

MINNESOTA CRIME VICTIMS REPARATIONS CLAIM FORM

Date Received: (Office Use Only)	Complete and submit to: Minnesota Crime Victims Reparations Board 445 Minnesota Street, Suite 2300 St. Paul MN 55101-1515 651.201.7300 or 1.888.622.8799 (Toll-Free) 651.296.5787 (Fax) 651.205.4827 (TDD)	Claim Number: Claims Specialist: (Office Use Only)
Please contact the Board if you need assistance completing this form		

SECTION 1. VICTIM INFORMATION		Name of person injured or killed as the result of the violent crime. If there was more than one victim, complete a separate claim form for each victim.	
Victim's Name (last, first, m.i.)		Date of Birth (MM/DD/YY) / /	Social Security Number (required)
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Other _____		Is Victim Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes
Street Address (including apartment #)		City	State
Home Phone () ()	Work Phone () ()	Cell Phone () ()	E-Mail Address

SECTION 2. CLAIMANT INFORMATION		Name of person filing on behalf of a deceased victim, minor victim, or an incapacitated adult victim.	
Claimant's Name (last, first, m.i.)		Date of Birth (MM/DD/YY) / /	Social Security Number (required)
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Victim <input type="checkbox"/> Parent <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Former Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____		
Street Address (including apartment #)		City	State
Home Phone () ()	Work Phone () ()	Cell Phone () ()	E-Mail Address

SECTION 3. CRIME INFORMATION		Date of Crime / /	Date Reported to Police / /	County Where Crime Occurred
Name of Police Department Investigating Crime		Police Case Number		Investigating Officer's Name
Was the offender the victim's spouse/partner, former spouse/partner, relative, family member or resident of the same household? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Type of Crime: (please check one)				
<input type="checkbox"/> Assault 5 th Degree	<input type="checkbox"/> Criminal Vehicular Operation	<input type="checkbox"/> Kidnapping	<input type="checkbox"/> Sexual Assault Adult	
<input type="checkbox"/> Assault Felony	<input type="checkbox"/> Driving Under the Influence	<input type="checkbox"/> Murder	<input type="checkbox"/> Stalking	
<input type="checkbox"/> Child Sexual Abuse	<input type="checkbox"/> Harassment	<input type="checkbox"/> Property Crime	<input type="checkbox"/> Terrorism	
<input type="checkbox"/> Child Physical Abuse	<input type="checkbox"/> Hit and Run	<input type="checkbox"/> Robbery	<input type="checkbox"/> Other _____	
Briefly describe crime and injuries. Attach additional pages if necessary.				
_____ _____ _____ _____				

SECTION 4. OFFENDER AND RESTITUTION INFORMATION		Provide information regarding the offender of the crime, criminal charges, and restitution ordered by the court.		
Name of Offender (last, first, m.i.)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YY) / /	
Has the offender been charged? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, what are the charges?		Name of agency prosecuting the case	
Was the offender ordered to pay restitution? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, what amount?	Have you received any payments? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how much?	

SECTION 5. REFERRAL SOURCE		How did you learn of the reparations program?	
<input type="checkbox"/> County Attorney/Prosecutor	<input type="checkbox"/> Hospital	<input type="checkbox"/> Poster/Brochure/Media	<input type="checkbox"/> Victim/Witness Assistance Program
<input type="checkbox"/> Crime Victims Reparations Board	<input type="checkbox"/> Other (Friend or Relative)	<input type="checkbox"/> Sexual Assault Program	<input type="checkbox"/> Website
<input type="checkbox"/> Domestic Abuse Program/Shelter	<input type="checkbox"/> Police	<input type="checkbox"/> Social Services, Cleric or School	
<input type="checkbox"/> Funeral Home	<input type="checkbox"/> Probation Agent	<input type="checkbox"/> Other State Agency	

SECTION 6. CONTACT INFORMATION			The Minnesota Crime Victims Reparations Board is authorized to release private and confidential data about this claim to the persons listed below (parent, spouse, child, etc).		
Name		Relationship to you		Phone Number	
Name		Relationship to you		Phone Number	

SECTION 7. REPRESENTATION BY OTHERS						The Minnesota Crime Victims Reparations Board is authorized to release private and confidential data about this claim to the attorney and/or advocate listed below.					
ATTORNEY INFORMATION						VICTIM SERVICE PROGRAM INFORMATION					
Are you represented in this matter by an attorney <input type="checkbox"/> No <input type="checkbox"/> Yes						Did a victim advocate assist you in completing this form? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Name of Attorney						Name of Advocate					
Law Firm						Victim Service Program					
Street Address						Street Address					
City			State	Zip Code		City			State	Zip Code	
Telephone #		Fax #		Telephone #		Fax #		Telephone #		Fax #	
()		()		()		()		()		()	

SECTION 8. OTHER SOURCES OF PAYMENT				All bills must first be submitted to your insurance company for payment. The Board will not pay if you fail to use other sources available to you.								
Was there insurance or another source of payment to cover expenses related to the crime? <input type="checkbox"/> No <input type="checkbox"/> Yes												
Check all that apply:												
<input type="checkbox"/> Automobile Insurance			<input type="checkbox"/> Health Insurance			<input type="checkbox"/> Medicare			<input type="checkbox"/> Veteran's Benefits			
<input type="checkbox"/> Charitable Donations			<input type="checkbox"/> Homeowner's Insurance			<input type="checkbox"/> MN Care			<input type="checkbox"/> Worker's Compensation			
<input type="checkbox"/> Dental Insurance			<input type="checkbox"/> Medical Assistance/GAMC			<input type="checkbox"/> Social Security Disability			<input type="checkbox"/> Other _____			
Complete for all collateral sources available to pay for crime related expenses												
Name of insurance company		Street Address			City		State	Zip Code		Policy #		Group #
Name of insurance company		Street Address			City		State	Zip Code		Policy #		Group #
Name of insurance company		Street Address			City		State	Zip Code		Policy #		Group #
ATTACH INSURANCE EXPLANATION OF BENEFITS FOR ALL PAYMENTS AND/OR REJECTIONS												

SECTION 9. LOSS OF EARNINGS				Complete if the victim/claimant lost income due to the physical or emotional injury from the crime. All leave time (vacation, sick) must be used first.							
Was the victim/claimant employed at the time of the crime? <input type="checkbox"/> No <input type="checkbox"/> Yes				Is the victim/claimant self employed? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, submit copy of most recent federal tax return							
Name of Employee		Job Title		Supervisor Name and Phone			Net Hourly Wage		Hours worked per week		
Name of Employer				Street Address			City		State	Zip Code	
Dates absent from work due to crime related injury				Was vacation or sick leave available?				Do you have short or long term disability?			
From:		To:		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes			
Name of doctor/counselor who can verify disability				Street Address			City		State	Zip	

SECTION 10. MEDICAL AND DENTAL EXPENSES		List the names and addresses of all medical and dental providers who treated the victim and/or claimant. Providers must also be listed on the release form on page 4.			
Name of Provider	Street Address	City	State	Zip Code	
Name of Provider	Street Address	City	State	Zip Code	
Name of Provider	Street Address	City	State	Zip Code	
Name of Provider	Street Address	City	State	Zip Code	

SECTION 11. MENTAL HEALTH COUNSELING EXPENSES		List the names and addresses of all mental health providers who treated the victim and/or claimant. Providers must also be listed on the release form on page 4.			
Patient Name	Counselor/Clinic Name	Street Address	City	State	Zip Code
Patient Name	Counselor/Clinic Name	Street Address	City	State	Zip Code

SECTION 12. REPLACEMENT CHILD CARE AND HOUSEHOLD SERVICES		Complete if the victim paid someone else to provide childcare or to perform household services due to the victim's disability resulting from the crime.					
Replacement Child Care				Replacement Professional Household Services			
Name of Provider		Licensed Provider <input type="checkbox"/> No <input type="checkbox"/> Yes		Name of Provider		Licensed Provider <input type="checkbox"/> No <input type="checkbox"/> Yes	
Street Address	City	State	Zip Code	Street Address	City	State	Zip Code
Is the provider a family or household member? <input type="checkbox"/> No <input type="checkbox"/> Yes	Dates care was provided From: To:		Hourly Rate Paid	Is the provider a family or household member? <input type="checkbox"/> No <input type="checkbox"/> Yes	Dates care was provided From: To:		Hourly Rate Paid
Doctor who can verify victim's disability		Street Address		City	State	Zip Code	

SECTION 13. FUNERAL EXPENSES		Complete if the victim died as a result of the crime.			
Name of Funeral Home/Cemetery	Street Address	City	State	Zip Code	
Name of Funeral Home/Cemetery	Street Address	City	State	Zip Code	

SECTION 14. LOSS OF SUPPORT FOR DEPENDENTS OF DECEASED VICTIMS		Loss of support benefits are paid to dependents (spouse/partner, minor children) of the deceased victim. The legal guardian must file on the minor child's behalf.				
Was the victim providing support to a spouse/partner at the time of his/her death? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Spouse/Partner Name		Street Address		City	State	Zip Code
Does the victim have dependent children under the age of 18? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Dependent's Name	Name of Guardian	Street Address	City	State	Zip Code	
Dependent's Name	Name of Guardian	Street Address	City	State	Zip Code	
Dependent's Name	Name of Guardian	Street Address	City	State	Zip Code	

SECTION 16 AND SECTION 19 MUST BE COMPLETED IN FULL

SECTION 15. ASSIGNMENT OF SUBROGATION RIGHTS

I agree that the Board is subrogated to the extent of reparations awarded, and to all my rights to recover benefits for economic loss from another source. I assign such rights to the Board so that they may protect their subrogation interest. I agree to inform the Board in writing if I pursue a civil suit or receive any restitution moneys related to the crime.

SECTION 16. INFORMED CONSENT TO RELEASE PATIENT INFORMATION

I consent to the release of all patient health care records for _____, Date of Birth ____/____/____, including reports of alcohol or drug abuse and psychiatric treatment, to the Minnesota Crime Victims Reparations Board from all providers of medical and mental health treatment services, including but not limited to the providers listed below. I authorize CVRB staff to complete this section on my behalf, if necessary.

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

The consent to release patient information covers the time period of: / / to: / /

SECTION 17. AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I authorize any law enforcement agency, employer, insurance company, social service agency, victim advocacy program, county, state or federal prosecutor's office, or any other federal, state or local government agency to release all records and information that the Board determines will help in deciding my eligibility or level of benefits in this claim. I specifically authorize the Minnesota Department of Revenue to release a copy of my tax returns to the Board for the purpose of determining my lost wages.

I authorize the Minnesota Crime Victims Reparations Board to release private and confidential data about my claim to the court administrator, prosecutor, and any officers of the court and probation & parole officials for the purpose of assessing the economic impact of the crime upon me and for determining the amount of restitution to be paid by the offender.

I authorize the Board to release private and confidential data about my claim to a local Emergency Fund administrator for the purpose of coordinating benefits.

SECTION 18. MISCELLANEOUS CONSENTS/AGREEMENTS

I agree that any reparations awarded may be paid directly to the provider of the service on my behalf.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment by a health provider.

I understand that my refusal to provide information or not allow access to information needed to analyze my claim may result in the denial of reparations.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the redisclosure of protected health information may not be protected by federal privacy rules.

This consent will remain in effect for one year from the date of my signature. I understand that I may revoke this authorization at any time by submitting a written notification to the Board. This revocation will not apply to information that has already been released in response to this authorization.

A photocopy of this consent form may be accepted as the original.

SECTION 19. VICTIM AND CLAIMANT SIGNATURES

The victim must sign and date the claim form. If the victim is deceased, under the age of eighteen, or an incapacitated adult victim, the claimant must sign and date the claim form.

I have read and understand the statements in Sections 15-18 above. I hereby certify that the information contained in this application is true and correct to the best of my knowledge. I understand that it is a gross misdemeanor to knowingly file a false claim.

Victim/Patient Signature	Victim/Patient Printed Name	Date of Birth	Date Signed
Claimant Signature	Claimant Printed Name	Date of Birth	Date Signed
Claimant's relationship to victim		Reason victim cannot sign claim form <input type="checkbox"/> Deceased <input type="checkbox"/> Minor <input type="checkbox"/> Incapacitated Adult	