Crime Victims Compensation
ND Department of Corrections
PO Box 1898 • Bismarck, ND 58502-1898
701-328-6195
Fax: 701-328-6651
1-800-445-2322 (in state only)
ND Relay TDD: 1-800-366-6888

FOR OFFICE USE ONLY

CLAIM # CVC

DATE RECEIVED

APPLICATION

SECTION I – VICTIM INFORMATION (If under 18, Parent/Guardian must complete and sign.)

VICTIM'S NAME: (Please Print)

ADDRESS:	CELL:
CITY: COUNTY:	HOME PHONE:
STATE: ZIP:	WORK PHONE:
DATE OF BIRTH:	AGE AT TIME OF INCIDENT:

SEX: ☐ Male ☐ Female MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

THE FOLLOWING IS USED TO COMPLY WITH FEDERAL REGULATIONS

Resident of North Dakota	☐ Yes	☐ No
Victim on Indian Reservation	☐ Yes	☐ No
Victim on Military Reservation	☐ Yes	☐ No
Handicapped	☐ Yes	☐ No

RACE
☐ White ☐ Black ☐ American Indian ☐ Hispanic ☐ Asian ☐ Other

REFERRED TO THE COMPENSATION PROGRAM BY:
☐ Victim Advocate ☐ Law Enforcement ☐ Medical Facility ☐ Attorney
☐ Posters/Brochures ☐ Media ☐ Other _____

SECTION II – CLAIMANT INFORMATION (Person applying, if other than victim, must complete and sign.)

CLAIMANT'S NAME: (Please Print)

ADDRESS:	HOME PHONE:
CITY, STATE, ZIP:	WORK PHONE:
RELATIONSHIP TO VICTIM:	

SECTION III – CRIME INFORMATION

CRIME REPORTED TO LAW ENFORCEMENT: ■ Yes ☐ No	DATE OF INCIDENT: TIME:
NAME OF AGENCY:	DATE INCIDENT REPORTED:
LOCATION OF INCIDENT:	

TYPE OF CRIME

DOMESTIC VIOLENCE
☐ Assault
☐ Sexual Assault
☐ Homicide
☐ Other _____

OTHER ADULT – AGE 18+
☐ Assault
☐ Sexual Assault
☐ Homicide
☐ Other _____

CHILD – AGE 17 & UNDER
☐ Sex Abuse/Assault by Family Member
☐ Sex Abuse/Assault by Non-Family Member
☐ Physical Abuse/Assault
☐ Other _____

VEHICLE RELATED
☐ Drunk Driver/DUI
☐ Hit and Run
☐ Negligent Homicide/Manslaughter
☐ Aggravated Reckless Driving

DESCRIPTION OF INCIDENT: *(add pages if necessary)*

OFFENDER'S NAME:

OFFENDER'S RELATIONSHIP TO VICTIM:

NAME(S) OF WITNESS(ES) AND COMPLETE ADDRESS(ES): *(add pages if necessary)*

SECTION IV – EMPLOYMENT INFORMATION

ARE YOU, THE VICTIM, REQUESTING LOST WAGES AS A RESULT OF CRIME RELATED INJURIES?
☐ Yes ☐ No If Yes, complete Section IV. If No, go to Section V.

EMPLOYER'S BUSINESS NAME:	CONTACT PERSON & PHONE NO.:
STREET ADDRESS:	CITY, STATE, ZIP:

DATES ABSENT FROM WORK DUE TO CRIME-RELATED INJURIES. FROM THROUGH

DID YOU RECEIVE, OR ARE YOU ENTITLED TO RECEIVE ANY BENEFITS WHILE ABSENT FROM WORK? ☐ Yes ☐ No
☐ Disability ☐ Workers Compensation ☐ Sick Leave ☐ Vacation Pay ☐ Other (explain) _____

SECTION V – MEDICAL INFORMATION

ARE YOU, THE VICTIM, REQUESTING PAYMENT FOR MEDICAL/THERAPY BILLS FROM CRIME RELATED INJURIES? ☐ Yes ☐ No

PHYSICIAN/HOSPITAL ETC.	DATES OF SERVICE	AMOUNT OF BILL
		$
		$
		$

SECTION VI – RESOURCES FOR MEDICAL BILL PAYMENT

DO YOU HAVE OR ARE YOU ENTITLED TO RECEIVE ANY OF THE FOLLOWING MEDICAL RESOURCES? ☐ Yes ☐ No
☐ Medical/Health Insurance ☐ Public/Indian Health Service ☐ Medicaid/Medical Assistance ☐ Medicare ☐ Veteran's ☐ Workers Comp.
☐ Vehicle Insurance (If vehicle involved in incident) ☐ Other (explain) _____

If you marked Medical or Vehicle Insurance, please list insurance company name, address, and policy number.

MEDICAL INSURANCE: Name_____ Address_____ Policy Number_____

VEHICLE INSURANCE: Name_____ Address_____ Policy Number_____

SECTION VII – FUNERAL INFORMATION

ARE YOU REQUESTING FUNERAL BENEFITS FOR A DECEASED VICTIM? ☐ Yes ☐ No

If Yes, have the funeral expenses been paid? ☐ Yes ☐ No *(Attach copy of bill/receipt)*

WERE THERE ANY OF THE FOLLOWING RESOURCES? ☐ Yes ☐ No
☐ Social Security ☐ Burial Insurance ☐ Life Insurance ☐ Veterans Insurance ☐ Other_____

WHO RECEIVED THE BENEFITS? _____ Amount Received: _____

RELATIONSHIP TO VICTIM: _____

IF APPROPRIATE, PLEASE LIST DEPENDENTS, WITH ADDRESSES ON AN ADDITIONAL SHEET, AND THE EXTENT TO WHICH EACH WAS DEPENDENT UPON THE VICTIM FOR CARE AND SUPPORT.

SECTION VIII – AUTHORIZATION - DECLARATION

AUTHORIZATION I hereby authorize any hospital, physician, medical facility, insurer, employer or any other person or agency who has knowledge relative to my claim to furnish information to the North Dakota Crime Victims Compensation Program.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS EFFECTIVE AND VALID AS THE ORIGINAL

DECLARATION I must inform Crime Victims Compensation, in writing, of any impending civil suit. I understand that any recovery of my losses through legal action/insurance shall be reimbursed to the extent of any compensation awarded me. I swear that the information contained herein is true to my best knowledge and I understand that the filing of false information shall be a Class A misdemeanor punishable by a $2000 fine and/or 1 year imprisonment.

SIGNATURE: (Victim or Claimant) DATE: (No Expiration)