

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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		6. Email Address	
7. Contact Phone Number		8. Preferred Method of Notification <input type="checkbox"/> USPS Mail <input type="checkbox"/> Email	
9. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			

Complete Section 2 ONLY if the victim is		
<input type="checkbox"/> a Minor	<input type="checkbox"/> Deceased	<input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		15. Email Address	
16. Contact Phone Number		17. Preferred Method of Notification <input type="checkbox"/> USPS Mail <input type="checkbox"/> Email	
18. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
19. 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 _____			
20. 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 _____			
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)

<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

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

<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

43. Race/Ethnic Background

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

<input type="checkbox"/> Medical Expense Benefits for the Victim	<input type="checkbox"/> Funeral Benefits for the Survivor(s)
<input type="checkbox"/> Loss of Earnings Benefits for the Victim	<input type="checkbox"/> Loss of Support Benefits for the Survivor(s)
<input type="checkbox"/> Counseling	<input type="checkbox"/> Crime Scene Clean-Up (homicide only)
<input type="checkbox"/> Grief Counseling (homicide only)	

46. Have you or will you suffer a minimum out-of-pocket loss of \$200? <input type="checkbox"/> No <input type="checkbox"/> Yes	47. Have you lost at least two continuous weeks of earnings? <input type="checkbox"/> No <input type="checkbox"/> Yes
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48. Is your injury the result of a Criminal Sexual Assault? (waivers may apply) <input type="checkbox"/> No <input type="checkbox"/> Yes	49. Are you retired by reason of age or disability? (waivers may apply) <input type="checkbox"/> No <input type="checkbox"/> Yes
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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).

<input type="checkbox"/> Health Insurance	<input type="checkbox"/> Dental/Vision Insurance	<input type="checkbox"/> Veterans Administration
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Workers Compensation
<input type="checkbox"/> State Medical Plan	<input type="checkbox"/> Automobile Insurance	<input type="checkbox"/> Other Public Assistance
<input type="checkbox"/> Homeowners Insurance	<input type="checkbox"/> None	<input type="checkbox"/> 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).

<input type="checkbox"/> Life Insurance	<input type="checkbox"/> Health Insurance	<input type="checkbox"/> None
<input type="checkbox"/> Social Security Death	<input type="checkbox"/> Homeowners Insurance	<input type="checkbox"/> Other _____
<input type="checkbox"/> State Emergency Relief	<input type="checkbox"/> 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

<input type="checkbox"/> Long- or Short-Term Disability	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Social Security
<input type="checkbox"/> None	<input type="checkbox"/> 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
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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.

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.

<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.