Application

Minnesota Crime Victims Reparations Board

The Minnesota Crime Victims Reparations 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
- 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 Reparations 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 REPARATIONS APPLICATION FORM

Date Received:	Complete and submit to:	Claim Number:
(Office Use Only)	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 (TTY) dps.justiceprograms@state.mn.us	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 ❒	
Gender ❒ Male ❒ Female	What is the language preference of the victim and/or claimant? ❒ English ❒ Spanish ❒ Other_____		Is Victim Deceased? ❒ No ❒ 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 ❒	
Gender ❒ Male ❒ Female	Relationship to Victim ❒ Parent ❒ Spouse/Partner ❒ Former Spouse/Partner ❒ Child ❒ Sibling ❒ Grandparent ❒ 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 ❒	
Gender ❒ Male ❒ Female	Relationship to Victim ❒ Parent ❒ Spouse/Partner ❒ Former Spouse/Partner ❒ Child ❒ Sibling ❒ Grandparent ❒ Other _____		
Address	City	State	Zip Code
Phone	Email Address		

SECTION 3. REFERRAL SOURCE	How did you learn of the reparations program?		
❒ County Attorney	❒ Hospital	❒ Sexual Assault Program	❒ Website
❒ Domestic Abuse Program	❒ Police	❒ Social Services, Cleric or School	❒ Other_____
❒ Funeral Home	❒ Probation	❒ 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? ❒ Domestic or Family Violence ❒ Bullying ❒ Elder Abuse ❒ Hate Crime ❒ Mass Violence

Type of Crime (check all that apply)

❒ Assault	❒ Child Sexual Abuse	❒ Other Vehicular Crime	❒ Fraud/Financial Crime
❒ Homicide	❒ Child Pornography	❒ Stalking	❒ Terrorism
❒ Robbery	❒ Human Trafficking	❒ Arson	❒ Other
❒ Adult Sexual Assault	❒ Kidnapping		

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

Name of Offender(s) (last, first, m.i.)	Gender ❒ Male ❒ 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 ❒ American Indian/ Alaskan Native ❒ Asian	❒ Black/African American ❒ Hawaiian/Other Pacific Islander	❒ Hispanic/Latino ❒ Multi-Racial ❒ Other ❒ White	Country of Birth	Was the victim disabled prior to the crime? ❒ No ❒ Yes

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? ❒ No ❒ Yes			Are you working with an advocate? ❒ No ❒ 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? ❒ No ❒ Yes

Check all that apply

❒ Automobile Insurance ❒ Homeowner's Insurance ❒ Medicare ❒ Veteran's Benefits
❒ Dental Insurance ❒ Long/short term Disability ❒ MNSure ❒ Worker's Compensation
❒ Health Insurance ❒ Medical Assistance (MA) ❒ Social Security Disability ❒ 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.

Victim Employment Information

Were you employed on date of crime? ❒ No ❒ Yes	Were you self-employed on the date of the crime? ❒ No ❒ 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? ❒ No ❒ Yes		

Did you receive any benefits for time missed from work? ❒ No ❒ Yes

❒ Disability ❒ Workers Compensation ❒ Sick Leave ❒ Vacation Pay ❒ 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? ❒ No ❒ 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? ❒ To provide care to victim ❒ Medical/counseling appts. ❒ Emotional injury from crime		

Did you receive any benefits for time missed from work? ❒ No ❒ Yes

❒ Disability ❒ Workers Compensation ❒ Sick Leave ❒ Vacation Pay ❒ Bereavement ❒ 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. **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? ❒ No ❒ Yes		
Spouse/Partner	Address	Phone
Does the victim have dependent children under the age of 18? ❒ No ❒ Yes		

Child	Guardian	Address	Phone
Child	Guardian	Address	Phone
Child	Guardian	Address	Phone

MINNESOTA Management &Budget

400 Centennial Building
658 Cedar Street
St. Paul, MN 55155
Fax: (651) 797-1306
Vendor.mmbefax@state.mn.us

SUBSTITUTE FORM W-9

Name and Address

_____ *Date:*_____

_____ *Vendor Number:*_____

_____

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) 201-8201 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.

(Check One)	
☐ **Individual: Use SSN**	_____--____-- _____ **SOCIAL SECURITY NUMBER (SSN)**
☐ **Sole Proprietorship: Use SSN or FEIN**	
☐ **Corporation: Use FEIN**	____-- _____ **FEDERAL EMPLOYER IDENTIFICATION (FEIN)**
☐ **S Corporation**	
☐ **Legal Partnership: Use FEIN**	_____ **MINNESOTA TAX I.D. NUMBER (IF APPLICABLE)**
☐ **Tax Exempt Organization: Use FEIN and list the section number of the IRS code under which you are claiming exemption:_____**	
☐ **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.

COMPLETE SECTIONS 15 AND 18

SECTION 14. 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 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 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 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 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 17. 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 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.

Victim/Patient Signature	Victim/Patient Printed Name	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 ❒ Incapacitated Adult	

(Rev. 10/18)