

# CRIME VICTIM COMPENSATION MASS VIOLENCE APPLICATION

Michigan Department of Health and Human Services

## INSTRUCTIONS

- A separate application must be submitted for each victim
- If the victim is a minor, deceased, or legally incapacitated, please ensure a PARENT or LEGAL GUARDIAN completes section 2 and signs the application
- For assistance in completing this application, or for any questions, please call (877) 251-7373 or (517) 241-7373
- Return the completed application and any supporting documentation via one of the following methods:
  - **E-mail:** mdhhs-michigancrimevictim@michigan.gov
  - **Fax:** (517) 335-2439
  - **Mail:** Crime Victim Services Commission  
Grand Tower, Suite 1113  
235 S. Grand Avenue, PO Box 30037  
Lansing, MI 48909

### SECTION 1 – Victim Information

*Complete this section for the person who was injured*

1. Name of VICTIM (Last, First, Middle)			2. Date of Birth	3. Social Security Number	
4. Address (Number, Street, Apartment Number, etc.)			5. E-mail Address		
City	State	ZIP Code	6. Contact Phone Number ( )	7. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	

### SECTION 2 – Claimant Information

*Complete this section for the person who is applying on behalf of the person who was injured*

1. Name of CLAIMANT (Last, First, Middle)			2. Date of Birth	3. Social Security Number	
4. Address (Number, Street, Apartment Number, etc.)			5. E-mail Address		
City	State	ZIP Code	6. Contact Phone Number ( )	7. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
8. Your Relationship to the Victim					
<input type="checkbox"/> Spouse		<input type="checkbox"/> Parent		<input type="checkbox"/> Child	
<input type="checkbox"/> Grandparent		<input type="checkbox"/> Grandchild		<input type="checkbox"/> Sibling	
		<input type="checkbox"/> Guardian		<input type="checkbox"/> Other _____	

### SECTION 3 – 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, 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:			3. If Disabled, check one
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander			<input type="checkbox"/> BEFORE crime <input type="checkbox"/> As a RESULT of this crime
<input type="checkbox"/> White Non-Latino/Caucasian	<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	

## SECTION 4 – Crime Information

*Provide a copy of the Police Report if available*

- |   |   |   |
|---|---|---|
| 1. Date of Crime<br>July 26, 2025                             | 2. County in which Crime Occurred<br>Grand Traverse | 3. Incident Number                                      |
| 3. Location of Crime (Number and Street)<br>Walmart           |   | 5. Police Agency<br>Grand Traverse Sheriff's Department |
| 6. Briefly describe the injuries that resulted from the crime |   |   |

## SECTION 5 – Claim Information

*Provide a copy of the Police Report if available*

1. Check the type of Compensation Benefits you are requesting

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Dental Expense Benefits   | <input type="checkbox"/> Rehabilitative | <input type="checkbox"/> Transportation           | <input type="checkbox"/> Residential Security |
| <input type="checkbox"/> Medical Expense Benefits  | <input type="checkbox"/> Counseling     | <input type="checkbox"/> Funeral Expenses         | <input type="checkbox"/> Grief Counseling     |
| <input type="checkbox"/> Loss of Earnings Benefits | <input type="checkbox"/> Relocation     | <input type="checkbox"/> Loss of Support Benefits | <input type="checkbox"/> Crime Scene Clean-Up |

2. Please indicate which of the following sources (if any) are available to pay for out-of-pocket expenses

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Health Insurance      | <input type="checkbox"/> Medicare                | <input type="checkbox"/> State Medical Plan | <input type="checkbox"/> Medicaid    |
| <input type="checkbox"/> Homeowner's Insurance | <input type="checkbox"/> Other Public Assistance | <input type="checkbox"/> None               | <input type="checkbox"/> Other _____ |

## AUTHORIZATION AND AGREEMENTS

**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

**NOTE: A photocopy of this authorization is as effective and valid as the original.**

**Please keep a copy of all documentation for your records.**