

DCH-0560, CRIME VICTIM COMPENSATION APPLICATION

Michigan Department of Health and Human Services

(Revised 2-25)

Complete application.

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

Completed applications can be emailed to MDHHS-MichiganCrimeVictim@michigan.gov or faxed to 517-335-2439.

SECTION 1 – Victim Information: Complete this section for the person who was injured.

1. Name of Victim	2. Date of Birth	3. Social Security Number	
4. Address	City	State	Zip Code
5. Phone Number	6. Email Address		
7. Preferred Method of Contact		<input type="checkbox"/> Email	<input type="checkbox"/> Mail
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 <input type="checkbox"/> Other			

SECTION 2 – Claimant Information: Complete this section for the person applying on behalf of the victim.

10. Name of Claimant	11. Date of Birth	12. Social Security Number																	
13. Address	City	State	Zip Code																
14. Phone Number	15. Email Address																		
16. Preferred Method of Contact		<input type="checkbox"/> Email	<input type="checkbox"/> Mail																
17. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed																			
18. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other																			
19. Your relationship to the victim <table><tr><td><input type="checkbox"/> Spouse</td><td><input type="checkbox"/> Parent</td><td><input type="checkbox"/> Child</td><td><input type="checkbox"/> Sibling</td></tr><tr><td><input type="checkbox"/> Grandparent</td><td><input type="checkbox"/> Grandchild</td><td><input type="checkbox"/> Guardian</td><td><input type="checkbox"/> In-Law</td></tr><tr><td><input type="checkbox"/> Aunt</td><td><input type="checkbox"/> Uncle</td><td><input type="checkbox"/> Niece</td><td><input type="checkbox"/> Nephew</td></tr><tr><td><input type="checkbox"/> Caregiver</td><td><input type="checkbox"/> Dating Relationship</td><td><input type="checkbox"/> Household Member</td><td><input type="checkbox"/> Other</td></tr></table>				<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"/> In-Law	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Niece	<input type="checkbox"/> Nephew	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Dating Relationship	<input type="checkbox"/> Household Member	<input type="checkbox"/> Other
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<input type="checkbox"/> Caregiver	<input type="checkbox"/> Dating Relationship	<input type="checkbox"/> Household Member	<input type="checkbox"/> Other																
20. Were you dependent on the deceased victim for primary financial support or child support? <input type="checkbox"/> Yes, monthly amount \$ <input type="checkbox"/> No																			
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 – Statistical Information: Completion of this section is strictly voluntary.

22. Tell us how you first found out about the Crime Victim 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 | |

23. Race/Ethnic Background

- | | | |
|---|---|--|
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Multi-Racial | <input type="checkbox"/> White Non-Latino/Caucasian |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Alaska Native | |

24. If disabled, check one

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

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

25. 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"/> Stalking |
| <input type="checkbox"/> Child Abuse/Neglect | <input type="checkbox"/> Child Pornography | <input type="checkbox"/> Child Sexual Assault |
| <input type="checkbox"/> Human Trafficking | <input type="checkbox"/> Terrorism/Mass Violence | <input type="checkbox"/> Elder Abuse |
| <input type="checkbox"/> Kidnapping | <input type="checkbox"/> Bullying | <input type="checkbox"/> Hate Crime |
| <input type="checkbox"/> Fraud Financial Crimes | <input type="checkbox"/> Other | |

26. 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

27. Date of Crime

28. Date Crime was Reported

29. Law enforcement agency to which crime was reported

30. County in which Crime Occurred

31. Location of Crime

32. Incident Number

33. Briefly describe the crime and injuries that resulted from this crime.

34. If the crime was NOT reported to law enforcement, explain why.

35. If you are NOT filing this claim within five years of the date of crime, explain delay (waivers may apply).

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

36. Name of Offender(s), if known

37. Offender(s) has been charged in Criminal Court? ☐ Yes ☐ No

38. Name of Court and Case Number

39. Has the Court ordered Offender(s) to pay restitution?

☐ Yes, amount \$ ☐ No40. Have you filed, or do you intend to file, a Civil Court action? ☐ Yes ☐ No

41. Have you hired an attorney for a Civil Suit?

☐ Yes, Name ☐ No

42. Have you reached a settlement?

☐ Yes, amount \$ ☐ No**SECTION 6 – Compensation Benefits**

43. Check ALL Compensation Benefits you are requesting

- | | | |
|---|---|---|
| <input type="checkbox"/> Medical Expenses | <input type="checkbox"/> Dental Expenses | <input type="checkbox"/> Psychological Counseling |
| <input type="checkbox"/> Loss of Earnings | <input type="checkbox"/> Relocation (Temporary) | <input type="checkbox"/> Relocation (Permanent) |
| <input type="checkbox"/> Residential Security | <input type="checkbox"/> Transportation | <input type="checkbox"/> Bereavement |
| <input type="checkbox"/> Accessibility & Rehabilitative Equipment | <input type="checkbox"/> Replacement Services | <input type="checkbox"/> Non-Medical Remedial Treatment |
| <input type="checkbox"/> Funeral and Burial Expenses | <input type="checkbox"/> Replacement Costs | <input type="checkbox"/> Loss of Support |
| <input type="checkbox"/> Grief Counseling | <input type="checkbox"/> Crime Scene Clean-up | |

44. Have you or will you suffer a loss of at least \$200? ☐ Yes ☐ No45. Have you lost at least five days of earnings? ☐ Yes ☐ No46. Is your injury the result of a sexual assault? (waivers may apply) ☐ Yes ☐ No47. Are you retired by reason of age or disability? (waivers may apply) ☐ Yes ☐ No48. Are you experiencing undue hardship and do you request an emergency award? ☐ Yes ☐ No**SECTION 7 – Collateral Resources**

49. Check ALL financial resources available to you (if any) to cover expenses resulting from the crime.

- | | | |
|---|---|---|
| <input type="checkbox"/> Health Insurance | <input type="checkbox"/> Dental/Vision Insurance | <input type="checkbox"/> Social Security Disability |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Disability Insurance | <input type="checkbox"/> Social Security Supplemental |
| <input type="checkbox"/> Medicaid Spend-down | <input type="checkbox"/> Veteran's Administration | <input type="checkbox"/> Social Security Death |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Homeowner's/Renter's Insurance | <input type="checkbox"/> Worker's Compensation |
| <input type="checkbox"/> State Medical Assistance | <input type="checkbox"/> Civil Lawsuit | <input type="checkbox"/> Auto Insurance |
| <input type="checkbox"/> Short/Long-Term Disability | <input type="checkbox"/> State Emergency Relief | <input type="checkbox"/> Restitution |
| <input type="checkbox"/> Life Insurance | | <input type="checkbox"/> Other |

50. Did you receive charity care, donations, settlements, etc. from any other source? ☐ Yes ☐ No

51. Will additional treatment be required?

☐ Yes, explain ☐ No

52. Name of primary medical/dental insurer

SECTION 8 – Loss of Earnings and Bereavement

53. Employer's Name

54. Number of days absent from work due to crime

55. Are you currently unable to work due to the crime? ☐ Yes ☐ No

AUTHORIZATIONS AND AGREEMENTS

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.

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
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Return completed, signed application, and supporting documentation by email, fax, or mail.

Keep a copy of all documentation for your records.

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

Call 517-241-7373 (TTY 711).

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The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

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 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, Suite 411
PO Box 30037
Lansing, MI 48909

517-284-1018 (Main), (TTY number—if covered entity has one), 517-335-6146 (Fax),
MDHHS-Section-1557@michigan.gov (Email).

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

<p>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:</p> <p>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)</p> <p>Complaint forms are available at https://bit.ly/2IKsHMS.</p>	<p>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:</p> <p>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.</p> <p>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</p> <p>Fax: 202-690-7442; or Email: program.intake@usda.gov</p>
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MDHHS is an equal opportunity provider.