FOR OFFICE USE ONLY
Claim No.

MISSOURI DEPARTMENT OF PUBLIC SAFETY

APPLICATION FOR CRIME VICTIMS' COMPENSATION

INSTRUCTIONS:
1. Type or Print clearly in ink.
2. Last page of this form must be signed by claimant.
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 APPPLICABLE, 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 749, JEFFERSON CITY, MISSOURI 65102-0749	**1-800-347-6881**	**1-800-735-2466 (VOICE)**

How did you find out about the Crime Victims' Compensation Program?

☐ Police (Agency Code _____) ☐ Victim Assistance (Agency Code _____) ☐ Prosecutor (Agency Code _____)
☐ Hospital ☐ Funeral Home ☐ Friend/Family

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 ☐ Transgender ☐ Female | Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race *(Check One)* *
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Multiple Races ☐ Native Hawaiian/Pacific Islander ☐ Other: _____ ☐ White/Caucasian

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

Date Crime Occurred:

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 ☐ Transgender ☐ Female | Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race *(Check One)* *
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Multiple Races ☐ Native Hawaiian/Pacific Islander ☐ Other: _____ ☐ White/Caucasian

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 ☐ Transgender ☐ Female | Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race *(Check One)* *
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Multiple Races ☐ Native Hawaiian/Pacific Islander ☐ Other: _____ ☐ White/Caucasian

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

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

SECTION IV — CRIME INFORMATION

Was a 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 Agency Incident Reported To	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 the 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 the above expenses.

Source Type: ☐ Health Insurance/HMO/PPO ☐ Veterans Administration ☐ Armed Services (TRICARE)
☐ 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/MOTORCYCLE INSURANCE INFORMATION — COMPLETE THIS SECTION ONLY FOR MOTOR VEHICLE CLAIM

Does convicted operator have liability insurance coverage on auto/motorcycle? ☐ 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/motorcycle? ☐ 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 if victim was gainfully employed at the time of the crime and a loss is being claimed.)

Was victim gainfully 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 application, 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").

SUBMIT Reset Form Print Form

MICHAEL L. PARSON
Governor

SANDRA K. KARSTEN
Director

Mailing Address: P.O. Box 1589
Jefferson City, MO 65102-1589
Telephone: 573-526-6006
Toll Free: 800-347-6881
Fax: 573-526-4940

STATE OF MISSOURI
DEPARTMENT OF PUBLIC SAFETY
OFFICE OF THE DIRECTOR

Application for Crime Victims' Compensation Instructions

1) If the victim is a minor or an incompetent person, the claimant must be a parent or guardian.
2) The application must be signed by the victim (or claimant).
3) Along with the application, submit a copy of the following:
    a. For medical or counseling claims, submit a copy of the medical or counseling bills received from the crime injuries and any paid receipts.
    b. For funeral claims, submit a copy of the death certificate, a copy of the funeral bill and any paid receipts.
        i. If life insurance is available, submit the policy information including the beneficiary name and mailing address.
    c. For lost wages or support, submit a copy of the last three paycheck stubs prior to the crime incident.
        i. If the victim is (was) self-employed, send a copy of the two state and federal tax returns prior to the crime.
4) If health insurance is available, all medical or counseling bills must be submitted to the health insurance carrier first.
5) A completed and signed application shall be filed not later than two years after the occurrence of the crime or the discovery of the crime upon which it is based.
6) Once the application is received and reviewed, other information or documentation may be required. A letter informing you of the additional requirement will be mailed to you.
7) If the additional information is not submitted in a timely manner, the claim may be denied.
8) If you move, please send your new address with your signature. If the Crime Victim's Compensation office is unable to locate you by mail, your claim may be denied.