

Application

Minnesota Crime Victims Reimbursement Board



The Minnesota Crime Victims Reimbursement Board provides financial assistance to victims of violent crime and their family members for related expenses that cannot be reimbursed by insurance or other sources. Expenses for damaged/stolen property are not covered.

Instructions

If you need help completing this application form, contact our office or your local victim assistance program. Visit our website for a listing of victim assistance programs. Please read the following before completing the form:

- Print clearly and provide as much information as possible.
- Submit application as soon as possible. Additional bills/documents can be sent later.
- Complete a separate application form for each victim.
- A parent, guardian or relative must file the application on behalf of a minor, incapacitated or deceased victim.
- Include copies of all expenses (medical bills, receipts, insurance statements), if available.
- Complete the W9 form (page 5) for the person who may receive a direct payment.
- Sign and date the release form (page 6). The time period in Section 15 should cover from the crime date through the last expected treatment date.
- Mail, fax or email your completed application form. See below.

Eligibility Requirements

- Victim of a crime in Minnesota or a Minnesota resident victimized while traveling in another country
- Claim submitted within 3 years of the crime (some exceptions apply)
- Crime reported to police within 30 days (exceptions for child abuse and sexual assault)
- Victim/claimant cooperated fully with police and prosecution
- Victims who contributed through serious misconduct or criminal activity may be disqualified or receive reduced benefits.

*There are other factors not listed that might make you ineligible.

Expenses Covered

- Medical/Dental
- Counseling by a licensed provider
- Mileage to medical/counseling appts.
- Lost Wages
- Funeral/Burial
- Survivor's benefits
- Miscellaneous expenses (see brochure)

*Caps/limits apply



Office of Justice Programs
Crime Victims Reimbursement Board
445 Minnesota Street, Suite 2300•St. Paul, MN 55101
651-201-7300•888-622-8799•Fax 651-296-5787•TTY 651-205-4827
dps.justiceprograms@state.mn.us
ojp.dps.mn.gov



MINNESOTA CRIME VICTIMS REIMBURSEMENT APPLICATION FORM

Date Received: (Office Use Only)	Complete and submit to: Minnesota Crime Victims Reimbursement 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 (TTY) dps.justiceprograms@state.mn.us	Claim Number: Claims Specialist: (Office Use Only)
--	---	--

SECTION 1. VICTIM INFORMATION	Name of person injured or killed as the result of the violent crime. Complete a separate application form for each victim.		
Victim's Name (last, first, m.i.)	Date of Birth (MM/DD/YY)	Social Security Number None <input type="checkbox"/>	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	What is the language preference of the victim and/or claimant? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		Is Victim Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes
Address	City	State	Zip Code
Phone	Email Address		

SECTION 2. CLAIMANT INFORMATION	Complete only if the person(s) submitting the application is not the victim. This section must be completed by a parent, guardian or relative if the victim is a minor, deceased or incapacitated.
--	---

Claimant 1			
Claimant's Name (last, first, m.i.)	Date of Birth (MM/DD/YY)	Social Security Number None <input type="checkbox"/>	
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		
Address	City	State	Zip Code
Phone	Email Address		

Claimant 2			
Claimant's Name (last, first, m.i.)	Date of Birth (MM/DD/YY)	Social Security Number None <input type="checkbox"/>	
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		
Address	City	State	Zip Code
Phone	Email Address		

SECTION 3. REFERRAL SOURCE	How did you learn of the reimbursement program?		
<input type="checkbox"/> County Attorney	<input type="checkbox"/> Hospital	<input type="checkbox"/> Sexual Assault Program	<input type="checkbox"/> Website
<input type="checkbox"/> Domestic Abuse Program	<input type="checkbox"/> Police	<input type="checkbox"/> Social Services, Cleric or School	<input type="checkbox"/> Other
<input type="checkbox"/> Funeral Home	<input type="checkbox"/> Probation	<input type="checkbox"/> Victim Assistance Program	

SECTION 4. CRIME INFORMATION		Date of Crime	Date Reported to Police	County Where Crime Occurred	
Police Department			Police Case Number	Investigating Officer's Name	
Did the crime involve? <input type="checkbox"/> Domestic or Family Violence <input type="checkbox"/> Bullying <input type="checkbox"/> Elder Abuse <input type="checkbox"/> Hate Crime <input type="checkbox"/> Mass Violence					
Type of Crime (check all that apply)		<input type="checkbox"/> Child Physical Abuse	<input type="checkbox"/> DWI	<input type="checkbox"/> Burglary	
<input type="checkbox"/> Assault	<input type="checkbox"/> Child Sexual Abuse	<input type="checkbox"/> Other Vehicular Crime	<input type="checkbox"/> Fraud/Financial Crime		
<input type="checkbox"/> Homicide	<input type="checkbox"/> Child Pornography	<input type="checkbox"/> Stalking	<input type="checkbox"/> Terrorism		
<input type="checkbox"/> Robbery	<input type="checkbox"/> Human Trafficking	<input type="checkbox"/> Arson	<input type="checkbox"/> Other		
<input type="checkbox"/> Adult Sexual Assault	<input type="checkbox"/> Kidnapping				
Briefly describe crime and injuries. Attach additional pages if necessary.					
Name of Offender(s) (last, first, m.i.)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YY)	

SECTION 5. FEDERAL REPORTING INFORMATION		The following voluntary information is for the victim for whom this application was filed and is used for statistical purposes only to comply with federal regulations.			
Ethnicity	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic/Latino	Country of Birth	Was the victim disabled prior to the crime?	
<input type="checkbox"/> American Indian/Racial Alaskan Native	<input type="checkbox"/> American	<input type="checkbox"/> Multi-Pacific Islander		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> Asian	<input type="checkbox"/> Hawaiian/Other	<input type="checkbox"/> Other			
	<input type="checkbox"/> White				

SECTION 6. AUTHORIZED CONTACT INFORMATION		Your claim is confidential. If you would like the Board to be able to discuss your claim with anyone (parent, spouse, social worker) you must list their information below.		
Name		Relationship to you	Phone	
Name		Relationship to you	Phone	

SECTION 7. REPRESENTATION BY OTHERS			The Board is authorized to release private and confidential data about this claim to the representatives listed below.		
ATTORNEY INFORMATION			VICTIM ASSISTANCE PROGRAM INFORMATION		
Are you represented in this matter by a private attorney? <input type="checkbox"/> No <input type="checkbox"/> Yes			Are you working with an advocate? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Name of Attorney			Name of Advocate		
Law Firm			Victim Assistance Program		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Phone	Fax		Phone	Fax	

SECTION 8. OTHER SOURCES OF PAYMENT		All bills must first be submitted to your insurance company. The Board may deny payment if you fail to use other available sources.		
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"/> Homeowner's Insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> Veteran's Benefits	
<input type="checkbox"/> Dental Insurance	<input type="checkbox"/> Long/short term Disability	<input type="checkbox"/> MNSure	<input type="checkbox"/> Worker's Compensation	
<input type="checkbox"/> Health Insurance	<input type="checkbox"/> Medical Assistance (MA)	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Other	
Complete for all other sources available to pay for crime related expenses, or attach a copy of insurance card.				
Insurance company	Address	Phone	Policy	Group
Insurance company	Address	Phone	Policy	Group
Insurance company	Address	Phone	Policy	Group
ATTACH INSURANCE EXPLANATION OF BENEFITS FOR ALL PAYMENTS AND/OR DENIALS				

SECTION 9. LOSS OF EARNINGS	Complete if the victim and/or claimant lost income due to the crime. Your employer will be contacted to verify your wage loss.
------------------------------------	--

Victim Employment Information				
Were you employed on date of crime? <input type="checkbox"/> No <input type="checkbox"/> Yes	Were you self-employed on the date of the crime? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach a copy of your most recent federal tax return	Your Occupation/Job Title		
Employer's Business Name	Supervisor's Name	Phone	Fax	
Address		City	State	Zip Code
First Date Missed	Date Returned	Did the crime occur while you were on the job? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Did you receive any benefits for time missed from work? <input type="checkbox"/> No <input type="checkbox"/> Yes				
<input type="checkbox"/> Disability <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Sick Leave <input type="checkbox"/> Vacation Pay <input type="checkbox"/> Other (explain) _____				
Doctor/Counselor who can verify disability	Hospital/Clinic	Address		

Claimant Employment Information (If more than 1, attach a separate sheet with all requested information.)				
Claimant's Name		Were you self-employed on date of crime? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, attach a copy of your most recent federal tax return		
Employer's Business Name	Phone	Fax	Your Occupation/Job Title	
Address		City	State	Zip Code
First Date Missed	Date Returned	Why did you miss work? <input type="checkbox"/> To provide care to victim <input type="checkbox"/> Medical/counseling appts. <input type="checkbox"/> Emotional injury from crime		
Did you receive any benefits for time missed from work? <input type="checkbox"/> No <input type="checkbox"/> Yes				
<input type="checkbox"/> Disability <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Sick Leave <input type="checkbox"/> Vacation Pay <input type="checkbox"/> Bereavement <input type="checkbox"/> Other (explain)				

SECTION 10. MEDICAL AND DENTAL EXPENSES		List the healthcare providers who treated crime related injuries, including pharmacies. Attach itemized bills and receipts, if available. Providers must also be listed on the release form on page 6.	
Provider	Address	Phone	
Provider	Address	Phone	
Provider	Address	Phone	
Provider	Address	Phone	

SECTION 11. MENTAL HEALTH COUNSELING EXPENSES		List the mental health providers who treated the victim and/or claimant. Attach itemized bills if available. Unlicensed providers are not covered. Providers must also be listed on the release form on page 6.	
Patient	Counselor/Clinic	Address	Phone
Patient	Counselor/Clinic	Address	Phone
Patient	Counselor/Clinic	Address	Phone

COMPLETE SECTIONS 12 & 13 ONLY IF THE VICTIM DIED AS A RESULT OF THE CRIME

SECTION 12. FUNERAL EXPENSES		List all funeral homes/cemeteries that provided services. Attach a copy of funeral and burial contracts, if available. Attach receipts if you had travel/lodging expenses to attend the funeral.	
Funeral Home/Cemetery	Address	Phone	
Funeral Home/Cemetery	Address	Phone	

SECTION 13. 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	Address	Phone	
Does the victim have dependent children under the age of 18? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Child	Guardian	Address	Phone
Child	Guardian	Address	Phone
Child	Guardian	Address	Phone



Return to:
Crime Victims Reimbursement Board
445 Minnesota Street, #2300
St. Paul, MN 55101
Fax: (651) 296-5787
Phone: 651-201-7300
dps.justiceprograms@state.mn.us

SUBSTITUTE FORM W-9

Name and Address

Blank lines for Name and Address, and Date

SUBJECT: Request for Taxpayer Information. (Failure to furnish a taxpayer identification number makes you subject to a penalty of \$50.)

The purpose of this form is to obtain or confirm your correct taxpayer name and identification number. Federal and state tax regulations require that we have this information from recipients of certain payments in order to report such payments to the Internal Revenue Service on the Form 1099 Return.

Please complete items 1, 2, and 3 below. If you have any questions, phone (651) 201-7300 for assistance. Send, fax or e-mail the completed form to the address in the upper right corner.

1. Check your tax filing status below and enter your social security number or federal employer identification number. If you have been issued a separate Minnesota tax identification number, write it in the space provided.

If you have recently applied for a taxpayer number, write "Applied For" in the space for the number.

Form with checkboxes for tax filing status (Individual, Sole Proprietorship, Corporation, S Corporation, Legal Partnership, Tax Exempt Organization, Other) and fields for SOCIAL SECURITY NUMBER (SSN), FEDERAL EMPLOYER IDENTIFICATION (FEIN), and MINNESOTA TAX I.D. NUMBER (IF APPLICABLE).

2. Print the full name belonging to the social security number or employer identification number written above.

Blank line for printing full name

3. Certification. Under penalty of perjury, I certify the number shown on this form is my correct taxpayer identification number.

Signature and Date lines

Email and Phone lines

PRIVACY ACT NOTICE - Internal Revenue code Section 6109 requires you to furnish your correct taxpayer identification number to payers who must file information returns with IRS. IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. Payers must generally withhold 28% of taxable interest and certain other payments to a payee who does not furnish a TIN to a payer.

COMPLETE SECTIONS 15 AND 18

SECTION 14. ASSIGNMENT OF SUBROGATION RIGHTS	
I agree that the Board is subrogated to the extent of reimbursement 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 15. 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 Reimbursement 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: _____			

DATE OF CRIME _____ ONE YEAR or more FROM DATE OF CRIME _____

SECTION 16. 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 Reimbursement Board to release private and confidential data about my claim to the court administrator, prosecutor, and any officers of the court and probation and 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 obtain and release private and confidential data about my claim to a local Emergency Fund administrator, the Minnesota Heals Family Support Fund administrator or any other program funded through OJP for the purpose of coordinating benefits.	

SECTION 17. MISCELLANEOUS CONSENTS/AGREEMENTS	
I agree that any reimbursement 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 my claim.	
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 consent to the release of healthcare records created after the date of my signature below. 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 18. VICTIM AND CLAIMANT SIGNATURES	The victim must sign and date the application form. If the victim is deceased, under the age of eighteen or an incapacitated adult victim, the claimant must sign and date the application form.		
I have read and understand the statements in Sections 14-17 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.			
<input type="checkbox"/> By checking this box, I agree that my electronic signature has the same legal validity and effect as my handwritten signature on the document, and that it has the same meaning as my handwritten signature.			
Victim/Patient Signature	Victim/Patient Printed	Date of Birth	Date Signed
Claimant 1 Signature	Claimant Printed Name	Date of Birth	Date Signed
Claimant 2 Signature	Claimant Printed Name	Date of Birth	Date Signed
Claimant 1's relationship to victim	Claimant 2's relationship to victim	Reason victim cannot sign claim form Deceased Minor <input type="checkbox"/> Incapacitated Adult	