

CRIME VICTIM COMPENSATION APPLICATION

Claim Number
Cross Reference Number
For Office Use Only

COMPLETION: Is Voluntary, but is required if Crime Victim Compensation is desired. Information on this form is exempt from disclosure under the Freedom of Information Act.	The application does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
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INSTRUCTIONS

Please PRINT CLEARLY or TYPE all information in this application. Separate application must be completed for each victim.

- Enclose copies of crime-related itemized medical, dental, burial or counseling bills received to date if not fully paid by insurance
- Submit Explanation of Benefit for each date of service that was not paid in full by your insurance
- Submit 2 or 3 paystubs paid just before the date of injury, showing gross, net and tax deductions if applying for loss of wages
- Submit a written disability statement from your physician verifying dates you were unable to work
- For assistance in completing this application, call the **victim only** toll free number 800-337-4242, 8:00 a.m. - 4:30 p.m. CT
- Return the completed application to the below address:

Crime Victim Services

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, Street, Apartment Number, etc.)			5. Home Telephone Number	6. Cell Phone Number	
City	State	ZIP Code	7. Work Telephone Number		
8. Marital Status					
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					9. Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female

SECTION 2 - Claimant Information:

Please complete this section if the victim is a Minor Deceased Incapacitated

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	6. Cell Phone Number	
City	State	ZIP Code	7. Work Telephone Number		
8. Marital Status					
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					9. Gender
					<input type="checkbox"/> Male <input type="checkbox"/> Female
10. Your Relationship to the Victim					
<input type="checkbox"/> Spouse <input type="checkbox"/> Grandparent		<input type="checkbox"/> Parent <input type="checkbox"/> Grandchild	<input type="checkbox"/> Child <input type="checkbox"/> Guardian	<input type="checkbox"/> Sibling <input type="checkbox"/> Other	
11. Are you or were you dependent on the deceased victim for either					
Primary Financial Support		<input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, monthly amount _____		
Child Support or Alimony		<input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, monthly amount _____		
12. Dependents: Please list names and Birthdates of ALL Victim's Legal Dependents					
Names	Birthdates	Names	Birthdates		

SECTION 3 – Crime Information:

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

1. Type of Crime (Check ONLY ONE)

<input type="checkbox"/> Homicide	<input type="checkbox"/> Assault	<input type="checkbox"/> DWI/DUI	<input type="checkbox"/> Vehicular Crime (other)
<input type="checkbox"/> Robbery	<input type="checkbox"/> Arson	<input type="checkbox"/> Burglary	<input type="checkbox"/> Sexual Assault
<input type="checkbox"/> Child Abuse/Neglect	<input type="checkbox"/> Child Sexual Assault	<input type="checkbox"/> Child Pornography	<input type="checkbox"/> Stalking
<input type="checkbox"/> Human Trafficking	<input type="checkbox"/> Terrorism	<input type="checkbox"/> Fraud Financial Crimes	<input type="checkbox"/> Kidnapping
<input type="checkbox"/> 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 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 resulted 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?				
<input type="checkbox"/> YES (If YES, complete questions 3 & 4)		<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN	
3. Name of Court		4. Court Case Number		
5. Did the court order the offender to pay restitution to you?				
<input type="checkbox"/> YES (If YES, complete questions 6, 7 & 8)		<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN	
6. Restitution Order Date		7. Court Case Number	8. Amount Ordered \$	
9. Have you filed, or do you intend to file a civil court action?				
<input type="checkbox"/> YES (If YES, complete questions 10, 11, 12 & 13)		<input type="checkbox"/> NO		
10. Have you settled with a third party regarding this case?				
<input type="checkbox"/> YES		<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN	
11. Name of Attorney		12. Attorney's Telephone Number		
13. Attorney's Address (Number, Street, Suite, etc.)		City	State	Zip Code

SECTION 5 – Statistical Information for Crime Victim Program:

For statistical purposes only. Completion of this section is strictly voluntary.

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

<input type="checkbox"/> Police/Officer	<input type="checkbox"/> Victim Service Agency	<input type="checkbox"/> Friend/Acquaintance	<input type="checkbox"/> Other
2. Race/Ethnic Background:		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black-African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other	
3. If Disabled, check one			
<input type="checkbox"/> BEFORE Crime <input type="checkbox"/> As a RESULT of this crime			

SECTION 6 – Claim Determination Information:

1. Check the Type of Compensation Benefits you are requesting.

<input type="checkbox"/> Medical Expense Benefits for the Victim	<input type="checkbox"/> Funeral Benefits for the Survivor(s)
<input type="checkbox"/> Loss of Earnings Benefits for the Victim	<input type="checkbox"/> Loss of Support Benefits for the Survivor(s)
<input type="checkbox"/> Counseling	<input type="checkbox"/> Crime Scene Clean-up for homicide only

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

<input type="checkbox"/> YES	<input type="checkbox"/> NO
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3. Have you lost at least 2 continuous weeks of earnings?

<input type="checkbox"/> YES	<input type="checkbox"/> NO
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<input type="checkbox"/> YES	<input type="checkbox"/> NO
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4. Is your injury the result of a Criminal Sexual Assault?

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

<input type="checkbox"/> YES	<input type="checkbox"/> NO
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<input type="checkbox"/> YES	<input type="checkbox"/> NO
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SECTION 7 – If you are applying for MEDICAL, DENTAL, COUNSELING:

Please complete this section, otherwise skip to Section 8. Please include all itemized medical bills, explanation of benefit and receipts.

1. Please indicate which of the following sources (if any) are available to pay any medical bills or out-of-pocket expenses: (check ALL that apply). Please attach any "Explanation of Benefit" statements that you have received to date.

<input type="checkbox"/> Health Insurance	<input type="checkbox"/> Dental/Vision Insurance	<input type="checkbox"/> Veterans Administration	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Medicare	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> State Medical Plan	<input type="checkbox"/> None
<input type="checkbox"/> Automobile Insurance	<input type="checkbox"/> Homeowners Insurance	<input type="checkbox"/> Other Public Assistance	<input type="checkbox"/> Other (explain in #2)

2. Did the victim receive charity care, payments, donations, or other insurance settlement from any other source due to this incident?

<input type="checkbox"/> YES	If yes explain below:	<input type="checkbox"/> NO
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3. Will Additional Medical Treatment be Required? (Please explain):

4. Name of Primary Medical Insurer:

SECTION 8 – If you are applying for FUNERAL EXPENSES, GRIEF COUNSELING, CRIME SCENE CLEAN UP, LOSS OF SUPPORT: Please complete this section, otherwise skip to Section 9. Please include itemized bills.

1. Please indicate which of the following sources (if any) are available to pay any bills or out-of-pocket expenses: (check ALL that apply). Please attach any "Explanation of Benefit" statements that you have received to date.

<input type="checkbox"/> Life Insurance	<input type="checkbox"/> Health Insurance	<input type="checkbox"/> Social Security Death	<input type="checkbox"/> Homeowners Insurance
<input type="checkbox"/> State Emergency Relief	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Automobile Insurance	<input type="checkbox"/> Other
<input type="checkbox"/> None			

2. Did you receive donations or money from any source due to this incident?

<input type="checkbox"/> YES	If yes explain below:	<input type="checkbox"/> NO
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SECTION 9 – If you are applying for LOSS OF EARNINGS:

If the victim was working, was disabled for 2 continuous weeks, and had taxable income, please complete this section, otherwise skip to Section 10.

- Attach pay stubs showing gross, net and tax deductions for 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. Please indicate which of the following sources are available to pay for loss of earnings:

<input type="checkbox"/> Long or Short term disability	<input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Social Security	<input type="checkbox"/> Other
<input type="checkbox"/> None	

SECTION 10 – Income Information:

Indicate YOUR HOUSEHOLD INCOME. If Parent or Guardian of a deceased, incapacitated, or minor victim, complete this section showing the CLAIMANT'S income.

1. Annual Household Income – We cannot accept zero

\$

IMPORTANT:
Completion of this section is required for ALL Applicants.
We cannot accept zero

AUTHORIZATION AND AGREEMENTS

Name of Victim: _____

Please print

Name of Claimant: _____

Please print

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

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.

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.

Please keep a copy of all documentation for your records.

RETURN COMPLETED, SIGNED APPLICATION AND SUPPORTING DOCUMENTATION TO:

Crime Victim Services Commission

For Assistance Call: Victim only toll-free: 1-800-392-3777
All others: 1-800-392-3777

CRIME VICTIM SERVICES

Phone: _____ • Fax: _____ • Victims Only Line: _____

Mailing Address: Crime Victim Services, _____

COMPENSATION CHECKLIST

Use The Checklist Below For The Specific Compensation You Are Requesting

Please be advised that additional information may be necessary at a later date in the application process

Processing of an application may take 12 to 16 weeks

Please make sure that you have answered all sections of the application

MAKE SURE REQUIRED DOCUMENTS ARE INCLUDED WITH YOUR APPLICATION

For All Applications:

- ____ Make sure your household income is entered on the application in the appropriate section- It can NOT be blank or "0"- Show your source of support
- ____ Submit a copy of the **police report** if you have it
- ____ **IF THE DATE OF CRIME HAS BEEN OVER 1 YEAR, A COPY OF THE POLICE REPORT IS REQUIRED TO BE SENT IN WITH THE APPLICATION** along with written explanation as to why you didn't apply within a year from the date of the crime
- ____ Submit a copy of the **Case Action Notice** verifying eligibility from the Department of Health and Human Services if they assisted you after the crime

Applying for Medical Bills and/or Counseling?:

- ____ Submit Itemized copies of all medical/counseling bills, plus copies of any paid receipts AND.....
- ____ All medical/counseling bills should be submitted to your insurance, Medicaid, or Medicare carrier first; then **provide copies of the Explanation of Benefits (or Case Action Notice if you have Medicaid) showing rejection of coverage or partial payment**
- ____ If you have injuries that require medication or replacement of medical equipment such as glasses, dentures, etc.; send a copy of the prescription, the **itemized bill or itemized estimate**, and copy of the receipt if you have already paid
- ____ If you are applying for a medical procedure that has not taken place yet, and you need a pre-authorization, please provide a written **itemized estimate** from the provider for the procedure
- ____ If you are permanently disabled because of your injury, send a copy of the prescription and two cost estimates for any necessary rehabilitative equipment or modifications of your home or vehicle
- ____ If you are applying for counseling, submit a copy of the **initial assessment and goal oriented treatment plan** from your counselor or therapist

Continued On Page 2...

COMPENSATION CHECKLIST Continued...

Applying for Burial Benefits?:

- ____ Submit an **Itemized** copy of the funeral bill, including cemetery and funeral home bills, **plus copies of any paid receipts**
- ____ If somebody other than you made a payment toward the funeral costs, and they allow you to be reimbursed for their payment; provide a **notarized** statement from that person **authorizing you** to be reimbursed for that payment
- ____ Submit the Life Insurance Benefit Statement

Applying for Loss of Earnings or Support?:

- ____ If you are applying for loss of earnings and are **NOT self-employed**, provide copies of 2 or 3 pay stubs paid **just before** the date of injury
- ____ If you are applying for loss of earnings and **ARE self-employed**, provide a copy of the **most recent** Federal and State Income Tax Return including Schedule C
- ____ If you are applying for loss of earnings, submit a written disability statement from your physician **verifying your physical disability** and **specific** dates off work
- ____ If you are applying for loss of support, provide a copy of the Life Insurance Benefit Statement **and/or** Social Security Survivor's Benefit Statement for you and your children
- ____ If you are applying for loss of support, please provide a copy of the court order for child support
- ____ If you are applying for loss of support, please provide a copy of the victim's **most recent** Federal and State Income Tax Returns and W-2 forms