MISSOURI DEPARTMENT OF PUBLIC SAFETY

APPLICATION FOR CRIME VICTIMS' COMPENSATION

FOR OFFICE USE ONLY
Claim No.

INSTRUCTIONS:
1. Type or Print clearly in ink.
2. Last page of this form must be signed by claimant and notarized.
3. If victim is a minor or an incompetent person, application MUST be made by a parent or guardian.
4. If a question is NOT APPLICABLE, answer with N/A.

MAILING ADDRESS	TELEPHONE NUMBER	RELAY MISSOURI
CRIME VICTIMS' COMPENSATION PROGRAM	573-526-6006	1-800-735-2966 (TDD)
P.O. BOX 3001, JEFFERSON CITY, MISSOURI 65102-3001	1-800-347-6881	1-800-735-2466 (VOICE)

How did you find out about the Crime Victims' Compensation Program?
☐ Police ☐ Victim Assistance Program ☐ Prosecutor ☐ Funeral Home ☐ Friend/Family
☐ Hospital ☐ Public Service Announcement ☐ Poster/Brochure ☐ Collection Agency

SECTION I PRIMARY VICTIM INFORMATION

Name of Victim *(Last, First and Middle)* | Social Security Number

Current Street Address | City | State | Zip Code

Home Telephone Number | Work Telephone Number | Country of Birth - National Origin* | Is Victim Deceased? ☐ Yes ☐ No

Birthdate | Age | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race Ethnic *(Check One)** ☐ 1. White ☐ 2. African American ☐ 7. Other: _____ ☐ 3. Hispanic ☐ 4. American Indian/Alaskan Native ☐ 5. Asian Pacific Islander ☐ 6. Race Ethnic (optional)

Handicapped Prior to Crime* ☐ Yes ☐ No *(Explain)*

Date Crime Occurred

Has the victim been convicted of two felonies within the past ten (10) years? ☐ Yes ☐ No Explain : _____

SECTION II CLAIMANT INFORMATION Complete this section if someone other than the victim is filing claim (i.e. parent/legal guardian).

Name of Claimant *(Last, First and Middle)* | Social Security Number

Street Address | City | State | Zip Code

Relationship to Victim | Was victim living with you at the time of the crime? ☐ Yes ☐ No | Home Telephone Number | Work Telephone Number

Birthdate | Age | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

SECTION III OTHER COMPENSABLE VICTIM *CHAPTER 595 (If more than one, use additional sheet.)

Name of other compensable victim *(Last, First and Middle)* | Social Security Number

Current Street Address | City | State | Zip Code

Home/Work Telephone Number | Relationship to Primary Victim | Country of Birth - National Origin* | Handicapped Prior to Crime* ☐ Yes ☐ No

Birthdate | Age | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race Ethnic *(Check One)** ☐ 1. White ☐ 2. African American ☐ 3. Hispanic ☐ 4. American Indian/Alaskan Native ☐ 5. Asian Pacific Islander ☐ 6. Race Ethnic (optional) ☐ 7. Other: _____

Was the other compensable victim living with the primary victim at the time of the crime? (Chapter 595) ☐ Yes ☐ No If yes, explain: _____

Has the other compensable victim been convicted of two felonies within the past ten (10) years? ☐ Yes ☐ No If yes, explain: _____

* This information is requested solely for compliance with Federal Civil Rights under Section 1407(c) of the Victims of Crimes Act of 1984. It will be used only for statistical purposes.

NOTE ▸ APPLICATION MUST BE SIGNED AND NOTARIZED ON BACK PAGE. PHOTOCOPIES ARE NOT ACCEPTABLE.

SECTION IV CRIME INFORMATION

Was a Police Report Filed? ☐ Yes ☐ No

Type of Crime: ☐ Child Abuse ☐ Domestic Violence ☐ Assault ☐ Sexual Assault ☐ Homicide ☐ DWI* ☐ Involuntary Manslaughter* ☐ Robbery With Injury ☐ Hit & Run* ☐ Other (Explain:)_____

(*Be Sure To Complete Insurance Under Section VII)

Brief Description of Crime:

_____

_____

_____

Date Crime Occurred	Date Crime Was Reported	Has Arrest Been Made? ☐ Yes ☐ No	Have Charges Been Filed? ☐ Yes ☐ No ☐ Unknown

Place of Crime: Street Address	City/State	County

Name and Address of Police Department	Name of Investigating Officer(s)

Who Committed the Crime? (If Known)	Police Report Number	Docket Number

Did victim know the person who committed the crime? ☐ Yes ☐ No If, Yes, in what way? _____

Was victim related to the person who committed the crime? ☐ Yes ☐ No If Yes, in what way? _____

Was victim living in the same household as the offender at the time of the crime? ☐ Yes ☐ No

If Yes, is victim still living in same house as offender? _____

SECTION V MEDICAL (INCLUDING PSYCHOLOGICAL) EXPENSES

Enter below all expenses for service rendered as a result of this crime.
(Attach all bills available)

Will there be more bills? ☐ Yes ☐ No

Name of Doctor, Hospital or Other Provider of Service	Account Number	Street Address	City	State	Zip Code

SECTION VI FUNERAL EXPENSES (Attach Copy of Death Certificate and Funeral Bill)

Will dependent(s) receive funeral benefits from the following?

Social Security $	Workers' Compensation $	Life Insurance $	Other (Specify) $

Name of Funeral Home	Street Address		
City	**State**	**Zip Code**	**Amount of Funeral and Burial Expenses $**

Have Burial Expenses Been Paid? ☐ Yes ☐ No	If Yes, by whom?	Relationship to Victim

City	State	Zip Code

Will dependent(s) receive any accident or life insurance? ☐ Yes ☐ No If yes, complete the following:

Name of Beneficiary	Street Address		
City	**State**	**Zip Code**	**Phone (If Known)**

SECTION VII INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION

Indicate below if any sources are paying or will pay any of above expenses.

Source Type: ☐ **Health Insurance/HMO/PPO** ☐ **Veterans Administration** ☐ **Armed Services (CHAMPUS)**
☐ **Life Insurance** ☐ **Auto Insurance** ☐ **Medicare**
☐ **Medicaid No.**_____ ☐ **Workers' Compensation No.**_____

Provide the following information for each source. (If more than one source is paying, provide additional information on separate sheet)

Insurance Name			Policy Number
Street Address	City	State	Zip Code
Name of Policy Holder	Social Security Number of Policy Holder		Effective Date of Policy/Coverage

AUTO INSURANCE INFORMATION - COMPLETE THIS SECTION ONLY FOR MOTOR VEHICLE CLAIM

Does convicted operator have liability insurance coverage on auto? ☐ Yes ☐ No	If Yes, enter name of carrier and policy limits.			
Street Address	City	State	Zip Code	Policy Number
Does the victim have uninsured motorist coverage on auto? ☐ Yes ☐ No	If Yes, enter name of carrier and policy limits.			
Street Address	City	State	Zip Code	Policy Number
Has settlement been made with carrier? ☐ Yes ☐ No	If Yes, which one? (Attach copy of settlement)			

SECTION VIII WAGE LOSS/LOSS OF SUPPORT

(Fill out only if victim was employed at the time of the crime and a loss is being claimed)

Was victim employed at time of crime? ☐ **Yes** ☐ **No**	**Is victim applying for lost wages?** ☐ **Yes** ☐ **No**	**Is a dependent applying for loss of support?** ☐ **Yes** ☐ **No**

Victim's Employer (at time of crime)		Telephone Number
Victim's Employer Address	City	State / Zip Code

If victim was self-employed, submit copies of signed Federal Income Tax returns from the year of the crime and the year preceding the crime.

Victim's net (take home) earnings or income at time of crime (including tips and bonuses) if time loss or loss of support benefits are claimed:
$ _____ per week.

Date left work due to crime: (Month, Day, Year) _____

Date returned to work: (Month, Day, Year) _____

Days off for which victim received compensation in the form of accrued sick/vacation leave ▶

Was the crime work-related? ☐ Yes ☐ No
If Yes, has the victim applied for Workers' Compensation or other employment benefits? ☐ Yes ☐ No
If Yes, please describe. _____

Are you receiving or have you received accident or disability benefits from your employer as a result of this injury? ☐ Yes ☐ No
If Yes, please describe. _____

SECTION IX OTHER INFORMATION

Is the victim or claimant considering a civil action against the offender or some other third party for damages claimed herein? ☐ Yes ☐ No
If Yes, please provide the name and mailing address of attorney who will handle the civil action: _____

RESTITUTION

If the court has ordered the offender to make restitution to you (pay you back), complete the following:
Restitution Order Date _____ Court _____ Amount $ _____
Judge_____ How Is It To Be Paid? _____

ATTORNEY INFORMATION

It is not necessary to retain an attorney; however, if claimant wishes to be represented by an attorney in applying for benefits under Crime Victims' Compensation, please complete the following. Attorneys are entitled to up to 15% of any award issued. The attorney will need to file an entry of appearance.

Attorney's Name *(Last, First, MI)*		Telephone Number	
Address	City	State	Zip Code
Signature of Attorney (if representing claimant in Crime Victims' claim)		Date	

AUTHORIZATION FOR RELEASE OF INFORMATION TO CONDUCT AN INVESTIGATION, TO MAKE PAYMENTS DIRECTLY TO SUPPLIERS AND ASSIGNMENT OF SUBROGATION RIGHTS

I give permission to any attorney, hospital, funeral home, doctor, law enforcement agency, insurance company, employer, welfare or social agency, or any federal, state or local government agency to release all records and information that will help the Missouri Crime Victims' Compensation Program to process my claim for compensation, to allow copies of such records to be made and to answer any questions made by or on behalf of the Missouri Crime Victims' Compensation Program.

I understand that after receiving this form, the Missouri Crime Victims' Compensation Program will investigate the truth of the information provided as well as other matters regarding this claim; and I consent to such investigation. This authorization is valid for three years from the date given below.

I acknowledge and agree that all or any part of any compensation awarded may be paid directly to any supplier of goods or services on my behalf.

I further acknowledge and agree that the State of Missouri is subrogated, to the extent of any compensation awarded to me, to all the claimant's rights to recover benefits or advantages for economic loss from a source which is, or if readily available to the victim or claimant would be, a collateral source, and I hereby assign such rights to the State of Missouri so that it may protect its subrogation rights, and agree to assist the state in pursuing its subrogation rights.

I agree to notify the Department if I retain an attorney to represent me in a lawsuit related to this crime. I also agree to notify the Department: 1) in the event I receive restitution payments from the offender, or 2) in the event I initiate any legal proceeding or negotiations to recover damages related to the crime upon which this claim is based.

I certify that I have read and understand the statements above; and that the information I have given is true and correct to the best of my knowledge and belief and that these benefits will be denied if any such statements are not true.

Signature of Claimant	Date

(If the victim is under 18 years of age, this application must be signed by the parent or legal guardian whose name appears in "Section II Claimant Information").

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this _____ day of _____ 20 ____ , before me personally appeared _____ ,
(Name of Claimant)

to me known to be the person described in and who executed the foregoing Crime Victims' Compensation Application and acknowledged that _____ executed the same as _____ free act and deed. And said claimant declares that the information
(S/He) *(His/Her)*

provided is true and correct to the best of _____ knowledge.
(His/Her)

Subscribed and sworn to before me at my office in _____ the day and year first above written.
(Notary's Office Location)

(Notary Seal)

_____
Notary Signature

My commission expires: _____