Victim Compensation Claim Form

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

~ EACH VICTIM MUST COMPLETE A SEPARATE CLAIM FORM~
Incomplete claim forms will be returned unprocessed

SECTION A Victim Information

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

Victim Name: _____
Last *First* *M.I.*

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

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

Home Phone: _____ **Work Phone:** _____

Email Address: _____

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 the relationship to the Primary Victim: _____

SECTION B Claimant Information

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: _____ **Email Address:** _____

SECTION C Type of Crime

Date of Crime _____
Date Reported to Law Enforcement _____
Date Crime Discovered by Parent or Guardian _____
Name of Law Enforcement Agency Reported to _____
Law Enforcement Case Number (if known)_____
Location of Crime _____
Name of Offender _____
Victim's Relationship to Offender _____
Has Prosecution Taken Place? [ ] Yes [ ] No
If Yes,
[ ] City [ ] District [ ] Justice [ ] Juvenile [ ] Federal
Court Case Number (if known): _____

Mark all that apply:

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

SECTION D Incident Summary

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

_____
_____

SECTION E Insurance Types

Collateral sources are primary payers and must be billed prior to CVC.

Please identify your current insurance providers. Check all that apply:

☐ 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 for crime related injuries.

Medical Facility Name	Mailing Address	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 physical injuries sustained: [ ] Yes [ ] No
Length of actual work time lost as a result of injuries: _____**Hours**
Name of Employer: _____
Mailing Address of Employer: _____
Street or PO Box *City* *ST* *Zip*

PLEASE FILL OUT THE OTHER SIDE OF THIS FORM

CVC USE ONLY **CLAIM 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**

Victims must sign and date above before the claim will be considered for benefits

PLEASE COMPLETE THE FOLLOWING

SECTION H
Knowledge of Compensation Program

How did you learn of the Crime Victim Compensation Program?

[ ] Law Enforcement [ ] Doctor/Hospital [ ] Media

[ ] City/County Attorney [ ] Therapist/Counselor [ ] Victim Assistance [ ] Other _____

[ ] Victim Advocacy Program Organization Name _____

Staff Member Name _____ Phone Number _____

Email Address _____

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 _____ Business Name _____ 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 [ ] Other

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

[ ] Hearing impairment [ ] Visual impairment [ ] Mobility impairment

[ ] Mental impairment [ ] Multiple disabilities [ ] Other _____

----------F O L D----------

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

POSTAGE WILL BE PAID BY ADDRESSEE

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 29 HELENA MT

CONFIDENTIAL

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NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES