Victim Compensation Claim Form

Crime Victim Compensation Program (CVC)
P.O. Box 201410
Helena, MT 59620-1410
1-800-498-6455 ~ 406-444-3653

~ INFORMATION REQUESTED IN BOLD MUST BE COMPLETED ~

SECTION A Victim Information

Please Print

NOTE: Secondary victims must complete all Sections <u>except</u> G.

Victim Name ______________________________
Last *First* *M.I.*

Check appropriate box: [ ] **Primary Victim** [ ] **Secondary Victim** [ ] **Deceased Victim**

Mailing Address: ______________________________
Street or PO Box *City* *ST* *Zip*

Date of Birth: ___/___/___ **Sex:** [ ] Female [ ] Male **Social Security #:** ______________

Home Phone: ______________ **Work Phone:** ______________

Benefits Requested: [ ] Medical [ ] Mental Health [ ] Wage Loss [ ] Death Benefits

If this application is for a Secondary Victim please indicate the name of the Primary Victim and your relationship to the Primary Victim:

____

SECTION B Claimant Information

Complete if victim is a minor, deceased, or mentally impaired

Check appropriate box: Victim is: [ ] A Minor [ ] Deceased [ ] Mentally Impaired

Claimant Name: ______________ **Relationship to Victim:** ______________

Mailing Address: ______________________________
Street or PO Box *City* *ST* *Zip*

Date of Birth: ___/___/___ **Sex:** [ ] Female [ ] Male

Social Security #: ______________ **Home Phone:** ______________

Work Phone: ______________

SECTION C Type of Crime

** In child sexual abuse cases, indicate the date parent or guardian was made aware of the crime.*

Date of Crime ______________
Date Reported to Law Enforcement ______________
***Date Crime Discovered by Parent or Guardian** ______________
Law Enforcement Agency Reported to ______________
Law Enforcement Case Number ______________
Location of Crime ______________
Name of Offender ______________
Victim's Relationship to Offender ______________
Has Prosecution Taken Place? [ ] Yes [ ] No
If Yes, What Court? ______________

Mark all that apply:

- [ ] Assault
- [ ] Homicide
- [ ] Stalking
- [ ] Domestic Violence
- [ ] DUI
- [ ] Arson
- [ ] Robbery
- [ ] Hate Crime
- [ ] Elder Abuse
- [ ] Child Pornography
- [ ] Child Physical Abuse
- [ ] Child Sexual Abuse
- [ ] Adult Sexual Assault
- [ ] Human Trafficking
- [ ] Teen Dating Violence
- [ ] Terrorism/Mass Violence
- [ ] Other (identify) ______________ ______________

SECTION D Additional Information

Please summarize the incident to the best of your memory (you may use additional paper if necessary):

____
____
____
____

SECTION E Additional Information

Collateral sources are primary payers and must be billed prior to CVC.
THIS SECTION MUST BE COMPLETED

Please check all of the appropriate box(es) for the sources that may help pay the expenses related to this crime:

☐ Medicaid	☐ Social Security	☐ Worker's Compensation	☐ Employer Wage Contribution
☐ Medicare	☐ Veteran's Benefits	☐ Sick Leave	☐ SSDI/Disability
☐ Indian Health (IHS)	☐ Vehicle Insurance	☐ Loss of Wages Insurance	☐ None

☐ Private Health Insurance ______________________________
Name of Insurance Company & Policy #

SECTION F Medical Information

List all medical/mental health or funeral home providers.

Medical Provider Name	Street Address, City, ST, Zip	Initial Treatment Date

SECTION G Employment Information

Physical injuries only.

Was the victim employed at the time the crime occurred? [ ] Yes [ ] No
Did the victim lose work as a result of the injuries sustained: [ ] Yes [ ] No
Length of actual work time lost as a result of injuries ________**Hours**
Name of Employer ______________________________
Address of Employer ______________________________
Street or PO Box *City* *ST* *Zip*

PLEASE FILL OUT THE OTHER SIDE OF THIS FORM
APPLICATION MUST BE COMPLETED IN FULL

CVC USE ONLY	CRIME VICTIM UNIT NUMBER ______	
Name of Victim ______	Social Security # ______	Date of Birth ______
Date of Crime ______	Date of Treatment ______	Crime ______

INFORMATION RELEASE

I authorize any hospital, clinic, doctor, insurance company, employer, person or agency to give needed information to the Montana Crime Victim Compensation Program from which I am seeking benefits for the above listed crime. I further authorize the Montana Department of Public Health and Human Services to release any information to this program pertaining to my Medicaid eligibility. I understand the information will be used to determine compensation benefits, and that only information needed to make a decision about compensation benefits will be requested by the Compensation Program. I understand that Montana and federal laws require the Compensation Program to keep any confidential information it receives confidential. I understand this information release is valid upon my signature, and that I can cancel this release by writing to the Compensation Program at any time, except if any information has already been received and used, it is not subject to cancellation. I understand a photocopy of this signed form is as valid as the original, and that my signature gives permission for the release of the information and all information specific to this permission form.

Your disclosure of this information is allowed under the Health Insurance Portability and Accounting Act (HIPAA). This disclosure is required by Montana law (See MCA §53-9-102). Under HIPAA, you may disclose health information without a HIPAA written authorization (See 45 CFR §164.508) if the disclosure is required by law (See 45 CFR §164.512). Also, since your disclosure is required by law, it is not subject to HIPAA's minimum necessary standard, 45 CFR §164.502(b)(2)(v).

REPAYMENT AND SUBROGATION AGREEMENT

I understand that Montana law requires me to contact and repay any benefits paid out by the Compensation Program if I receive payments from the offender, a civil lawsuit, an insurance program, or any other government or private agency after I receive payment from the Compensation Program. I also agree to notify the Compensation Program if I hire an attorney to represent me in any civil action related to this offense. I certify the information in this application is true and correct to the best of my knowledge. I understand that my signature says I agree to all statements specified in this agreement.

______ **Victim's Signature** (Parent must sign if victim is a minor) ______ **Relationship to Victim** ______ **Date**

<u>Victim must sign and date here before the claim will be considered for benefits.</u>

PLEASE COMPLETE THE FOLLOWING

SECTION H
Knowledge of Compensation Program

How did you learn of the Crime Victim Compensation Program?

Law Enforcement Doctor/Hospital Victim Witness Program Media
City/County Attorney Therapist/Counselor Victim Assistance Other: ______

SECTION I
Attorney Contact

Are you represented by a private attorney in a civil lawsuit regarding this crime? yes no

If yes, please complete the following:

______ Name of Attorney ______ Phone number

______ Street Address City ST Zip

SECTION J
Statistical Information

The information regarding race and handicap status is for statistical purpose only.

Please check the appropriate box indicating the race of the victim:

[ ] Caucasian [ ] Native American [ ] Alaskan Native [ ] African American
[ ] Hispanic [ ] Asian or Pacific Islander

Please check the appropriate box indicating any major disability the <u>victim</u> had <u>prior</u> to the date of this crime.

[ ] Hearing impairment [ ] Visual impairment [ ] Mobility impairment
[ ] Mental impairment [ ] Multiple disabilities [ ] Other ______

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HELENA MT 59620-9928
PO BOX 201410
CRIME VICTIM COMPENSATION PROGRAM

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