CRIME VICTIM COMPENSATION APPLICATION

NORTH DAKOTA DEPARTMENT OF CORRECTIONS AND REHABILITATION
SFN 9325 (08-2018)

The ND Department of Corrections and Rehabilitation is an equal opportunity employer, services, and programs provider.

AUTHORITY: NDCC 54-23.4, NDAC 94-03
COMPLETION: Is voluntary, but is required if Crime Victim Compensation is desired. Information on this form is exempt from disclosure under the Freedom of Information Act.

INSTRUCTIONS

Complete **all** applicable information on this application. A separate application must be completed for **each** victim.
A delay may result in the processing of your application if all applicable information is not provided. Information about this claim is confidential and will not be released to another person unless that person is included as a claimant or as otherwise required by law.

SECTION 1 - VICTIM INFORMATION (Complete this section for the person who was injured)

The victim is the person who was injured or died as a result of crime. If the victim is a minor or deceased, the claimant information in SECTION 3 **MUST** be completed. If there is more than one victim **EACH** victim must submit a separate application.

Name of VICTIM (First, Last)		Date of Birth	Gender ☐ Male ☐ Female	
Address		City	State	ZIP Code
Telephone Number (cell)	Alternate Telephone Number	Email Address		

Statistical Information for Crime Victim Program

For statistical purposes only. Completion of this section is strictly voluntary.

Please tell us how you first found out about the Crime Victim's Compensation Program
☐ Attorney ☐ Friend/Acquaintance ☐ Media, Brochure, or Poster ☐ Medical Provider ☐ Police/Sheriff
☐ Prosecuting Attorney ☐ Victim Service Agency ☐ Other, explain:

Race/Ethnic Background
☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black-African American ☐ Hispanic or Latino ☐ Multi-racial
☐ Native Hawaiian or Other Pacific Islander ☐ White Non-Latino/Caucasian ☐ Other, explain:

If disabled, check one
☐ BEFORE Crime ☐ As a RESULT of this crime

SECTION 2 - CLAIMANT INFORMATION (Complete this section if victim is a minor, incapacitated, or deceased)

The Claimant is a person, other than the victim, who has eligible out of pocket expenses as a direct result of the crime or is an immediate family member(s) of the victim.

Victim is
☐ a Minor ☐ Incapacitated ☐ Deceased

Name of CLAIMANT (First, Last)			Date of Death *(if applicable)*	
Address		City	State	ZIP Code
Cell Telephone Number	Alternate Telephone Number	Email Address		

Your Relationship to the Victim
☐ Spouse ☐ Parent ☐ Child ☐ Sibling
☐ Grandparent ☐ Grandchild ☐ Guardian ☐ Other, explain:

Are you or were you dependent on the deceased victim for either?
Primary Financial Support ☐ No ☐ Yes, monthly amount:
Child Support or Alimony ☐ No ☐ Yes, monthly amount:

Please list names and birthdates of ALL victim's legal dependents

Name	Date of Birth	Name	Date of Birth

SECTION 3 - CRIME INCIDENT INFORMATION (Complete this section and provide a copy of the Police Report, if available)

Date of Crime	Date Crime was Reported	Law Enforcement Agency Crime was Reported to		
Location of Crime		City	State	ZIP Code

Type of Crime *(check only one)*

- ☐ Assault
- ☐ Robbery
- ☐ Child Abuse/Neglect
- ☐ Human Trafficking
- ☐ Homicide
- ☐ Arson
- ☐ Child Physical Abuse
- ☐ Terrorism
- ☐ DWI/DUI
- ☐ Burglary
- ☐ Child Sexual Assault
- ☐ Other, explain:
- ☐ Vehicular Crimes - Other
- ☐ Adult Sexual Assault
- ☐ Child Pornography

Alleged Suspect's Name(s), specify if unknown	Relationship of Suspect to Victim	Has the Suspect(s) been charged in court? ☐ No ☐ Yes ☐ Unknown

Brief Summary of Crime

Brief Description of Injuries

If the crime was NOT reported to the Law Enforcement within **96 hours**, please explain the reason for the delay.

If you are NOT filing this claim within **1 year** of the crime, please explain the reason for the delay.

SECTION 4 - ELIGIBLE COMPENSATION BENEFITS

Check the type of compensation benefits you are requesting

- ☐ Wage loss for the victim **(complete Section 7)**
- ☐ Medical expense benefits for the victim **(complete Section 6)**
- ☐ Mental health services/counseling for the victim **(complete Section 6)**
- ☐ Funeral benefits for the survivor(s) **(complete Section 8)**
- ☐ Loss of support benefits for the survivor(s) **(complete Section 8)**
- ☐ Mental health services/counseling for the survivor(s) **(complete Section 8)**

Have you lost at least 3 days of earning?
☐ No ☐ Yes

SECTION 5 - COLLATERAL RESOURCES, RESTITUTION AND RECOVERY INFORMATION

(Complete this section and provide all information you currently have available)

Did the court order the offender to pay restitution to you?
☐ No ☐ Yes, **complete the following questions** ☐ Unknown

Restitution Order Date	Court Case Number	Amount Ordered

Did the victim or claimant receive charity care, payments, donations, or other insurance settlement from any other source due this incident?
☐ No ☐ Yes, **explain:** ☐ Unknown

Are you retired by reason of age or disability?
☐ No ☐ Yes

Have you filed, or do you intend to file a civil court action? ☐ No ☐ Yes, **complete the following questions** ☐ Unknown	Have you settled with a third party regarding this case? ☐ No ☐ Yes ☐ Unknown
Attorney Name	Telephone Number

SECTION 6 - MEDICAL, DENTAL OR MENTAL HEALTH SERVICES

If applying for medical, dental or mental health services, please include the Release of Information (SFN 61353), Reimbursement Request (SFN 61509), available on the following website: https://docr.nd.gov/victims-services/crime-victims-compensation), and all supporting documents to include itemized billing, explanation of benefits for each date of service not paid in full by your insurance, and receipts.

Sources You are Able to Pay Out-of-Pocket *(check all, if any, that apply)*

☐ Health Insurance ☐ Dental/Vision Insurance ☐ Veterans Administration ☐ Medicaid
☐ Medicare ☐ Workers Compensation ☐ State Medical Plan ☐ Other, explain below:
☐ Automobile Insurance ☐ Homeowners Insurance ☐ Other Public Assistance

Did the victim or claimant receive charity care, payments, donations, or other insurance settlement from any other source due this incident?
☐ No ☐ Yes, **explain:**

Will additional medical treatment be required?
☐ No ☐ Yes, **explain:**

Name of Primary Medical Insurer

SECTION 7 - WAGE LOSS

When applying for lost wages, if the victim was working at the time of the crime and lost at least 3 days of taxable earnings, your claim must include a completed Employer's Report (SFN 12437) AND Physician's Report (SFN 60497), found on the following website: https://docr.nd.gov/victims-services/crime-victims-compensation.

- Attach copies of 2-3 pay stubs paid just before the date of injury (showing gross, net and tax deductions for the victim's taxable earnings at the time of the crime).
- Attach copies income tax returns, **if the victim is/was self-employed at the time of the crime**.
  - showing gross, net, and tax deductions for the victim's taxable earnings
  - for the year before the crime and the year of the crime, if available

Victim's Employer Name	Dates Absent from Work Due to Crime Related Injuries FROM TO
Supervisor's Name	Supervisor's Telephone Number

Sources Available to Pay for Wage Loss
☐ Long or Short Term Disability ☐ Social Security ☐ Workers Compensation ☐ Other, explain:

Did the victim or claimant receive charity care, payments, donations, or other insurance settlement from any other source due this incident?
☐ No ☐ Yes, **explain:**

SECTION 8 - FUNERAL EXPENSES, MENTAL HEALTH SERVICES OR LOSS OF SUPPORT

When applying for reimbursement for funeral expenses, mental health services or loss of support, please include a completed reimbursement form and all supporting documents to include itemized billing, explanation of benefits for each date of service not paid in full by your insurance, and receipts.

Sources Available to Pay for Wage Loss
☐ Life Insurance ☐ Health Insurance ☐ Social Security Death Benefits ☐ Other, explain below:
☐ Workers Compensation ☐ Automobile Insurance ☐ Homeowners Insurance

Did the victim or claimant receive charity care, payments, donations, or other insurance settlement from any other source due this incident?
☐ No ☐ Yes, **explain:**

AUTHORIZATION - DECLARATION

(A photocopy of this Authorization is as effective and valid as the original)

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize any hospital, physician, medical facility, insurer, employer or any other person or agency who has knowledge relative to my claim to furnish information to the North Dakota Crime Victim Compensation Program.

DECLARATION:

I must inform Crime Victim Compensation, in writing, of any impending civil suit. I understand that any recovery of my losses through legal action/insurance shall be reimbursed to the extent of any compensation awarded me. I swear that the information contained herein is true to my best knowledge and I understand that the filing of false information shall be a Class A misdemeanor punishable by a $2000 fine and/or 1 year imprisonment.

Signature	Date

Return the completed, signed application and supporting documents to:
ND DOCR Crime Victims Compensation
PO Box 1898, Bismarck, ND 58502-1898
Email: DOCRcompensation@nd.gov