

Maryland Criminal Injuries Compensation Board (CICB)
 Department of Public Safety and Correctional Services • 6776 Reisterstown Rd, Ste. 206 • Baltimore, MD 21215
 410-585-3010 • 1-888-679-9347 • (fax) 410-764-3815 •
http://www.dpscs.state.md.us/victimservs/commitment/main_pages/vs-cicb.shtml

APPLICATION FOR CRIME VICTIM COMPENSATION

(Please print clearly and complete the entire form)

SECTION 1: VICTIM INFORMATION		VICTIM'S FULL NAME:				Soc. Security No.
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____ (MM/DD/YY)	Primary Language	Marital Status	Safe Telephone Number	Email Address	
Current Address:					County:	

SECTION 2: CLAIMANT INFORMATION		CLAIMANT'S FULL NAME (If claimant is the same as victim, write "SELF")				Soc. Security No.*
Relationship to Victim _____ (Check all that apply)						
<input type="checkbox"/> Parent of a Minor Child <input type="checkbox"/> Legal Guardian of Victim <input type="checkbox"/> Person Responsible for Crime-Related Expenses <input type="checkbox"/> Secondary Victim						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____ (MM/DD/YY)	Primary Language	Marital Status	Safe Telephone Number	Email Address	
Current Address:					County:	

* Under authority of the Tax Reform Act of 1976, 42 U.S.C. § 405(c)(2)(C)(i), CICB requires that if a claimant has a Social Security Number, it must be provided for verification of payment of Maryland state taxes or other debts owed to the State. Social Security Numbers are also useful to CICB for verifying medical bills & benefits, wages, social security benefits, and workers' compensation benefits. CICB's use of your Social Security Number for these additional purposes can help speed up the processing of your claim. Please indicate by initialing below whether you wish to permit CICB to use your Social Security Number for these other verification purposes:

_____ I agree to permit CICB to use my Social Security Number for the additional purposes listed above.

_____ I do not agree to permit CICB to use my Social Security Number for any purpose other than verification of payment of Maryland state taxes or other debts owed to the State.

SECTION 3: CRIME INFORMATION		Date and Time of Crime ____/____/____ TIME : <input type="checkbox"/> AM <input type="checkbox"/> PM (MM/DD/YY)		Date and Time Reported to Authorities ____/____/____ TIME : <input type="checkbox"/> AM <input type="checkbox"/> PM (MM/DD/YY)	
Location of Crime (street address, if known)					
City	County	State	Police Department	Police Report No.	
Detective Name		Phone Number		Court Where Case Is Pending	
Court Case No.		Name of Person(s) Who Committed Crime (if known)		Did the crime involve a motor vehicle?	
Relation: _____		Relation: _____		Relation: _____	
Relation: _____		Relation: _____		Relation: _____	
Relation: _____		Relation: _____		Relation: _____	
Relation: _____		Relation: _____		Relation: _____	
Description of Crime: (If necessary, attach separate paper)					

SECTION 4: MEDICAL EXPENSES

If requesting reimbursement for medical expenses, attach ALL itemized bills and ALL itemized insurance statements. PLEASE NOTE: All claimants except those with private insurance, must apply for and receive a determination from Medical Assistance and Charity Care (if appropriate) before CICB will process your application.

Description of Injuries:

List or attach on a separate sheet the names, addresses, and phone numbers of ALL hospitals, doctors, dentists, and treatment providers:

Did you receive benefits from medical insurance? Yes No If no, have you applied for medical insurance? Yes No

Carrier: Policy Number: Group No: Amount Paid:

Did you receive benefits from medical assistance? Yes No If no, have you applied for Medical Assistance? Yes No

Account Number:

Did you receive social services benefits? Yes No If no, have you applied for social service benefits? Yes No

Amount Paid:

SECTION 5: COUNSELING EXPENSES

If the victim or the claimant is filing for counseling expenses, attach ALL itemized bills and ALL itemized insurance statements.

Are counseling expenses for the victim?

 Yes No If no, name of the person claiming counseling expenses:

List names, addresses, and phone numbers of treatment providers:

SECTION 6: LOSS OF EARNINGS

Complete if the victim or claimant is filing for loss of earnings. CICB may consider loss of earnings by the claimant, the victim, or a person who provided support to the victim or claimant.

As a result of the crime, did the victim, claimant, or a party supporting the victim or claimant miss work or lose pay due to:

Crime-related physical injuries? Yes NoCrime-related mental injuries? Yes No

Dates Absent from Work (MM/DD/YY):

FROM ___/___/___ TO ___/___/___

Physician certification is only needed when filing for loss of earnings due to injury. Provide a copy of certification from the treatment provider certifying the dates that the victim or the claimant was unable to work as the result of the injury.

Name of Treatment Provider Certifying Inability to Work

Name

Address

City

State

Zip

Phone Number

Employment Information

Employer Name:

Employer Address

Contact and Phone Number

Provide Copies of the Following: Pay stubs immediately prior to the crime AND copies of your W-2 statements or 1099 statements OR copies of your most recently filed IRS tax returns

Did you receive workers' compensation benefits? Yes No -If no, have you applied for worker's compensation? Yes No

Carrier: Claim Number: Amount Paid:

Did you receive vacation, annual, sick, or personal pay (Circle)? Yes No Amount Paid:

SECTION 7: DISABILITY

Complete this section only if the victim or claimant is seeking compensation for a disability caused by the crime. CICB may consider loss of earnings by the victim when considering disability. When completing this section, you must complete Section 6 of this application.

Which of the following statements best describes your disability:

- I am still recovering and I cannot work, but I expect to return to work at some point. (Temporary Total Disability)
- I have returned to work, but I am still recovering from my disability. I am only able to perform limited or part-time work. (Temporary Partial Disability)
- I am no longer recovering and have returned to work, but I am limited in what I can do. I will not completely return to the abilities that I had before. (Permanent Partial Disability)
- I am no longer recovering, but I am still unable to return to work. I will not completely return to the abilities that I had before. (Permanent Total Disability)

Description of Your Disability:

Did you receive Social Security Disability Benefits? Yes No If no, have you applied for Social Security Disability? Yes No
Carrier: Policy Number: Amount Paid:

SECTION 8: LOSS OF SUPPORT

Complete only if the victim or the claimant is filing for loss of support. CICB may consider loss of support when the claimant or victim lost financial support as the result of this crime. Loss of support can result from the death or in some cases the incarceration of the individual providing support. When completing this section, you must complete Section 6 of this application as it applies to the individual from whom you are claiming dependency.

Name of Dependent	Date of Birth (MM/DD/YY)	Relationship to Victim

If you are claiming loss of support, please provide copies of the following documents:

- Copies of court orders for child or spousal support
- Statements for any benefits received as a result of the death, e.g. life insurance, veteran's benefits, pension benefits
- Birth certificates for dependent children
- Guardianship documents, if someone other than the parent of a child is filing for a claimant
- Marriage certificates for spousal support claims
- Statement regarding determination of your eligibility for Social Security Survivor benefits

Did you receive Social Security Survivor benefits? Yes No Amount Paid:
If no, have you applied for Social Security Survivor benefits? Yes No

SECTION 9: FUNERAL EXPENSES

Complete if the victim or the claimant is filing for funeral expenses. Monetary limits apply.

Please provide a copy of the death certificate and all funeral bills and receipts in the name of the claimant.

Name of Funeral home:		Name of Decedent:	
Address of Funeral Home:			Telephone Number:
Total Funeral Expenses:	Amount Paid by Claimant:	Amount Paid by Others:	Amount Due:
Did you receive Social Security Income or Death Benefits?		Amount Paid:	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did you or do you expect to receive life insurance benefits?		Amount Paid:	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Carrier:	Policy Number:	Amount Paid:	

SECTION 10: OTHER EXPENSES INCURRED**You may also be eligible for the benefits listed below. Monetary limits apply.**

If you have had to clean a crime scene, you may be eligible for compensation. Did you incur any expenses related to crime scene clean-up?

 Yes No If yes, please provide receipts.**SECTION 11: VICTIM STATISTICAL INFORMATION****The following information is used for statistical purposes only. The submission of this information is strictly voluntary.****Race. In which category, or categories, do you feel that you belong?**

- White, European American Black, African American Hispanic, South or Central American
 American Indian/Alaska Native Asian/Pacific Islander Biracial or Multiracial Other _____

Disability. Are you a person living with a disability? Yes NoIf yes, what is the nature of the disability? Physical Mental Developmental**Referral Source. Who referred you to the Criminal Injuries Compensation Board?**

- Hospital Prosecutor Police Victim Service Program Poster/Brochure Attorney Other

SECTION 12: REPRESENTATION BY OTHERS**If you, as the victim or claimant, are being represented by any other person or entity in this claim and want CICB to communicate with that person or entity with regard to your claim, please complete the information below.**

ATTORNEY INFORMATION (Not States' Attorney)			VICTIM SERVICE PROVIDER INFORMATION		
Are you represented by an attorney:			Did a victim advocate or victim service provider assist you in completing this form or is a victim service provider assisting you with other matters related to this crime?		
In filing this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
In a civil lawsuit related to this crime? <input type="checkbox"/> Yes <input type="checkbox"/> No					
In an insurance action related to this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No					
In the criminal justice system? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of Attorney			Name of Victim Service Provider:		
Name of Firm or Organization			Name of Victim Service Program or Agency		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Telephone Number	Fax Number		Telephone Number	Fax Number	
Email Address			Email Address		
Did you receive other financial benefits as a result of the crime that you haven't listed otherwise? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Type of Benefit Received:			Amount Paid:		
My signature below signifies that the attorney(s) and/or victim service provider(s) listed above are my representatives for the purposes of this claim. As such, the Maryland Criminal Injuries Compensation Board has my permission to share information with, request information from, and discuss this claim with the attorney(s) and/or victim service provider(s) listed above. I also understand that if I wish to revoke this authorization, I may do so, in writing, to the Maryland Criminal Injuries Compensation Board (CICB) at any time.					
_____			_____		
Claimant's Signature			Date		

SECTION 13: AUTHORIZATION TO OBTAIN INFORMATION**Please read and sign this Authorization for the CICB to obtain Information on your behalf.**

I hereby authorize the release of the following information to the Maryland Criminal Injuries Compensation Board:

- Any funeral records, or related service records, pertaining to the crime stated in the claim above.
- Any verification of employment from the employer listed previously on this application.
- Any medical bill or statement of services provided, pertaining to the crime stated in the claim above. PLEASE NOTE: The Maryland Criminal Injuries Compensation Board will not seek to obtain, or obtain, any medical records related to this claim without expressly notifying you of the request and asking you to sign a separate release of information.
- Any police record or record of another governmental entity, including State and federal taxing authorities, pertaining to the crime stated in the claim above.
- Any financial statement of benefits already paid to the victim or claimant pertaining to the crime stated in the claim above.

I also understand that if I wish to revoke this authorization, I may do so, in writing to the Maryland Criminal Injuries Compensation Board, at any time

Claimant's Signature

Date
SECTION 14: ACKNOWLEDGEMENT AND REIMBURSEMENT AGREEMENT**Please read and sign this Acknowledgement and Reimbursement Agreement.**

The claimant understands that the Maryland Criminal Injuries Compensation Board (CICB) is the payer of last resort. If an award is granted, the claimant specifically agrees to inform the CICB of and to repay the State of Maryland for any funds that the claimant receives from any other source that has not already been considered. The claimant agrees to repay any funds that the claimant receives from the offender, any other person or source, including any award for pain and suffering. An award creates a lien in favor of the State of Maryland.

The claimant further agrees, understands and is put on notice that if the claims, or the statements made in this application, are determined to be intentionally in error, false, or fraudulent, the claimant may be considered to have committed perjury and as a result may be disqualified from receiving CICB benefits and may be required to refund to the CICB all money paid by CICB on the claimant's behalf.

Claimant's Signature

Date