing for a medical report to prove victimization instead of a police report, is recommended. Finally, the claim review process must become more efficient and transparent to restore trust between vulnerable communities and government institutions. Especially under the current administration, with its focus on slashing federal funding, state and local efforts become increasingly important in supporting victims of violent crime in their

recovery. HVIPs should be given the necessary training, resources and support from their hospitals and states to include CVC education and application assistance with each of their patients. Incorporating CVC referrals into Level I trauma center quality metrics and funding criteria could significantly increase rates of CVC application among violently injured patients who present to hospitals.

Transforming CVC Programs

1. *Eligibility Criteria*

A significant majority of survey respondents felt that a medical report should be accepted in lieu of a police report as proof of victimization, citing cooperation with law enforcement as the third most common barrier their patients encountered when trying to access CVC. Interviews confirmed that cooperation with law enforcement, which can be especially damaging for those who face fear of retaliation, and the loose application of 'victim misconduct,' in some cases including individuals on probation, parole, or affiliated with gangs, preclude many victims who are most in need from accessing reimbursement. The first recommendation coming from this study is that CVC programs nationwide should accept a medical report in lieu of a police report, and that a universal definition of 'victim misconduct' be adopted, one which does not deem individuals on probation, parole, or affiliated with a gang immediately ineligible.

2. *Efficiency and Transparency*

Several interview participants cited frustration with significant delays their patients dealt with while waiting for CVC applications to be processed, with one stating they were told it would take up to 7-years for a claim's appeal to be reviewed. Opaque application processes often left HVIP workers feeling unequipped to comprehensively assist their patients, and unable to

confidently determine if their patient would receive reimbursement in a timely manner. Survey responses indicated patients trust in HVIPs decreased after they were denied CVC, confirming the essential need for transparency throughout the application process. A national standard should be adopted, compelling CVC programs to release claim decisions within two months of an application's submission. Such a model would be easier to implement in less populous states where fewer claims are filed, but it should follow that in states with more claims, more funds would be allocated to their respective CVC programs, enabling the hiring of more staff to address the greater number of claims. Additionally, a mobile app should be developed and rolled out, whereby claimants receive live updates about their claim review and are notified immediately once a claim has been processed.

3. From Reimbursement to Direct Payment

CVC functions as a reimbursement program of last resort, forcing victims to exhaust all other funding sources before being eligible. In several interviews, participants indicated dissatisfaction with the current CVC model, with some expressing an explicit desire to move to a new arrangement: "I would love to see … just us being a satellite, you know, so that we're directly dealing with it, we could … get those funds to help support our patients." Fundamentally, the goal of CVC is to provide victims with financial compensation so that they may access the services they need to fully recover from the injuries incurred from their victimization. There is clearly a more effective way to deliver these necessary recovery services to victims, without forcing them to first bear the up-front costs themselves. Transitioning CVC to a direct payment model would allow states to provide funds to trusted organizations and have them allocate their services directly to victims. Rather than filling out a lengthy application for reimbursement, victims could immediately be connected with different organizations focused on

specific recovery needs — mental health counseling, funeral arrangements, housing relocation and employment assistance, among others. Moving to a direct payment model would take considerable initial investment, building up a sustainable network of trusted service providers across the state and allocating CVC funds appropriately to them. Once this ecosystem is built, it would have the potential to comprehensively address victims' needs, unlike current reimbursement models, fulfilling the true goal of any victim compensation program — to attempt to substantially *improve* victim's lives in the aftermath of their injury.

Increasing CVC Uptake

1. *Expanding and Supporting HVIPs*

Community hospitals in underserved areas, which most likely provide medical care to victims of violent crime, often lack the capacity to access the resources to implement and maintain an in-house HVIP. In the survey I circulated, respondents indicated that HVIP workers are the most likely members of the trauma care team to assist patients apply for CVC. Given the crucial role HVIPs play in helping their patients access CVC, along with the other diverse global-injury recovery needs, HVIPs should be implemented broadly nationwide, particularly in hospitals operating emergency rooms and trauma centers that service areas with high burdens of violent crime. This would necessitate making state and federal grants that fund HVIPs more accessible, particularly to community hospitals, as well as adopting Medicaid reimbursement for violence intervention services in all 50 states. The HAVI will continue to be instrumental in building a nationwide network of HVIPs and advocating for funding on their behalf. Survey responses also indicated that the training HVIP workers received about CVC eligibility and application processes was inconsistent, a finding further supported during qualitative interviews.

HVIP workers are on the front lines, directly helping violently injured patients attempt to access reimbursement while also assisting them navigate the complex recovery process. Yet, HVIP workers are often only provided a patchwork of training and support, at times left to simply learn about CVC while on the job. Each state should implement standardized CVC training protocols for HVIP workers in their hospitals, ensuring they have the necessary knowledge to comprehensively assist their patients. The HAVI should be consulted when crafting these trainings and will be instrumental in bridging the gap between state level changes and HVIPs. Ultimately, the HAVI may be able to assist states implement new CVC trainings in HVIPs.

2. *Integrating CVC into Trauma Care Workflow*

HVIPs nationwide should screen every violently injured patient they serve for potential CVC eligibility. Eligible patients should then receive CVC education and initial application assistance while they are in the hospital. HVIPs should also follow up longitudinally, or ensure a community partner organization is doing so, to confirm patients file a claim, and appeal it if necessary. CVC screening, education, and application assistance protocols should be adopted by HVIPs and trauma centers in each state. It is also essential to note that HVIP workers have many responsibilities beyond just helping patients access CVC. What emerged during interviews with HVIP workers was a desire for their hospitals to staff a representative from their respective state's office for victims of crime: "I would love to see that there was actual staff from these victim services present for like, asking a lot of these questions, being able to help problem solve." This would allow HVIP workers to fully focus on spreading awareness of the program to their patients and assisting them fill out the application, without having to maintain perfect knowledge of all the intricate, at times hidden, details of the CVC application process. If questions arose, they would be able to approach the victim services representative and receive

answers in real time, expediting the application process. Having a representative available in-house within the HVIP would ensure patients' applications were filled out correctly prior to submission, increasing the success rate and lowering the number of appeals needing to be filed.

3. *Linking CVC to Trauma Center Funding and Quality Metrics*

The ACS-COT is responsible for accrediting trauma centers, and designating whether they qualify as Level I, II, III or IV centers. Level I trauma centers must meet certain criteria which include: 24-hour coverage to care for all traumatic injuries, minimum annual volume of trauma activations, operate robust teaching and research programs, provide leadership in violence prevention and public health to surrounding communities, and conduct regular quality assessments. The final recommendation emerging from this study is that rates of CVC application be monitored as a part of the required regular quality assessment checks trauma centers conduct. Subsequently, this should be reported to the American College of Surgeon's Committee on Trauma and used as an additional criterion for trauma center level designation and funding. This recommendation would have to account for state-by-state differences in CVC and is likely only feasible once each state has significantly improved its CVC program.

CONCLUSION

Findings from this study offer clear suggestions for how to transform CVC into a more accessible, equitable, and reparative program for survivors of violent crime, with HVIPs playing a critical role in this evolution. This is crucial to protect against the potential erosion of trust that HVIPs across the US can incur by generating false hope in an imperfect system of post-violence

reimbursement. The following recommendations are made based on quantitative, qualitative, and survey-based data:

1. Accept a medical report in lieu of a police report to verify victimization
2. Clearly define what constitutes 'victim misconduct' to limit bias in determining CVC eligibility
3. Drastically reduce CVC processing times and improve transparency throughout the claim review process
4. Implement comprehensive CVC trainings in existing HVIPs with the help of the HAVI
5. Support existing HVIPs to incorporate CVC education and application assistance into their workflow
6. Staff a representative from the state's victim services office within HVIPs to streamline the application process and answer questions in real time
7. Transition CVC from a reimbursement model to a direct payment model, building a network of trusted providers to connect victims directly with the services they need

In this study I also propose a radical reconceptualization of what a victim compensation program should accomplish. Violent crime victimization, in the contexts eligible for CVC reimbursement, represent a failure on the State's behalf to protect its citizens. We should not settle for only helping cover hospital bills. Rather, CVC must be transformed into a reparative policy tool, directly connecting victims with services to maximize their recovery, and prevent future victimizations, often a result of historic inequities and policy-driven injustices that persist today.

> Every aspect of her life will be different because she is now paralyzed and wheelchair bound, and so Crime Victim Compensation is never going to make that better, right? Like no amount of money will ever change the fact that she can no longer walk, and at the same time, it helps her parents and herself pay.

While many victims like this young girl have their lives permanently altered following violent injury, in the wake of injury victims should have access to resources to optimize their recovery and wellbeing. For victims of violent crime who can make a full recovery, their time spent in the

hospital, and their recovery process, should not only endeavor to return them to baseline, but rather to substantively improve their daily lives long after they are discharged — helping them access stable housing, receive wraparound counseling services, find new employment, receive social benefits and more. The goal of victim compensation programs nationwide should first be to help victims recover, then ensure they access resources and services necessary for recovery and improved wellbeing, which could potentially break cycles of violence that no human being deserves to experience.

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APPENDIX

Appendix 1: Survey questions

Professional role:

- Physician
- Physician Assistant
- Nurse
- Violence Intervention Worker
- Social Worker
- Prefer not to say
- Other (please specify)

What hospital is your hospital-based violence intervention program (HVIP) affiliated with? (Please leave blank if you prefer not to say)

Who in your hospital might be the most likely to help patients following intentional interpersonal violence access crime victim compensation (CVC)?

- Physician
- Physician Assistant
- Nurse
- Violence Intervention Worker / Myself
- Social Worker
- I don't know
- Other (please specify)

Are you aware that victims of intentional interpersonal violence in the United States can receive CVC as a benefit of the Victims of Crime Act (VOCA)?

- Yes / No / Don't know / Don't feel comfortable answering

How well informed do you consider yourself about the eligibility criteria for patients receiving CVC in your state on a scale from 1-10 (1: completely unaware, 10: completely informed)

How well informed do you consider yourself about the application process for receiving CVC in your state on a scale from 1-10 (1: completely unaware, 10: completely informed)

Does your hospital have any specific guidelines/resources to assist patients applying for CVC?

- Yes / No / Don't know / Don't feel comfortable answering

Does your hospital provide you with specific training related to VOCA and the CVC application process?

- Yes / No / Don't know / Don't feel comfortable answering

Does your HVIP directly assist patients in applying for CVC?

- Yes / No but we outsource this to community organizations / No / Don't know / Don't feel comfortable answering

What do you think about this statement: "CVC helps my violently injured trauma patients"

- Strongly agree / Agree / Neutral / Disagree / Strongly disagree / Don't know / Don't feel comfortable answering

With your patients, what are the most common barriers to applying for and receiving CVC, in order of importance:

- Difficulty with application itself
- Lack of awareness
- Failure to cooperate with law enforcement
- No police report
- Difficulty compiling records of expenses
- Contributory misconduct
- Failure to file claim or report crime in time
- Other

As your best guess, what proportion of your patients are denied CVC?

- 0% / 10% / 20% / 30% / 40% / 50% / 60% / 70% / 80% / 90% / 100%

What happens to the amount of trust your patients may have in HVIP programs when they are denied CVC?

- Trust increases / No change in trust / Trust decreases / Don't know / Don't feel comfortable answering

What happens to the amount of trust your patients may have in HVIP programs when they successfully receive CVC?

- Trust increases / No change in trust / Trust decreases / Don't know / Don't feel comfortable answering

What do you think about replacing the police report with a medical report when applying for CVC?

- Strongly agree / Agree / Neutral / Disagree / Strongly disagree / Don't know / Don't feel comfortable answering

When was the last time you helped a patient apply for CVC?

- Prefer not to answer / Within the last month / Within the last 6 months / Within the last year / Never because I was unaware of the program

Appendix 2: Open text responses grouped by theme — "In your opinion, what would the ideal victim compensation program look like?"

Theme	Representative Quotes
1. Transitioning to Direct Payment Model	"Compensation would be offered upfront instead of reimbursed especially in emergency relocation and income loss situations."
2. Cooperation with Law Enforcement	"A program that relied on less … involvement of law enforcement." "No police report/cooperation with police required as it can be re-traumatizing for families to engage with police" "CVC would be available to all victims of crime, regardless of willingness to cooperate with law enforcement. Our patients are targeted by retaliation if they collaborate with law enforcement, and miss out on much needed benefits."
3. Bureaucratic Barriers	"A program that relied on less documentation"

	"Less barriers to receive funding for clients in need." "User friendly. Clear instructions and descriptions."
4. Processing Delays	"That our pts get support immediately, timely manner, with compassion and urgency!"
5. Staffing VOCA Representative in the Hospital	"Have direct contact with someone at the hospital and VOCA"
6. Other	"The ideal Victims compensation program would consider the nature of injury" "The ideal compensation program will align with the social determents of health" "No minimum accrual before being able to apply (for example- must have $100 work of bills before applying)"

Appendix 3: Interview questions

How do you tend to learn about the social programs that your patients may be entitled to?
- How do patients at your hospital tend to learn about the social programs they may be entitled to?
- Are there any resources or trainings provided to you regarding these programs?
- Can you describe what you know about your state's crime victim compensation program and its purpose?
- Do you feel equipped with the necessary information, training, and resources to assist your patients access crime victim compensation?

Have you ever recommended applying for crime victim compensation to your patients? Why or why not?
- Can you tell me about a time you had a patient access CVC and/or helped them navigate the application process?
- What effect do you think receiving crime victim compensation could have on your patients' recovery and well-being
- Do you think crime victim compensation is effective at helping address the needs of your patients? Why or why not

What role do you think hospital-based violence intervention programs should play in the uptake of crime victim compensation?
- Whose role do you think it is to inform about and/or assist violently injured patients with CVC? Why?

In your opinion, what are the primary barriers that may prevent patients from accessing CVC?
- Are there sufficient resources at your institution to help patients navigate the CVC application process?
- What additional support could make it easier for patients to access crime victim compensation?
- Are there any cultural, institutional, or systemic barriers you've identified within healthcare settings that could prevent healthcare providers from promoting these programs?

Would you recommend any changes be made to the application process or program more generally?

Is there anything else you would like to share about your perspective on crime victim compensation programs?