



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 ~

<p>SECTION A Victim Information</p> <p><i>Please Print</i></p> <p>NOTE: Secondary victims must complete all Sections except F, and G.</p>	<p>Victim Name <u>Johnson Jackson J.</u> <small>Last First M.I.</small></p> <p>Check appropriate box: [] Primary Victim <input checked="" type="checkbox"/> Secondary Victim [] Deceased Victim</p> <p>Mailing Address <u>PO Box 123 Malta MT 59730</u> <small>Street or PO Box City ST Zip</small></p> <p>Date of Birth: <u>A / 5 / 17</u> Sex: [] Female <input checked="" type="checkbox"/> Male Social Security # <u>501-73-0000</u></p> <p>Home Phone: <u>N/A</u> Work Phone: <u>N/A</u></p> <p>Benefits Requested: [] Medical <input checked="" type="checkbox"/> Mental Health [] Wage Loss [] Death Benefits</p> <p>If this application is for a Secondary Victim please indicate the name of the Primary Victim and your relationship to the Primary Victim: <u>Jane Johnson</u></p>																				
<p>SECTION B Claimant Information</p> <p>Complete if victim is a minor, deceased, or mentally impaired</p>	<p>Check appropriate box: Victim is: <input checked="" type="checkbox"/> A Minor [] Deceased [] Mentally Impaired</p> <p>Claimant Name: <u>Jane Johnson</u> Relationship to Victim: <u>Mother</u></p> <p>Mailing Address: <u>PO Box 123 Malta MT 59730</u> <small>Street or PO Box City ST Zip</small></p> <p>Date of Birth: <u>7 / 1 / 69</u> Sex: <input checked="" type="checkbox"/> Female [] Male</p> <p>Social Security # <u>500-00-0000</u> Home Phone <u>406-700-0000</u></p> <p>Work Phone <u>406-711-1111</u></p>																				
<p>SECTION C Type of Crime</p> <p>* In child sexual abuse cases, indicate the date claimant was made aware of the crime.</p>	<p>Date of Crime <u>7-10-2024</u></p> <p>Date Reported to Law Enforcement <u>7-10-2024</u></p> <p>*Date Crime Discovered by Parent or Guardian _____</p> <p>Law Enforcement Agency Reported to <u>Malta PD</u></p> <p>Law Enforcement Case Number <u>24-12345</u></p> <p>Location of Crime <u>45 Loop St. Malta, MT 59730</u></p> <p>Name of Offender <u>Joe Johnson</u></p> <p>Victim's Relationship to Offender <u>Son</u></p> <p>Has Prosecution Taken Place? [] Yes [] No</p> <p>If Yes, What Court? _____</p> <p>Mark all that apply:</p> <table border="0"> <tr> <td><input type="checkbox"/> Assault</td> <td><input type="checkbox"/> Child Physical Abuse</td> </tr> <tr> <td><input type="checkbox"/> Homicide</td> <td><input type="checkbox"/> Child Sexual Abuse</td> </tr> <tr> <td><input type="checkbox"/> Stalking</td> <td><input type="checkbox"/> Adult Sexual Assault</td> </tr> <tr> <td><input checked="" type="checkbox"/> Domestic Violence</td> <td><input type="checkbox"/> Human Trafficking</td> </tr> <tr> <td><input type="checkbox"/> DUI</td> <td><input type="checkbox"/> Teen Dating Violence</td> </tr> <tr> <td><input type="checkbox"/> Arson</td> <td><input type="checkbox"/> Terrorism/Mass Violence</td> </tr> <tr> <td><input type="checkbox"/> Robbery</td> <td><input type="checkbox"/> Other (identify) _____</td> </tr> <tr> <td><input type="checkbox"/> Hate Crime</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Elder Abuse</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Child Pornography</td> <td></td> </tr> </table>	<input type="checkbox"/> Assault	<input type="checkbox"/> Child Physical Abuse	<input type="checkbox"/> Homicide	<input type="checkbox"/> Child Sexual Abuse	<input type="checkbox"/> Stalking	<input type="checkbox"/> Adult Sexual Assault	<input checked="" type="checkbox"/> Domestic Violence	<input type="checkbox"/> Human Trafficking	<input type="checkbox"/> DUI	<input type="checkbox"/> Teen Dating Violence	<input type="checkbox"/> Arson	<input type="checkbox"/> Terrorism/Mass Violence	<input type="checkbox"/> Robbery	<input type="checkbox"/> Other (identify) _____	<input type="checkbox"/> Hate Crime		<input type="checkbox"/> Elder Abuse		<input type="checkbox"/> Child Pornography	
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<p>SECTION D Additional Information</p>	<p>Please summarize the incident to the best of your memory (you may use additional paper if necessary): <u>My son witnessed his father physically assaulting me.</u></p>																				
<p>SECTION E Additional Information</p> <p>Collateral sources are primary payers and must be billed prior to CVC. THIS SECTION MUST BE COMPLETED</p>	<p>Please check all of the appropriate box(es) for the sources that may help pay the expenses related to this crime:</p> <table border="0"> <tr> <td><input type="checkbox"/> Medicaid</td> <td><input type="checkbox"/> Social Security</td> <td><input type="checkbox"/> Worker's Compensation</td> <td><input type="checkbox"/> Employer Wage Contribution</td> </tr> <tr> <td><input type="checkbox"/> Medicare</td> <td><input type="checkbox"/> Veteran's Benefits</td> <td><input type="checkbox"/> Sick Leave</td> <td><input type="checkbox"/> SSDI/Disability</td> </tr> <tr> <td><input checked="" type="checkbox"/> Private Health Insurance</td> <td><input type="checkbox"/> Vehicle Insurance</td> <td><input type="checkbox"/> Loss of Wages Insurance</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Indian Health (IHS)</td> <td><input type="checkbox"/> Other: _____</td> <td></td> <td></td> </tr> </table> <p><u>Blue Cross Blue Shield of Montana</u></p>	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Social Security	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Employer Wage Contribution	<input type="checkbox"/> Medicare	<input type="checkbox"/> Veteran's Benefits	<input type="checkbox"/> Sick Leave	<input type="checkbox"/> SSDI/Disability	<input checked="" type="checkbox"/> Private Health Insurance	<input type="checkbox"/> Vehicle Insurance	<input type="checkbox"/> Loss of Wages Insurance	<input type="checkbox"/> None	<input type="checkbox"/> Indian Health (IHS)	<input type="checkbox"/> Other: _____						
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<p>SECTION F Medical Information</p> <p>List all medical/mental health or funeral home providers.</p>	<table border="1"> <thead> <tr> <th>Medical Provider Name</th> <th>Street Address, City, ST, Zip</th> <th>Initial Treatment Date</th> </tr> </thead> <tbody> <tr> <td><u>Yellowstone Counseling</u></td> <td><u>PO Box 700 Malta, MT 59730</u></td> <td><u>8-22-2024</u></td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Medical Provider Name	Street Address, City, ST, Zip	Initial Treatment Date	<u>Yellowstone Counseling</u>	<u>PO Box 700 Malta, MT 59730</u>	<u>8-22-2024</u>														
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<p>SECTION G Employment Information</p> <p>Physical injuries only.</p>	<p>Was the victim employed at the time the crime occurred? [] Yes [] No</p> <p>Did the victim lose work as a result of the injuries sustained: [] Yes [] No</p> <p>Length of actual work time lost as a result of injuries _____ Hours</p> <p>Name of Employer _____</p> <p>Address of Employer _____ <small>Street or PO Box City ST Zip</small></p>																				

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.

<u>James M. Johnson</u>	<u>Mother</u>	<u>10-1-2024</u>
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? <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Doctor/Hospital <input checked="" type="checkbox"/> Victim Witness Program <input type="checkbox"/> Media <input type="checkbox"/> City/County Attorney <input type="checkbox"/> Therapist/Counselor <input type="checkbox"/> Victim Assistance <input type="checkbox"/> Other _____
SECTION I Attorney Contact	Are you represented by a private attorney in a civil lawsuit regarding this crime? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no If yes, please complete the following: Name of Attorney _____ Phone number _____ Street Address _____ City _____ ST _____ Zip _____
SECTION J Statistical Information <i>The information regarding race and handicap status is for statistical purpose only.</i>	Please check the appropriate box indicating the race of the victim: <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> African American <input checked="" type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander Please check the appropriate box indicating any major disability the victim had prior to the date of this crime. <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Visual impairment <input type="checkbox"/> Mobility impairment <input type="checkbox"/> Mental impairment <input type="checkbox"/> Multiple disabilities <input type="checkbox"/> Other <u>N/A</u>

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

POSTAGE WILL BE PAID BY ADDRESSEE

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

CONFIDENTIAL



NO POSTAGE
 NECESSARY
 IF MAILED
 IN THE
 UNITED STATES


