Victim Compensation Claim Form

Instructions

A Victim Information

- Enter the Victims Last Name, First Name, and Middle Name or Initial
- Check whether they are a Primary, Secondary or Deceased Victim (see below)

Primary Victim: An individual physically or sexually assaulted or a homicide victim.

Secondary Victim: Immediate family members of a child of sexual abuse or,
Immediate family members of a homicide victim or,
Minor children of a domestic abuse victim who witness the crime at home.

Deceased Victim: Refers to the victim of a homicide.

- Benefits Requested

There are (4) categories of benefits, Select all that apply

Medical Benefits include (but not limited to):

- Hospital services
- Physician expenses
- Prescription drugs
- Ambulance charges
- Dental treatment
- Physical therapy
- Chiropractic service
- Prosthetic Devices
- Funeral/death benefits (Max $3500)
- Other approved costs

Mental Health Benefits include (but not limited to):

- Mental health treatment
- Mental health counseling
- Mental health therapist
- A mental health therapist can be a medical doctor (a psychiatrist), clinical psychologist, licensed social worker, or a licensed professional counselor.
- It is a good idea to check if your counselor is licensed by the State of Montana or the state you reside in.

Wage Loss Benefits:

- Wage loss benefit applies to those victims who are physically unable to work due to their crime related injuries.
- Crime Victim Compensation is unable to pay wage benefits related to mental impairment suffered as a result of the crime.
- Payments are made for lost wages if the victim was employed at the time the crime occurred and loses one week or more of work, then Wage loss is paid from the date the loss began.
- Wage loss benefits continue until the victim returns to work or is released by a physician.
- Amounts paid for wage loss are made bi-weekly.
- If approved for the wage loss benefit, the amount paid is 66.66% or up to the state maximum amount whichever is lesser of the two amounts.

Death Benefits:

- The surviving immediate family member may apply for the deceased victim's death benefits, medical costs and funeral expenses.
- Reasonable burial expenses, including a marker for the grave, are allowed up to $3,500.

Victim Compensation Claim Form

Instructions Continued

B	- Claimant Information • Claimant is the immediate family member completing the application if the victim is a minor, deceased, or mentally impaired.
C	- Type of Crime • Enter all known crime information. • Date crime occurred. * (in cases of child sexual abuse, indicate the date the claimant was made aware). • Enter name of Law enforcement agency that crime was reported to. • Enter Law enforcement case number if known. • Enter Where crime occurred; be as specific as possible. (street address, city, school, home, work) • Enter Name of Offender, if known. • Enter the relationship between victim and offender. • Check whether prosecution has taken place (Case has been adjudicated, A judgement has been issued). • If Prosecution has taken place Enter Court, if known. (Name of court, City, State)
D	- Write a short summary of the incident, attach additional sheets if necessary.
E	- Mark all boxes for sources that may help pay the expenses related to this crime.
F	- List all medical, mental health, or funeral providers.
G	- Complete this section if you are applying for wage loss benefits.
H	- Read and sign. - **If this section is not completed the application cannot be processed and may delay the process.**
I	- How did you hear of our program? Check the appropriate box or write in Other.
J	- If you are represented by a private attorney – complete this section.
K	- This section is optional and used for statistical purposes only. - Please select all races that apply - Please select only one from ethnicity

For assistance please contact us at: (406) 444-3653 or Toll-Free: 1-800-498-6455
E-mail: dojovs@mt.gov

MAIL this application and any additional sheets you may have needed to:

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

Victim Compensation Claim Form

A

Victim Name: _____ (Last Name) _____ (First Name) _____ (Middle)

☐ Primary Victim ☐ Secondary Victim ☐ Deceased Victim

If Secondary Victim indicate name of Primary Victim and relation to Primary Victim

_____ (Primary Victim: Last Name, First Name, Middle) _____ (Relation to Primary Victim)

Email: _____

Mailing Address: _____ (Street or PO Box) _____ (City) _____ (State) _____ (Zipcode)

Physical Address: _____ _____ _____ _____

Date of Birth: _____ (MM/DD/YYYY) Gender: _____ SSN: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Benefits Requested: ☐ Medical ☐ Mental Health ☐ Wage Loss ☐ Death Benefits

B

Complete this section if victim is a minor, deceased, or mentally impaired.

Victim is: ☐ A Minor ☐ Deceased ☐ Mentally Impaired

Claimant Name: _____ (Last Name) _____ (First Name) _____ (Middle) _____ (Relation to Primary Victim)

Mailing Address: _____ (Street or PO Box) _____ (City) _____ (State) _____ (Zipcode)

Physical Address: _____ _____ _____ _____

Date of Birth: _____ Gender: _____ SSN: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

C

Date of Crime: _____ Date Reported to Law Enforcement: _____

In child sexual abuse cases the date parent or guardian was made aware of crime: _____

Law Enforcement Agency Reported to: _____ Case # _____

Location of Crime: _____

Name of Offender: _____ Victims relation to Offender: _____

Has Prosecution taken place: ☐ Yes ☐ No If, Yes What Court: _____

Mark all that apply

☐ Assault	☐ Homicide	☐ Elder Abuse	☐ Adult Sexual Assault	☐ Domestic violence
☐ DUI	☐ Robbery	☐ Hate Crime	☐ Teen Dating Violence	☐ Human Trafficking
☐ Arson	☐ Stalking	☐ Child Pornography	☐ Child Physical Abuse	☐ Child Sexual Abuse
☐ Other				☐ Terrorism/Mass violence

D

Please summarize the incident to the best of your memory (Attach additional sheets if needed)

E

☐ None	☐ Indian Health (IHS)	☐ Sick Leave	☐ Loss of Wages insurance
☐ Medicaid	☐ Veteran's Benefits	☐ Vehicle Insurance	☐ Workers Compensation
☐ Medicare	☐ Social Security	☐ SSDI/Disability	☐ Employer wage Contribution
☐ Private Insurance	(Name of Private Insurance)		(Policy Number)

F

Medical Information

Provider	Street or PO Box City State Zipcode	Initial Treatment Date

Attach additional sheets if necessary

G

Was victim employed at the time the crime occurred: ☐ Yes ☐ No
Did the victim lose work as a result of physical injuries sustained: ☐ Yes ☐ No
Length of actual work time lost as a result of physical injuries: _____ Hours
Name of Employer: _____
Address of Employer: _____ _____ _____ _____
Street or PO Box *City* *State* *Zipcode*

CVC OFFICE USE ONLY CRIME VICTIM NUMBER _____
Name of Victim: _____ SSN: _____ DOB: _____
Date of Crime: _____ Date of Treatment: _____ Crime: _____

H

Victim must sign and date below before the claim will be considered for benefits

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.

I agree to the below stated INFORMATION RELEASE and REPAYMENT AND SUBROGATION AGREEMENT

Victim Signature:_____

Relation to Victim: _____ **Date:** _____

I

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 _____

J

Are you represented by a private attorney in a civil lawsuit regarding this crime: ☐ Yes ☐ No
Name of Attorney: _____ Phone: _____
Address: _____
City: _____ State: _____ Zipcode: _____

K

Statistical Information: **This section is Optional**

Race (Select All That Apply)			Ethnicity
☐ American Indian or Alaska Native	☐ Native Hawaiian or Other Pacific Islander		☐ Hispanic or Latino
☐ Asian	☐ White		☐ Not Hispanic or Latino
☐ Black or African American			