

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 Health and Human Services 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
 Grand Tower, Suite 1113
 235 South Grand Avenue
 PO Box 30037
 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 <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: 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 <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"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Guardian <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				

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"/> Arson | <input type="checkbox"/> Assault | <input type="checkbox"/> Child Abuse | <input type="checkbox"/> DWI / DUI |
| <input type="checkbox"/> Homicide | <input type="checkbox"/> Kidnapping | <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Robbery |
| <input type="checkbox"/> Sexual Assault | <input type="checkbox"/> Terrorism | <input type="checkbox"/> Human Trafficking | <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 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:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Prosecuting Attorney | <input type="checkbox"/> Medical Provider | <input type="checkbox"/> Attorney | <input type="checkbox"/> Media, Brochure, or Poster |
| <input type="checkbox"/> Police / Sheriff | <input type="checkbox"/> Victim Service Agency | <input type="checkbox"/> Friend / Acquaintance | <input type="checkbox"/> Other |

2. Race / Ethnic Background:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> White | <input type="checkbox"/> Black | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Asian / Pacific Islander | <input type="checkbox"/> American Indian | <input type="checkbox"/> Multi-racial |

3. If Disabled, check one

- | |
|--|
| <input type="checkbox"/> BEFORE Crime |
| <input type="checkbox"/> As a RESULT of this crime |

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
Grand Tower, Suite 1113
235 South Grand Avenue
PO Box 30037
Lansing MI 48909
FAX (517) 373-2439**

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