CRIME VICTIM COMPENSATION APPLICATION

Michigan Department of Health and Human Services

Complete application.

For questions about Crime Victim Compensation call 517-241-7373.

SECTION 1 – Victim Information: Complete this section for the person who was physically injured.			
1. Name of Victim (last, first, middle)	2. Date of Birth	3. Social Security Number	
4. Address	City	State	Zip Code
5. Gender ☐ Male ☐ Female ☐ Other	6. Email Address		
7. Contact Phone Number	8. Preferred Method of Notification ☐ USPS Mail ☐ Email		
9. Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			

Complete Section 2 ONLY if the victim is
☐ a Minor ☐ Deceased ☐ Incapacitated

SECTION 2 – Claimant Information			
10. Name of Claimant (last, first, middle)	11. Date of Birth	12. Social Security Number	
13. Address	City	State	Zip Code
14. Gender ☐ Male ☐ Female ☐ Other	15. Email Address		
16. Contact Phone Number	17. Preferred Method of Notification ☐ USPS Mail ☐ Email		
18. Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			

19. Your relationship to the victim
☐ Spouse ☐ Parent ☐ Child ☐ Sibling
☐ Grandparent ☐ Grandchild ☐ Guardian ☐ Other _____

20. 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 _____

21. Dependents: List names and birthdates of all Victim's Legal Dependents (complete this only if you are applying for loss of support)

Name	Birthdate	Name	Birthdate

SECTION 3 – Income Information: Indicate your household income. If Claimant is applying on behalf of a deceased, incapacitated, or minor victim, complete this section showing Claimant's Income.	
Annual Household Income	**IMPORTANT: Completion of this section is required for all applicants.**

SECTION 4 – Crime Information: Complete this section and provide copy of Police Report if available.

22. Type of Crime (check only one)

☐ Homicide	☐ Assault	☐ DWI/DUI	☐ Vehicular Crime (other)
☐ Robbery	☐ Arson	☐ Burglary	☐ Sexual Assault
☐ Stalking	☐ Child Abuse/Neglect	☐ Child Pornography	☐ Child Sexual Assault
☐ Human Trafficking	☐ Terrorism/Mass Violence	☐ Elder Abuse	☐ Kidnapping
☐ Bullying	☐ Hate Crime	☐ Fraud Financial Crimes	☐ Other

23. Was the person who caused the injury the victim's spouse, former spouse, in a dating relationship with the victim, an individual with whom the victim had a child in common, or a resident or former resident of the victim's household? (this does not affect your eligibility). ☐ Yes ☐ No

24. Date of Crime	25. Date Crime was Reported	26. County in which Crime Occurred

27. Police or Sheriff Agency to which crime was reported	28. Incident Number	
29. Location of Crime (number and street)	City	State

30. Briefly describe the crime and physical injuries that resulted from this crime

31. If the crime was NOT reported to Police/Sheriff within 48 hours, explain delay (waivers may apply)

32. If you are NOT filing this claim within one year of the date of crime, explain delay (waivers may apply)

SECTION 5 – Restitution and Recovery Information: Provide all information you have available.

33. Name of Offender(s), if known

34. Has the Offender(s) been charged in Criminal Court? ☐ Yes ☐ No ☐ Unknown

35. Name of Court	36. Court Case Number

37. Did the Court order the Offender(s) to pay restitution to you? If Yes, provide the amount ordered.
☐ Yes _____ ☐ No ☐ Unknown

38. Have you filed, or do you intend to file, a Civil Court action? If Yes, complete questions 39, 40, 41.
☐ Yes ☐ No

39. Have you reached a settlement? If Yes, explain. You may attach a separate sheet if necessary.
☐ Yes _____ ☐ No

40. Name of Attorney	41. Attorney's Telephone Number

SECTION 6 – Statistical Information for Crime Victim Program: For statistical purposes only. Completion of this section is strictly voluntary.

42. Tell us how you first found out about the Crime Victim Compensation Program

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

43. Race/Ethnic Background

☐ White Non-Latino/Caucasian	☐ American Indian	☐ Multi-Racial
☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic or Latino	☐ Black/African American
	☐ Asian	☐ Alaska Native

44. If disabled, check one ☐ BEFORE crime ☐ As a RESULT of this crime

SECTION 7 – Claim Determination Information

45. Check the type of Compensation Benefits you are requesting

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

46. Have you or will you suffer a minimum out-of-pocket loss of $200?
☐ No ☐ Yes

47. Have you lost at least two continuous weeks of earnings?
☐ No ☐ Yes

48. Is your injury the result of a Criminal Sexual Assault? (waivers may apply)
☐ No ☐ Yes

49. Are you retired by reason of age or disability? (waivers may apply)
☐ No ☐ Yes

SECTION 8 – Complete if you are applying for MEDICAL, DENTAL, COUNSELING

50. Indicate which of the following sources (if any) are available to pay any medical bills or out-of-pocket expenses (check ALL that apply).

- ☐ Health Insurance
- ☐ Dental/Vision Insurance
- ☐ Veterans Administration
- ☐ Medicaid
- ☐ Medicare
- ☐ Workers Compensation
- ☐ State Medical Plan
- ☐ Automobile Insurance
- ☐ Other Public Assistance
- ☐ Homeowners Insurance
- ☐ None
- ☐ Other

51. Did the victim receive charity care, payments, donations, or other insurance settlement from any other source due to this incident?
☐ Yes _____ ☐ No ☐ Unknown

52. Will additional medical treatment be required? (if Yes, please explain)
☐ Yes _____ ☐ No ☐ Unknown

53. Name of Primary Medical Insurer

SECTION 9 – Complete if the victim is deceased and you are applying for FUNERAL EXPENSES, GRIEF COUNSELING, CRIME SCENE CLEAN-UP, LOSS OF SUPPORT

54. Indicate which of the following sources (if any) are available to pay any bills or out-of-pocket expenses (check ALL that apply).

- ☐ Life Insurance
- ☐ Health Insurance
- ☐ None
- ☐ Social Security Death
- ☐ Homeowners Insurance
- ☐ Other _____
- ☐ State Emergency Relief
- ☐ Automobile Insurance

55. Did the victim receive charity care, payments, donations, or other insurance settlement from any other source due to this incident?
☐ Yes _____ ☐ No ☐ Unknown

SECTION 10 – Complete if you are applying for LOSS OF EARNINGS

56. Victim's Employer's Name

57. Employer's Phone Number

58. Employer's Street Address

59. Name of Doctor who will verify medical disability

60. Dates absent from work due to crime related injuries
From _____ To _____

61. Indicate which of the following sources are available to pay for loss of earnings

- ☐ Long- or Short-Term Disability
- ☐ Workers' Compensation
- ☐ Social Security
- ☐ None
- ☐ Other _____

Authorizations and Agreements

Name of Victim	Name of Claimant
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 compensation require 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.

Keep a copy of all documentation for your records.

Return completed, signed application and supporting documentation to:

Michigan Department of Health and Human Services
Crime Victim Services Commission, Suite 1113
PO Box 30037
Lansing, MI 48909

For assistance, Victims call, 877-251-7373 or all others call, 517-241-7373.

Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.

Call (TTY 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (TTY 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 （TTY 711）
Syriac (Assyrian)	ܙܘܗܪܐ: ܐܢ ܐܢܬ ܗܘܝܬ ܗܡܙܡܢܐ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܩܒܠܬ ܬܫܡܫܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ (TTY 711)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (TTY 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (TTY 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (TTY 711)번으로 전화해 주십시오.
Bengali	লক্ষ্য#করুনঃ#যদি#আপনি#বাংলা/#কথা#বলতে#পারেন/#তাহলে#নিঃখরচায়#ভাষা#সহায়তা#পরিষেবা#উপলব্ধ#আছে।#ফোন#করুন#১ ## (TTY#১ 711).#
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (TTY 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer (TTY 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (TTY 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。（TTY 711）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (TTY 711).

The Michigan Department of Health and Human Services (MDHHS) 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. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, 4th Floor
PO Box 30195
Lansing, MI 48909

517-284-1018 (Main), [TTY number—if covered entity has one], 517-335-6146 (Fax), [Email]

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.