



## DCVC: Employer's Report – Lost Wages/Support

PSD25

Department of Crime Victim Compensation (DCVC), Edgar A. Brown Building, 1205 Pendleton Street, Room 401, Columbia, SC 29201 • Telephone 803-734-1900  
[WWW.SOVA.SC.GOV](http://WWW.SOVA.SC.GOV) (Click on payment and reimbursement guide under the "For Providers" tab for more information)

### The referenced person must meet the criteria for Lost Wages:

(1) Employment (2) Missed time from work (3) Reportable income (4) Disability

The referenced person has filed a claim with our program as a result of a crime committed on [Crime Date]. **This is not a claim against the employer.** We only need to verify the referenced person was employed at the time of the crime. **This form must be completed by your Payroll or Human Resource Department.** Please complete this form and return it directly to our office by mail or fax (803)734-2261.

Legal name of the employee \_\_\_\_\_

Job Type \_\_\_\_\_ Social Security # (Last 5 digits) \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Date the above person was first employed by you \_\_\_/\_\_\_/\_\_\_

Date he/she was first absent due to the crime related injury(s) \_\_\_/\_\_\_/\_\_\_

Date he/she returned to work part time (if applicable) \_\_\_/\_\_\_/\_\_\_

Date he/she returned to work full time \_\_\_/\_\_\_/\_\_\_

\*Date he/she was terminated if no longer employed by you \_\_\_/\_\_\_/\_\_\_

\*Please provide an explanation \_\_\_\_\_

**Because DCVC is a payer of last resort, all sources such as annual or sick leave, long/short term disability, SSA/SSI must be exhausted before DCVC will consider lost wage benefits.**

Average work hours per week \_\_\_\_\_ Average hourly wage \_\_\_\_\_ Gross salary per week \_\_\_\_\_

Was this employee compensated for time absent from work? \_\_\_ Yes \_\_\_ No

If you answered yes, complete the following:

Deductions	Amount Per Week	From Date	To Date
Vacation/Sick	\$		
Disability/Other (specify)	\$		

Employer \_\_\_\_\_ Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Person Completing Form (print) \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_ Employer Identification Number (required) \_\_\_\_\_