Victim Compensation Claim Form

Crime Victims 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 except F, and 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 claimant 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
☐ Private Health Insurance ☐ Vehicle Insurance ☐ Loss of Wages Insurance ☐ None
☐ Indian Health (IHS) ☐ Other: _____

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.

_____ _____ _____

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

Claimant must sign and date here 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 [ ] 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 **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

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

POSTAGE WILL BE PAID BY ADDRESSEE

CONFIDENTIAL

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES