For Office Use Only

Claim Number
Other
Claim Examiner

CRIME VICTIM COMPENSATION APPLICATION

Michigan Department of Community Health

AUTHORITY: PA 223 of 1976 **COMPLETION:** Is Voluntary, but is required if Crime Victim Compensation is desired.	The Department of Community Health is an equal opportunity employer, services, and programs provider.

INSTRUCTIONS:

- Please PRINT CLEARLY or TYPE all information in this application.
- You DO NOT need an attorney to file a claim.
  If an attorney represents you in this claim, the attorney MUST file a Letter of Appearance with this application.
- Information provided on this form is exempt from disclosure under the Freedom of Information Act.
- You must sign your name and enter the date signed on Page 4 of this application.
- Mail this application form to:

  CRIME VICTIM SERVICES COMMISSION
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  320 S. Walnut Street
  LANSING MI 48913

  Phone: **(517) 373-7373** Fax**: (517) 334-9462**

  Victim only toll free (877) 251-7373

WARNING: Falsely presenting facts and circumstances to this commission, with the intent to defraud or cheat, may be a crime if compensation is awarded.

SECTION 1 - Victim Information: *(Complete this section for the person who was injured)*

1. Name of VICTIM (Last, First, Middle)			3. Date of Birth	4. Social Security Number
2. Address (Number and Street, Apartment Number, etc.)			5. Home Telephone Number ( )	Cell Phone Number ( )
City	State	ZIP Code	6. Work Telephone Number ( )	

7. Marital Status:
☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

8. Gender:
☐ **Male** ☐ **Female**

SECTION 2 – Claimant Information:

(Complete this section ONLY if you are the Parent or Guardian of a Minor Victim OR the Survivor of a Deceased Victim)

1. Name of CLAIMANT (Last, First, Middle)			3. Date of Birth	4. Social Security Number
2. Address (Number, Street, Apartment Number, etc.)			5. Home Telephone Number ( )	
City	State	ZIP Code	6. Work Telephone Number ( )	

7. Marital Status
☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

8. Gender
☐ **Male** ☐ **Female**

9. Your Relationship to the Victim:
☐ **Spouse** ☐ **Parent** ☐ **Child** ☐ **Sibling**
☐ **Grandparent** ☐ **Grandchild** ☐ **Guardian** ☐ **Other**

10. Are you or were you dependent on the deceased victim for either:

Primary Financial Support	☐ **NO**	☐ **YES** ➔	10A. If YES, Monthly Amount $
Child Support or Alimony	☐ **NO**	☐ **YES** ➔	10B. If YES, Monthly Amount $

SECTION 3 – Crime Information:

(Complete this section and provide a copy of the Police Report if available)

1. Type of Crime ***(Check ONLY ONE)***

☐ **Arson** ☐ **Assault** ☐ **Child Abuse** ☐ **DWI / DUI**
☐ **Homicide** ☐ **Kidnapping** ☐ **Motor Vehicle Accident** ☐ **Robbery**
☐ **Sexual Assault** ☐ **Terrorism**

☐ **Other (explain):**

2. Was the person who caused the injury the victim's spouse, former spouse, an individual with whom the victim had a child in common, or a resident or former resident of the victim's household? ☐ **YES** ☐ **NO**

3. Date of Crime	4. Date Crime was Reported	5. County in which Crime Occurred	
6. Police or Sheriff Agency to which crime was reported		7. Incident Number	
8. Location of Crime (Number and Street)	City	State	ZIP Code

9. Describe the Physical Injuries that result from this crime:

10. Brief Description of Crime:

11. If the crime was NOT reported to Police/Sheriff within **48 hours**, please explain the reason for the delay:

12. If you are NOT filing this claim within **1 year** of the crime, please explain the reason for the delay:

SECTION 4 – Restitution and Recovery Information:

(Complete this section, providing all information you currently have available)

1. Name of Offender(s) if known

2. Has the Offender(s) been charged in court?

☐ **YES (If YES, complete the questions 3, 4, & 5)** ☐ **NO** ☐ **UNKNOWN**

3. Name of Court	4. Court Case Number		
5. Court's Mailing Address	City	State	ZIP Code

6. Did the court order the offender to pay restitution to you?

☐ **YES (If YES, complete the questions 7, 8, & 9)** ☐ **NO** ☐ **UNKNOWN**

7. Restitution Order Date	8. Court Case Number	9. Amount Ordered **$**

10. Have you filed, or do you intend to file a civil court action?

☐ **YES (If YES, complete the questions 11, 12, 13, & 14)** ☐ **NO**

11. Have you settled with a third party regarding this case?

☐ **YES (If YES, please attach a copy of the legal settlement)** ☐ **NO** ☐ **UNKNOWN**

12. Name of Attorney	13. Attorney's Telephone Number		
14. Attorney's Address (Number and Street, Suite, etc.)	City	State	ZIP Code

SECTION 5 – Statistical Information for Crime Victim Program:

1. Please tell us how you first found out about the Crime Victim's Compensation Program:

☐ **Prosecuting Attorney** ☐ **Medical Provider** ☐ **Attorney** ☐ **Media, Brochure, or Poster**
☐ **Police / Sheriff** ☐ **Victim Service Agency** ☐ **Friend / Acquaintance** ☐ **Other**

Federal Civil Rights Information: ***(Providing any of the following information is voluntary)***

2. Race / Ethnic Background:

☐ **White** ☐ **Black** ☐ **Hispanic**
☐ **Asian / Pacific Islander** ☐ **American Indian** ☐ **Multi-racial**

3. If Disabled, check one

☐ **BEFORE Crime**
☐ **As a RESULT of this crime**

SECTION 6 - Claim Determination Information:

1. Check the Type of Compensation Benefits you are Requesting

☐ **Medical Expense Benefits for the Victim** ☐ **Funeral Benefits for the Survivor(s)**
☐ **Loss of Earnings Benefits for the Victim** ☐ **Loss of Support Benefits for the Survivor(s)**

2. Have you or will you suffer a minimum out-of-pocket loss of $200?

☐ **NO** ☐ **YES**

3. Have you lost at least 2 continuous weeks of earnings?

☐ **NO** ☐ **YES**

4. Is your injury the result of a Criminal Sexual Assault?

☐ **NO** ☐ **YES**

5. Are you Retired by reason of Age or Disability?

☐ **NO** ☐ **YES** ***(see question 6)***

6. Provide DATE and REASON for Retirement if Retired because of Age or Disability

SECTION 7 - Out-of-Pocket Expense Information: Please Submit itemized medical bills

(Complete this section ONLY if you are applying for Medical, Dental, Counseling, or Funeral Expenses)

IMPORTANT: Please enclose all available itemized bills for losses you are claiming. Include hospital, doctor, dentist, ambulance, radiology, therapy, prescription drugs, counseling, funeral home, cemetery, etc.

1. PROVIDER NAME	2. CITY and STATE	3. TELEPHONE NUMBER

4. Will Additional Medical Treatment be Required? (Please explain):

SECTION 8 – Insurance and Other Collateral Source Information:

1. Please indicate which of the following source (if any) are available to pay any **medical bills or out-of-pocket expenses**: ***(check ALL that apply)***

**** Please attach any "Explanation of Benefits" statements that you have received to date.***

☐ **Health Insurance *** ☐ **Dental/Vision Insurance *** ☐ **Veterans Administration *** ☐ **Medicaid**
☐ **Medicare *** ☐ **Workers Compensation *** ☐ **State Medical Plan** ☐ **NONE OF THESE**
☐ **Automobile Insurance *** ☐ **Homeowners Insurance *** ☐ **Other Public Assistance** ☐ **OTHER (explain in #2)**

2. Please explain any "other" source from above

3. Name of Primary Medical Insurer (if applicable)	4. Policy Number	5. Telephone Number ( )
6. Name of Secondary Medical Insurer (if applicable)	7. Policy Number	8. Telephone Number ( )

9. Please indicate which of the following source (if any) are available to pay any funeral or burial expenses: ***(check ALL that apply)***

**** Please attach any "Explanation of Benefits" statements that you have received to date.***

☐ **Life Insurance *** ☐ **Burial Benefit Policy *** ☐ **Family Independence Agency**
☐ **Workers Compensation *** ☐ **Automobile Insurance *** ☐ **Veterans Benefits / Insurance**
☐ **Social Security Death Benefit *** ☐ **NONE OF THE THESE** ☐ **OTHER (explain in #10)**

10. Please explain any "other" source from above

SECTION 9 – Income Information: Indicate YOUR HOUSEHOLD INCOME AND RESOURCES.

If Parent or Guardian of a Minor Victim, or the Survivor of a Deceased Victim, complete this section showing the CLAIMANT'S income.

1. Annual Household Income $	**IMPORTANT: Completion of Section 9 is required for ALL Applicants.**

2. SOURCES OF EARNINGS OR SUPPORT: *(check all that apply and indicate if received BEFORE or AFTER the injury)*

* ***Attach a Benefits Determination only if you completed Section 10.***	RECEIVED BEFORE	RECEIVED AFTER	* ***Attach a Benefits Determination only if you completed Section 10.***	RECEIVED BEFORE	RECEIVED AFTER
Employment	☐	☐	FIP Grant, Food Stamps	☐ *	☐ *
Interest / Dividends	☐	☐	State Disability Insurance	☐ *	☐ *
Income Property, Land Contracts	☐	☐	Veterans Benefits, Military Allotment	☐	☐
Employer Disability, Sickness, or Accident Benefits	☐ *	☐ *	Alimony / Child Support	☐	☐
Workers' Compensation	☐ *	☐ *	Life Insurance	☐	☐
Unemployment Compensation	☐ *	☐ *	None of these	☐	☐
Social Security Disability / SSI Benefits	☐ *	☐ *	**Other** *(Explain):*	☐	☐
Pension / Retirement Benefits	☐ *	☐ *			

3. DEPENDENTS: Please List Names and Birth Dates of Victim's Legal Dependents

If applying for loss of support; also attach a copy of the child's birth certificate, and for a spouse, attach a copy of the marriage certificate.

SECTION 10 – Earnings Information:

(Complete Section 10 ONLY if you are applying for Loss of Earnings or Loss of Support)

INSTRUCTIONS:

- Attach pay stubs showing the victim's earnings at the time of the crime.
- If at least 2 continuous weeks of work were missed, attach a doctor's letter verifying this absence and the reason why.
- If the victim is / was self employed, attach copies of income tax returns for the year before the crime, and the year of the crime, if available.

1. Victim's Employer Name			3. Supervisor's Name
2. Employer's Street Address			4. Supervisor's Telephone Number ( )
City	State	ZIP Code	5. Dates absent from work due to crime related injuries From: To:
6. Name of Doctor who will verify Medical Disability			7. Doctor's Telephone Number ( )
8. Is the Victim's Wage Loss covered by Disability Insurance or Worker's Compensation Insurance? ☐ **NO** ☐ **YES**			

SECTION 11 – Authorization to Release Information, Repayment Requirement, Financial Hardship, and Declaration:

(Your Signature Below indicates your Understanding and Agreement to the following)

AUTHORIZATION FOR RELEASE OF INFORMATION:
I authorize any hospital, doctor, counselor, or other treatment provider who attended _____ (Name of Victim); any funeral director or other person who rendered services; any employer; any police or other local government agency, including State and Federal revenue services; any insurance company; or other organization having knowledge; to furnish to the Michigan Crime Victim Services Commission, or its representative, all information concerning the incident which led to the victim's personal injury or death, and the claim made for compensation, including treatment, employment, insurance, or third-party payer information.

REPAYMENT REQUIREMENT:
I understand that payment by the victim compensation program is payment of last resort. If I receive a payment from another source for the same expenses, the State of Michigan is entitled to reimbursement up to the amount of any compensation awarded to me through the Crime Victim Services Commission. I also understand that my providers may be paid directly for debts that I owe.

FINANCIAL HARDSHIP:
I understand that my eligibility for crime victim's compensation required that losses represent a serious financial hardship for me. I attest that there are no other financial resources or income available to me. I attest that un-reimbursed losses claimed in this application will cause me serious financial hardship.

DECLARATION:
I declare, under penalty of perjury, information on this form is true, correct, and complete to the best of my knowledge and belief.

Claimant's Signature	Date of Signature	**NOTE: A photocopy of this authorization is as effective and valid as the original.**