CRIME VICTIM COMPENSATION APPLICATION

Michigan Department of Community Health

For Office Use Only:
Claim Number:
Cross Reference Number:

AUTHORITY: PA 223 of 1976 **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 Department of Community Health is an equal opportunity employer, services, and programs provider.

INSTRUCTIONS

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

- **Enclose copies of crime-related itemized medical, dental and/or counseling bills received to date if not fully paid by insurance**
- **Submit Explanation of Benefits 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**
- **A written disability statement from your physician verifying dates you are unable to work**
- **For assistance in completing this application, call the victim only toll free number (877) 251-7373 or (517) 373-7373**
- **Return the completed application to the below address:**

Crime Victim Services Commission
Capitol View Building
201 Townsend Street – PO Box 30195
Lansing MI 48909
Fax (517) 373-2439

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
☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

9. Gender
☐ **Male** ☐ **Female**

SECTION 2 – Claimant Information: *Complete this section ONLY if you are filing the application for a deceased, incapacitated, or minor 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 ( )	6. Cell Phone Number ( )
City	State	ZIP Code	7. Work Telephone Number ( )	

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

9. Gender
☐ **Male** ☐ **Female**

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

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

Primary Financial Support ☐ **NO** ☐ **YES -- If yes, monthly amount** _____

Child Support or Alimony ☐ **NO** ☐ **YES -- If yes, monthly amount** _____

12. **Dependents: Please list Names and Birthdates of ALL Victim's Legal Dependents**

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**	☐ **Human Trafficking**	☐ **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 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?

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

3. Name of Court	4. Court Case Number

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

☐ **YES (If YES, complete questions 6, 7, & 8)** ☐ **NO** ☐ **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?

☐ **YES (If YES, complete questions 10, 11, 12, & 13)** ☐ **NO**

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

☐ **YES** ☐ **NO** ☐ **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**

2. Race / Ethnic Background:			3. If Disabled, check one
☐ **White**	☐ **Black**	☐ **Hispanic**	☐ **BEFORE Crime**
☐ **Asian / Pacific Islander**	☐ **American Indian**	☐ **Multi-racial**	☐ **As a RESULT of this crime**

SECTION 6 - Claim Determination Information: Check the Type of Compensation Benefits you are requesting.

1. ☐ **Medical Expense Benefits for the Victim**
   ☐ **Loss of Earnings Benefits for the Victim**
   ☐ **Counseling** ☐ **Grief Counseling for homicide only**
   ☐ **Funeral Benefits for the Survivor(s)**
   ☐ **Loss of Support Benefits for the Survivor(s)**
   ☐ **Crime Scene Clean-Up for homicide only**

2. Have you or will you suffer a minimum out-of-pocket loss of $200?	3. Have you lost at least 2 continuous weeks of earnings?
☐ **NO** ☐ **YES**	☐ **NO** ☐ **YES**
4. Is your injury the result of a Criminal Sexual Assault?	5. Are you Retired by reason of Age or Disability?
☐ **NO** ☐ **YES**	☐ **NO** ☐ **YES**

SECTION 7 - If you are applying for MEDICAL, DENTAL, COUNSELING, please complete this section, otherwise skip to Section 8: Please enclose all itemized medical bills.

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 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. Did the victim receive charity care, payments, donations, or other insurance settlement from any other source due to this incident: ☐ **YES** ☐ **NO**
If yes, explain:

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 Benefits" statements that you have received to date.

☐ **Life Insurance** ☐ **Health Insurance** ☐ **Social Security Death** ☐ **Homeowners Insurance**
☐ **State Emergency Relief** ☐ **Workers Compensation** ☐ **Automobile Insurance** ☐ **Other**

2. Did you receive donations or other money from any other resource due to this incident: ☐ **Yes (If yes, please explain below:)** ☐ **No**

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:
☐ **Long or Short term disability** ☐ **Workers' Compensation**
☐ **Social Security** ☐ **Other**

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.**

RETURN COMPLETED, SIGNED APPLICATION AND SUPPORTING DOCUMENTATION TO:

CRIME VICTIM SERVICES COMMISSION
Capitol View Building
201 Townsend Street
PO Box 30195
Lansing MI 48909
FAX (517) 373-2439

For Assistance Call: Victim only toll free (877) 251-7373
All others: (517) 373-7373