

**APPLICATION FOR CRIME VICTIMS' COMPENSATION**

<b>FOR OFFICE USE ONLY</b>
Claim No. _____

**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> <b>CRIME VICTIMS' COMPENSATION PROGRAM</b> <b>P.O. BOX 1589, JEFFERSON CITY, MISSOURI 65102-1589</b>	<b>TELEPHONE NUMBER</b> <b>573-526-6006</b> <b>1-800-347-6881</b>	<b>RELAY MISSOURI</b> <b>1-800-735-2966 (TDD)</b> <b>1-800-735-2466 (VOICE)</b>
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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 ( <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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Transgender	Marital Status <input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Race ( <i>Check One</i> )* <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other: _____ <input type="checkbox"/> Asian <input type="checkbox"/> Multiple Races <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander				Handicapped Prior to Crime* <input type="checkbox"/> Yes <input type="checkbox"/> No ( <i>Explain</i> )	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Telephone Number		Work Telephone Number	
Birthdate	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Transgender	Marital Status <input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <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* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Transgender	Marital Status <input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Race ( <i>Check One</i> )* <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Multiple Races <input type="checkbox"/> Other: _____ <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian					
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 VII INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION</b>				
Indicate below if any sources are paying or will pay any of above expenses.				
<b>Source Type:</b> <input type="checkbox"/> Health Insurance/HMO/PPO <input type="checkbox"/> Veterans Administration <input type="checkbox"/> Armed Services (TRICARE) <input type="checkbox"/> Life Insurance <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid No. _____ <input type="checkbox"/> 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
<b>AUTO/MOTORCYCLE INSURANCE INFORMATION - COMPLETE THIS SECTION ONLY FOR MOTOR VEHICLE CLAIM</b>				
Does convicted operator have liability insurance coverage on auto/motorcycle? <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/motorcycle? <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)		
<b>SECTION VIII WAGE LOSS/LOSS OF SUPPORT</b>			<b>(Fill out only if victim was gainfully employed at the time of the crime and a loss is being claimed)</b>	
Was victim gainfully 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, has the victim applied for Workers' Compensation or other employment benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, please describe.				
<b>SECTION IX OTHER INFORMATION</b>				
Is the victim or claimant considering a civil action against the offender or some other third party for damages claimed herein? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, please provide the name and mailing address of attorney who will handle the civil action:				
<b>RESTITUTION</b>				
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? _____		

<b>ATTORNEY INFORMATION</b>			
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 ( <i>Last, First, MI</i> )			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
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(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").

**STATE OF MISSOURI** )  
 )  
**COUNTY OF** \_\_\_\_\_ ) SS

On this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_, before me personally appeared \_\_\_\_\_, (Name of Claimant),  
 to me known to be the person described in and who executed the foregoing Crime Victims' Compensation Application and acknowledged that \_\_\_\_\_ (S/He) executed the same as \_\_\_\_\_ (His/Her) free act and deed. And said claimant declares that the information provided is true and correct to the best of \_\_\_\_\_ (His/Her) knowledge.

Subscribed and sworn to before me at my office in \_\_\_\_\_ (Notary's Office Location) the day and year first above written.

(Notary Seal) \_\_\_\_\_  
 Notary Signature

My commission expires: \_\_\_\_\_