

Claim No.

**APPLICATION FOR CRIME VICTIMS' COMPENSATION**



**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.

|   |   |   |
|---|---|---|
| <b>MAILING ADDRESS</b><br>CRIME VICTIMS' COMPENSATION PROGRAM<br>P.O. BOX 1589, JEFFERSON CITY, MISSOURI 65102-1589 | <b>TELEPHONE NUMBER</b><br>573-526-6006<br>1-800-347-6881 | <b>RELAY MISSOURI</b><br>1-800-735-2966 (TDD)<br>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 ( <i>Last, First and Middle</i> )   |                       |  | Social Security Number  |   |  |
| Current Street Address   |                       | City   | State   | Zip Code  |  |
| Home Telephone Number  | Work Telephone Number | Country of Birth - National Origin*                                  |   | Is Victim Deceased?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                         |  |
| Birthdate  | Age                   | Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Separated <input type="checkbox"/> Widowed | Handicapped Prior to Crime* <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>Explain</i> ) |  |
| Race Ethnic ( <i>Check One</i> )*<br><input type="checkbox"/> 1. White <input type="checkbox"/> 2. African American <input type="checkbox"/> 7. Other: _____<br><input type="checkbox"/> 3. Hispanic <input type="checkbox"/> 4. American Indian/Alaskan Native<br><input type="checkbox"/> 5. Asian Pacific Islander <input type="checkbox"/> 6. Race Ethnic (optional) |                       |  | Date Crime Occurred   |   |  |
| Has the victim been convicted of two felonies within the past ten (10) years? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ( <i>Last, First and Middle</i> ) |  |  | Social Security Number  |                       |  |
| Street Address                                     |  | City   | State   | Zip Code              |  |
| Relationship to Victim                             | Was victim living with you at the time of the crime?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Home Telephone Number  |   | Work Telephone Number |  |
| Birthdate  | Age  | Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Separated <input type="checkbox"/> Widowed |                       |  |

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

|   |                                |  |   |   |  |
|---|--------------------------------|--|---|---|--|
| Name of other compensable victim ( <i>Last, First and Middle</i> )  |                                |  | 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*<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Birthdate   | Age                            | Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Separated <input type="checkbox"/> Widowed |   |  |
| Race Ethnic ( <i>Check One</i> )*<br><input type="checkbox"/> 1. White <input type="checkbox"/> 3. Hispanic <input type="checkbox"/> 5. Asian Pacific Islander <input type="checkbox"/> 7. Other: _____<br><input type="checkbox"/> 2. African American <input type="checkbox"/> 4. American Indian/Alaskan Native <input type="checkbox"/> 6. Race Ethnic (optional) |                                |  |   |   |  |
| Was the other compensable victim living with the primary victim at the time of the crime? (Chapter 595) <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, explain: _____  |                                |  |   |   |  |
| Has the other compensable victim been convicted of two felonies within the past ten (10) years? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

|  |                |                             |                      |   |   |   |
|--|----------------|-----------------------------|----------------------|---|---|---|
| <b>SECTION IV CRIME INFORMATION</b>  |                |                             |                      |   |   | Was a Police Report Filed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                |
| Type of Crime: <input type="checkbox"/> Child Abuse <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Assault <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Homicide <input type="checkbox"/> DWI* <input type="checkbox"/> Involuntary Manslaughter*<br><input type="checkbox"/> Robbery With Injury <input type="checkbox"/> Hit & Run* <input type="checkbox"/> Other (Explain:)<br>(*Be Sure To Complete Insurance Under Section VII) |                |                             |                      |   |   |   |
| Brief Description of Crime:<br><hr/> <hr/> <hr/>   |                |                             |                      |   |   |   |
| Date Crime Occurred  |                | Date Crime Was Reported     |                      | Has Arrest Been Made?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | Have Charges Been Filed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No    If, Yes, in what way? _____  |                |                             |                      |   |   |   |
| Was victim related to the person who committed the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, in what way? _____   |                |                             |                      |   |   |   |
| Was victim living in the same household as the offender at the time of the crime? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                |                             |                      |   |   |   |
| If Yes, is victim still living in same house as offender? _____  |                |                             |                      |   |   |   |
| <b>SECTION V MEDICAL (INCLUDING PSYCHOLOGICAL) EXPENSES</b>  |                |                             |                      |   |   | Will there be more bills?   |
| Enter below all expenses for service rendered as a result of this crime.<br>(Attach all bills available)   |                |                             |                      |   |   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Name of Doctor, Hospital or Other Provider of Service  | Account Number | Street Address              |                      |   | City  | State    Zip Code   |
|  |                |                             |                      |   |   |   |
|  |                |                             |                      |   |   |   |
|  |                |                             |                      |   |   |   |
|  |                |                             |                      |   |   |   |
|  |                |                             |                      |   |   |   |
|  |                |                             |                      |   |   |   |
| <b>SECTION VI FUNERAL EXPENSES</b> (Attach Copy of Death Certificate and Funeral Bill)   |                |                             |                      |   |   |   |
| Will dependent(s) receive funeral benefits from the following?   |                |                             |                      |   |   |   |
| Social Security<br>\$  |                | Workers' Compensation<br>\$ |                      | Life Insurance<br>\$  |   | Other (Specify)<br>\$   |
| Name of Funeral Home   |                |                             | Street Address       |   |   |   |
| City   |                | State                       | Zip Code             |   | Amount of Funeral and Burial Expenses<br>\$ |   |
| Have Burial Expenses Been Paid?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                | If Yes, by whom?            |                      |   | Relationship to Victim                      |   |
| City   |                |                             | State                |   | Zip Code                                    |   |
| Will dependent(s) receive any accident or life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No          | If Yes, enter name of carrier and policy limits. |       |          |
| Street Address  | City   | State | Zip Code |
| Policy Number   |  |       |          |
| Has settlement been made with carrier? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is victim applying for lost wages? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is a dependent applying for loss of support? <input type="checkbox"/> Yes <input type="checkbox"/> 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  NoIf Yes, has the victim applied for Workers' Compensation or other employment benefits?  Yes  NoIf Yes, please describe. \_\_\_\_\_  
\_\_\_\_\_Are you receiving or have you received accident or disability benefits from your employer as a result of this injury?  Yes  NoIf 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  NoIf 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? \_\_\_\_\_

