MINNESOTA CRIME VICTIMS REPARATIONS CLAIM FORM

Date Received:	Complete and submit to:	**Claim Number:**
	Minnesota Crime Victims Reparations 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 (TDD)	**Claims Specialist:**
(Office Use Only)	Please contact the Board if you need assistance completing this form	(Office Use Only)

SECTION 1. VICTIM INFORMATION — Name of person injured or killed as the result of the violent crime. If there was more than one victim, complete a separate claim form for each victim.

Victim's Name (last, first, m.i.)	Date of Birth (MM/DD/YY) / /	**Social Security Number** **None**___	
Gender ❒ Male ❒ Female	What is the language preference of the victim and/or claimant? Language preference: ❒ English ❒ Spanish ❒Other_____		Is Victim Deceased? ❒ No ❒ Yes
Street Address (including apartment #)	City	State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )	E-Mail Address

SECTION 2. CLAIMANT INFORMATION — Name of person filing on behalf of a deceased victim, minor victim, or an incapacitated adult victim.

Claimant's Name (last, first, m.i.)	Date of Birth (MM/DD/YY) / /	**Social Security Number** **None**___	
Gender ❒ Male ❒ Female	Relationship to Victim ❒ Parent ❒ Spouse/Partner ❒ Former Spouse/Partner ❒ Child ❒ Sibling ❒ Grandparent ❒ Other_____		
Street Address (including apartment #)	City	State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )	E-Mail Address

SECTION 3. FEDERAL REPORTING INFORMATION — The following **voluntary** information is for the person receiving compensation and is used for statistical purposes only to comply with federal regulations.

Ethnicity: ❒ American Indian or Alaskan Native ❒ Black ❒ Hispanic/Latino ❒ White ❒ Asian or Pacific Islander ❒ Other_____	Country of Birth:	Was the victim disabled prior to the crime? ❒ No ❒ Yes

SECTION 4. CRIME INFORMATION

Date of Crime / /	Date Reported to Police / /	County Where Crime Occurred
Name of Police Department Investigating Crime	Police Case Number	Investigating Officer's Name

Was the offender the victim's spouse/partner, former spouse/partner, relative, family member or resident of the same household? ❒ No ❒ Yes

Type of Crime: (please check one)

❒ Assault	❒ DWI/CVO/Hit and Run	❒ Stalking	❒ Sexual Assault
❒ Child Abuse	❒ Homicide	❒ Robbery	❒ Other_____

Briefly describe crime and injuries. Attach additional pages if necessary.

_____

_____

SECTION 5. OFFENDER AND RESTITUTION INFORMATION — Provide information regarding the offender of the crime, criminal charges, and restitution ordered by the court.

Name of Offender (last, first, m.i.)	Gender ❒ Male ❒ Female	Date of Birth (MM/DD/YY) / /

Has the offender been charged? ❒ No ❒ Yes	If yes, what are the charges?	Name of agency prosecuting the case

Was the offender ordered to pay restitution? ❒ No ❒ Yes	If yes, what amount?	Have you received any payments? ❒ No ❒ Yes	If yes, how much?

SECTION 6. REFERRAL SOURCE How did you learn of the reparations program?

❒ County Attorney/Prosecutor	❒ Hospital	❒ Poster/Brochure/Media	❒ Victim/Witness Assistance Program
❒ Crime Victims Reparations Board	❒ Other (Friend or Relative)	❒ Sexual Assault Program	❒ Website
❒ Domestic Abuse Program/Shelter	❒ Police	❒ Social Services, Cleric or School	
❒ Funeral Home	❒ Probation Agent	❒ Other State Agency	

SECTION 7. CONTACT INFORMATION The Minnesota Crime Victims Reparations Board is authorized to release private and confidential data about this claim to the persons listed below (parent, spouse, child, etc).

Name	Relationship to you	Phone Number
Name	Relationship to you	Phone Number

SECTION 8. REPRESENTATION BY OTHERS The Minnesota Crime Victims Reparations Board is authorized to release private and confidential data about this claim to the attorney and/or advocate listed below.

ATTORNEY INFORMATION			VICTIM SERVICE PROGRAM INFORMATION		
Are you represented in this matter by an attorney? ❒ No ❒ Yes			Did a victim advocate assist you in completing this form? ❒ No ❒ Yes		
Name of Attorney			Name of Advocate		
Law Firm			Victim Service Program		
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code
Telephone # ( )	Fax # ( )		Telephone # ( )	Fax # ( )	

SECTION 9. OTHER SOURCES OF PAYMENT All bills must first be submitted to your insurance company for payment. The Board will not pay if you fail to use other sources available to you. If the crime involved a vehicle, complete page 4.

Was there insurance or another source of payment to cover expenses related to the crime? ❒ No ❒ Yes

Check all that apply:

❒ Automobile Insurance (see p. 4)	❒ Health Insurance	❒ Medicare	❒ Veteran's Benefits
❒ Charitable Donations	❒ Homeowner's Insurance	❒ MinnesotaCare	❒ Worker's Compensation
❒ Dental Insurance	❒ Medical Assistance (MA)	❒ Social Security Disability	❒ Other _____

Complete for all collateral sources available to pay for crime related expenses

Name of insurance company	Street Address	City	State	Zip Code	Policy #	Group #
Name of insurance company	Street Address	City	State	Zip Code	Policy #	Group #
Name of insurance company	Street Address	City	State	Zip Code	Policy #	Group #

ATTACH INSURANCE EXPLANATION OF BENEFITS FOR ALL PAYMENTS AND/OR REJECTIONS

SECTION 10. LOSS OF EARNINGS Complete if the victim/claimant lost income due to the physical or emotional injury from the crime. All leave time (vacation, sick) must be used first.

Was the victim/claimant employed at the time of the crime? ❒ No ❒ Yes		Is the victim/claimant self employed? ❒ No ❒ Yes If yes, submit copy of most recent federal tax return		
Name of Employee	Job Title	Supervisor Name and Phone	Net Hourly Wage	Hours worked per week

Name of Employer	Street Address	City	State	Zip Code
Dates absent from work due to crime related injury From: To:	Was vacation or sick leave available? ❒ No ❒ Yes	Do you have disability insurance? ❒ No ❒ Yes		
Name of doctor/counselor who can verify disability	Street Address	City	State	Zip

ATTACH ITEMIZED COPIES OF BILLS, INSURANCE STATEMENTS AND RECEIPTS FOR ALL EXPENSES LISTED IN SECTIONS 10-13.

SECTION 11. MEDICAL AND DENTAL EXPENSES	List the names and addresses of all medical and dental providers who treated the victim and/or claimant. **Providers must also be listed on the release form on page 6.**			
Name of Provider	Street Address	City	State	Zip Code
Name of Provider	Street Address	City	State	Zip Code
Name of Provider	Street Address	City	State	Zip Code
Name of Provider	Street Address	City	State	Zip Code

SECTION 12. MENTAL HEALTH COUNSELING EXPENSES	List the names and addresses of all mental health providers who treated the victim and/or claimant. **Providers must also be listed on the release form on page 6.**				
Patient Name	Counselor/Clinic Name	Street Address	City	State	Zip Code
Patient Name	Counselor/Clinic Name	Street Address	City	State	Zip Code

SECTION 13. REPLACEMENT CHILD CARE AND HOUSEHOLD SERVICES	Complete if the victim paid someone else to provide childcare or to perform household services due to the victim's disability resulting from the crime.							
Replacement Child Care				**Replacement Professional Household Services**				
Name of Provider		Licensed Provider ❒ No ❒ Yes		Name of Provider			Licensed Provider ❒ No ❒ Yes	
Street Address	City	State	Zip Code	Street Address	City	State	Zip Code	
Is the provider a family or household member? ❒ No ❒ Yes	Dates care was provided From: To:		Hourly Rate Paid	Is the provider a family or household member? ❒ No ❒ Yes	Dates care was provided From: To.		Hourly Rate Paid	
Doctor who can verify victim's disability	Street Address			City		State	Zip Code	

SECTION 14. FUNERAL EXPENSES	Complete if the victim died as a result of the crime.			
Name of Funeral Home/Cemetery	Street Address	City	State	Zip Code
Name of Funeral Home/Cemetery	Street Address	City	State	Zip Code

SECTION 15. 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? ❒ No ❒ Yes					
Spouse/Partner Name	Street Address	City	State	Zip Code	
Does the victim have dependent children under the age of 18? ❒ No ❒ Yes					
Dependent's Name	Name of Guardian	Street Address	City	State	Zip Code
Dependent's Name	Name of Guardian	Street Address	City	State	Zip Code
Dependent's Name	Name of Guardian	Street Address	City	State	Zip Code

VEHICULAR INSURANCE PAGE

(If the crime did not involve a motor vehicle, skip this page and go to page 5.)

IF THE CRIME INVOLVED AN AUTOMOBILE, MOTORCYCLE OR BOAT, PLEASE COMPLETE THIS PAGE IN FULL. (If there is no insurance, please refer to Section 18 of this page for information about the Auto Assigned Claims Bureau.) Your information is important to the Board in determining the amount of benefits to be paid.

If there is insurance coverage, please complete all of sections 15, 16 and 17. (If you are unable to answer all of the questions, please provide an explanation.)

SECTION 16. VICTIM'S INFORMATION		
Victim's Name		
Victim's Auto Insurance Company, Name of Adjuster, and Address (Provide copy of policy declaration page)	Telephone No.	Policy No.
If victim is insured under another person's policy: Name of Insured: (Provide copy of policy declaration page)		
Owner's Name (If other than victim)	Address	
Auto Insurance Co., Name of Adjuster, & Address	Telephone No.	Policy No.
Driver's Name (if other than victim)	Address	
Auto Insurance Co. & Address	Telephone No.	Policy No.

SECTION 17. DEFENDANT'S VEHICLE		
Owner's Name		
Auto Insurance Co., Name of Adjuster & Address	Telephone No.	Policy No.
Driver's Name (If other than owner of vehicle)		
Auto Insurance Co., Name of Adjuster & Address	Telephone No.	Policy No.

SECTION 18. ATTORNEY INFORMATION		
Name and Address of Your Attorney	Agency	Telephone No.

SECTION 19. MINNESOTA AUTOMOBILE ASSIGNED CLAIMS BUREAU		
If there is no insurance coverage in your case, have you submitted a claim to the Minnesota Automobile Assigned Claims Bureau? For further information on the MAACB, please call (763)425-6634 or e-mail MAACBWEB@VISI.COM.	Yes _____	No _____.

MINNESOTA Management & Budget

ALL APPLICANTS MUST COMPLETE ITEMS 1, 2 AND 3 BELOW AND SIGN THIS PAGE.

SUBSTITUTE FORM W-9

Name (print your name clearly): ***DATE:*** _____

_____

FROM: CRIME VICTIMS REPARATIONS BOARD

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.

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.

(Check One)	(Fill in your social security number, or write "none".)
☐ Individual: Use SSN	_____ -- _____ -- _____
☐ Sole Proprietorship: Use SSN or FEIN	SOCIAL SECURITY NUMBER (SSN)
☐ Corporation: Use FEIN	_____ -- _____
☐ S Corporation	FEDERAL EMPLOYER IDENTIFICATION (FEIN)
☐ Legal Partnership: Use FEIN	_____
☐ Tax Exempt Organization: Use FEIN and list the section number of the IRS code under which you are claiming exemption: _____	MINNESOTA TAX I.D. NUMBER (IF APPLICABLE)
☐ Other: Please explain on reverse side and include a tax number.	

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

_____

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

Signature_____Phone No.:_____Date_____

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.

FOR MMB USE ONLY	TYPE	IND	TIN	USED

ALL APPLICANTS MUST COMPLETE SECTIONS 20 AND 23 FULLY AND SIGN THIS PAGE.

SECTION 20. ASSIGNMENT OF SUBROGATION RIGHTS

I agree that the Board is subrogated to the extent of reparations 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 21. 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 Reparations 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: / /

SECTION 22. 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 Reparations 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 release private and confidential data about my claim to a local Emergency Fund administrator for the purpose of coordinating benefits.

SECTION 23. MISCELLANEOUS CONSENTS/AGREEMENTS

I agree that any reparations 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 reparations.

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 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 24. VICTIM AND CLAIMANT SIGNATURES

The victim must sign and date the claim form. If the victim is deceased, under the age of eighteen, or an incapacitated adult victim, the claimant must sign and date the claim form.

I have read and understand the statements in Sections 20-23 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.

Victim/Patient Signature	Victim/Patient Printed Name	Date of Birth	Date Signed
Claimant Signature	Claimant Printed Name	Date of Birth	Date Signed
Claimant's relationship to victim		Reason victim cannot sign claim form ❒ Deceased ❒ Minor ❒ Incapacitated Adult	