DCH-0560, CRIME VICTIM COMPENSATION APPLICATION

Michigan Department of Health and Human Services
(Revised 8-23)

Complete application.

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

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. Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
8. Gender ☐ Male ☐ Female ☐ Other			
SECTION 2 – Claimant Information			
9. Name of Claimant	10. Date of Birth	11. Social Security Number	
12. Address	City	State	Zip Code
13. Phone Number	14. Email Address		
15. Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
16. Gender ☐ Male ☐ Female ☐ Other			
17. Your relationship to the victim ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Grandparent ☐ Grandchild ☐ Guardian ☐ In-Law ☐ Aunt ☐ Uncle ☐ Niece ☐ Nephew ☐ Caregiver ☐ Dating Relationship ☐ Household Member ☐ Other			
18. Were you dependent on the deceased victim for primary financial support or child support? ☐ Yes, monthly amount **$** ☐ No			
19. 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.

20. 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

21. Race/Ethnic Background

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

22. If disabled, check one

☐ BEFORE crime ☐ As a RESULT of this crime

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

23. 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

24. 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

25. Date of Crime	26. Date Crime was Reported
27. Law enforcement agency to which crime was reported	28. County in which Crime Occurred
29. Location of Crime	30. Incident Number

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

32. If the crime was NOT reported to law enforcement, explain why (waivers may apply)

33. 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.

34. Name of Offender(s), if known

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

36. Name of Court and Case Number

37. Has the Court ordered Offender(s) to pay restitution?
☐ Yes, amount $ ☐ No

38. Have you filed, or do you intend to file, a Civil Court action? ☐ Yes ☐ No

39. Have you hired an attorney for a Civil Suit?
☐ Yes, Name ☐ No

40. Have you reached a settlement?
☐ Yes, amount $ ☐ No

SECTION 6 – Compensation Benefits

41. Check ALL Compensation Benefits you are requesting

☐ Medical Expenses	☐ Dental Expenses	☐ Psychological Counseling
☐ Loss of Earnings	☐ Relocation (Temporary)	☐ Relocation (Permanent)
☐ Residential Security	☐ Transportation	☐ Bereavement
☐ Accessibility & Rehabilitative Equipment	☐ Replacement Services	☐ Non-Medical Remedial Treatment
☐ Funeral and Burial Expenses	☐ Replacement Costs	☐ Loss of Support
☐ Grief Counseling	☐ Crime Scene Clean-up	

42. Have you or will you suffer a loss of at least $200? ☐ Yes ☐ No

43. Have you lost at least five days of earnings? ☐ Yes ☐ No

44. Is your injury the result of a sexual assault? (waivers may apply) ☐ Yes ☐ No

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

SECTION 7 – Collateral Resources

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

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

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

48. Will additional treatment be required?
☐ Yes, explain ☐ No

49. Name of primary medical/dental insurer

SECTION 8 – Loss of Earnings and Bereavement

50. Employer's Name

51. Number of days absent from work due to crime

52. 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

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.

Michigan Department of Health and Human Services (MDHHS)
Please note if needed, free language assistance services are available.
Call 517-241-7373 (TTY 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 517-241-7373 (TTY 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 517-241-7373 (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 517-241-7373 （TTY 711）
Syriac (Assyrian)	ܙܘܼܗܵܪܵܐ: ܐܸܢ ܐܲܢ̱ܬ ܟܹܐ ܗܵܡܙܸܡܬ ܠܫܵܢܵܐ ܐܵܬܘܿܪܵܝܵܐ، ܟܡܵܨܝܬ ܕܩܲܒܠܲܬ ܡܲܥܕܪܵܢܘܼܬܵܐ ܕܗܲܡܙܲܡܬܵܐ ܒܠܫܵܢܵܐ ܡܲܓܵܢܵܐܝܼܬ. ܩܪܝ ܥܲܠ ܡܸܢܝܵܢܵܐ 517-241-7373 (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 517-241-7373 (TTY 711).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 517-241-7373 (TTY 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 517-241-7373 (TTY 711)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 517-241-7373 (TTY ১ 711).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 517-241-7373 (TTY 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 517-241-7373 (TTY 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 517-241-7373 (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。517-241-7373（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 517-241-7373 (телетайп 711).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 517-241-7373 (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 517-241-7373 (TTY 711).

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.

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.