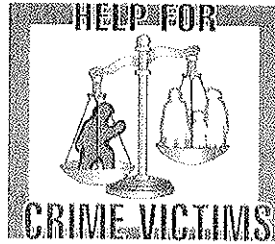


**Crime Victims Compensation**  
**ND Department of Corrections**  
 PO Box 1898 • Bismarck, ND 58502-1898  
 701-328-6195  
 Fax: 701-328-6651  
 1-800-445-2322 (in state only)  
 ND Relay TDD: 1-800-366-6888



**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      RACE  White  Black  American Indian  Hispanic  Asian  Other

Victim on Indian Reservation  Yes  No

Victim on Military Reservation  Yes  No      REFERRED TO THE COMPENSATION PROGRAM BY:  Victim Advocate  Law Enforcement  Medical Facility  Attorney

Handicapped  Yes  No       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: \_\_\_\_\_

<b>TYPE OF CRIME</b> <u>DOMESTIC VIOLENCE</u> <input type="checkbox"/> Assault <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Homicide <input type="checkbox"/> Other _____	<u>OTHER ADULT – AGE 18+</u> <input type="checkbox"/> Assault <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Homicide <input type="checkbox"/> Other _____	<u>CHILD – AGE 17 &amp; UNDER</u> <input type="checkbox"/> Sex Abuse/Assault by Family Member <input type="checkbox"/> Sex Abuse/Assault by Non-Family Member <input type="checkbox"/> Physical Abuse/Assault <input type="checkbox"/> Other _____	<u>VEHICLE RELATED</u> <input type="checkbox"/> Drunk Driver/DUI <input type="checkbox"/> Hit and Run <input type="checkbox"/> Negligent Homicide/Manslaughter <input type="checkbox"/> Aggravated Reckless Driving
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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  NoIf 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)