

## NEBRASKA CRIME VICTIM'S REPARATIONS CLAIMANT COMPENSATION REQUEST

As a person impacted by crime, filling out the following form may be triggering, please read carefully. Please reach out to your local victim advocacy program to help complete this form if necessary. To expedite the processing of your claim for compensation, be sure to submit the required information listed below. When all the necessary information is received, your claim will be carefully considered and then brought before the Hearing Officer for a decision. You will be notified by mail of the Hearing Officer's decision. **If you have a change of address, you must** notify the Crime Victim's Reparations (CVR) program by phone, email, fax, or mail.

Please submit the claim application via email, fax, or mail. The CVR mailing address, fax, and email is listed below.

**IMPORTANT:** Any person who knowingly makes a false claim shall be guilty of a Class I misdemeanor.

### Nebraska Crime Victim's Reparations Program

PO Box 94946  
Lincoln, NE 68509-4946  
Phone 402.471.2828  
Fax 402.471.2837

OR via email

ncc.cvr@nebraska.gov

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**In order to process your claim for compensation, the following information is required:**

1. The **Claim for Compensation** form must be thoroughly and accurately completed.
2. The **Release of Information** form (page 8) must be signed and dated.
3. The **Attestation** form (page 9) must be completed and signed.
4. Required attachments for requesting compensation for **Medical Expenses, Funeral Expenses, and/or Loss of Wages:**
  - a. **Medical Expenses:** Submit itemized copies of medical bills related to the incident with this claim form.
  - b. **Funeral Expenses:** Submit an itemized copy of the funeral bill **AND** a copy of the death certificate with this claim form.
  - c. **Loss of Wages:**
    - 1) A copy of the doctor's release stating the exact date you were released to return to work
    - 2) Copies of three payroll stubs from just prior to the incident
    - 3) If you are self-employed, a copy of the income tax return correlating with incident date to determine what you are making at the time. (incident in 2019, need tax return for 2019 fiscal year)

**NOTE:** You are responsible for bills relating to the incident. If you make payments on the bills, and if your claim is approved, you may be reimbursed. You are responsible for contacting service providers and notifying them that you have filed a claim with the Crime Victim's Reparations program.

If you have questions or concerns, please contact our office at (402) 471-2828 or the victim assistance program in your area.



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[NCC.CVR@nebraska.gov](mailto:NCC.CVR@nebraska.gov)

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Lincoln, NE 68509-4946  
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Section 1: Victim Information			
Full Name <i>(First, Middle Initial, Last)</i>		Social Security Number	
Address		City & State	Zip
Telephone Number	Date of Birth	Sex of Victim <i>(If applicable, please write other identity and/or preferred pronouns.)</i> <input type="checkbox"/> Male <input type="checkbox"/> Female or Other/ Preferred Pronouns: _____	
Occupation at Time of Incident <i>(if unemployed, enter "UNEMPLOYED")</i>		Place of Employment at Time of Incident <i>(Enter "N/A" if unemployed)</i>	
Marital Status	If Married, Spouse's Name	Number of Dependents	
<p><b>Federal Civil Rights Information:</b></p> <p>To comply with Federal regulations, The Department of Justice requires us to collect the following data. This information is used for statistical purposes only and will remain confidential.</p> <p style="text-align: center;"><b><i>This information relates to the victim only.</i></b></p> <p><b>Ethnic Group:</b></p> <p> <input type="checkbox"/> American Indian/Alaska Native              <input type="checkbox"/> Asian              <input type="checkbox"/> Black/African American              <input type="checkbox"/> Hispanic/Latino  <input type="checkbox"/> Native Hawaiian/Other Pacific Islander              <input type="checkbox"/> White Non-Latino/Caucasian              <input type="checkbox"/> Some Other Race         </p> <p>Country of Birth: _____</p>			
Was the victim disabled prior to this crime? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the victim disabled as a result of this crime? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If deceased, victims place of death <i>(City &amp; State)</i>		Date of Death <i>(submit copy of Death Certificate)</i>	

COMPLETE INFORMATION ON NEXT PAGE

**Section 2: Claimant Information**

Complete this section if **YOU** (Claimant) are filing for a victim who is deceased, incapable, or a minor under age 18 **OR** if you have incurred an actual financial loss as a direct result of the crime.

Claimant Full Name (First, Middle Initial, Last)	Claimant Social Security Number
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Claimant Address	City & State	Zip
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Claimant Telephone Number	Claimant Date of Birth	Sex of Claimant (If applicable, please write other identity and/or preferred pronoun below.) <input type="checkbox"/> Male <input type="checkbox"/> Female Other/Preferred Pronouns: _____
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Claimant Marital Status	Claimant Occupation	Claimant Place of Employment
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Claimant's Relationship to Victim:  
 Spouse  Parent  Child  Other (Explain): \_\_\_\_\_

Are you dependent on the victim?  
 No, I am not dependent on the Victim. *SKIP SECTION 3*

Yes, dependent on Victim for the below:  
 Principal Support  Child Support  Child  Other (Explain): \_\_\_\_\_

**Section 3: Minor/Dependent of Victim Information** \* A separate claim form is needed for each minor/dependent. \*

Complete this section if the claim is being made for a minor or loss of support for a dependent of the victim.

**REQUIRED:** Attach a copy of the victim's income tax return for the previous year.

Minor/Dependent Full Name		Minor/Dependent SSN
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Address	City & State	Zip
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Telephone Number	Date of Birth	Sex of Minor/Dependent <input type="checkbox"/> Male <input type="checkbox"/> Female or Other/ Preferred Pronouns: _____
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Minor's/Dependent's Relationship to Victim:  
 Child  Parent  Other (Explain): \_\_\_\_\_

Full Name of Person Having Legal Custody of Minor/Dependent	Custodian's Telephone Number
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Custodian's Address	City & State	Zip
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What other benefits were and are being received for the support of the minor/dependent?

Temporary Assistance for Families in Need (TANF)  Social Security  Supplemental Security Insurance (SSI)  Medicare  
 Medicaid  Other (Explain): \_\_\_\_\_

Section 4: Attorney Information <i>(if applicable)</i>		
Attorney Name		
Attorney Business Address	City & State	Zip
Attorney Telephone Number		Attorney Tax ID# or Social Security Number

Section 5: Crime Information		
Date of Crime	Time Crime Occurred <input type="checkbox"/> AM <input type="checkbox"/> PM	Where did crime occur? (City and approximate location)
Date Crime Reported		Name of Who Reported the Crime
Police Report and/or Incident Report# <i>(if available)</i>		What Law Enforcement Agency was the Crime Reported to?
<b>Crime Type</b> <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Child Sexual Abuse <input type="checkbox"/> Child Physical Abuse <input type="checkbox"/> Domestic Assault <input type="checkbox"/> Assault <input type="checkbox"/> Homicide <input type="checkbox"/> DUI/DWI <input type="checkbox"/> Other <i>(please specify)</i> _____		
Was the crime committed by a family member or person living with the victim? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was the crime related to any of the following in the law enforcement findings? <input type="checkbox"/> Bullying <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Elder Abuse/Neglect <input type="checkbox"/> Hate Crime <input type="checkbox"/> Mass Violence		
Who Committed the Crime <i>(if known)</i>		

**Section 5: Crime Information (continued)**

Provide a brief description of the crime in your own words (continue on a separate page if needed):

**Section 6: Loss of Wage Information**

Complete this section if YOU are the victim **AND** are claiming wage loss due to the crime/incident.

**Loss of Wage will only be considered if more than seven (7) days are missed from work.**

Name of Victim's Employer		Employer's Telephone Number	
Employer's Business Address		City & State	Zip
Dates Absent from Work Due to Crime Related Injuries Start Date:                      End Date:		Did you miss more than seven (7) days of work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Released from Doctor's Care

Did you receive any payment from sources such as sick pay, vacation pay, Worker's Compensation, etc. while you were absent from work for crime related injuries?  Yes  No

If yes, please explain:

**Remember to include:**

- 1) Doctor's Release Note *and* three (3) most recent Payroll Stubs from your job, just prior to the incident *or* (if Self-Employed) submit Corresponding Year's Tax Return, Copies of Estimates, Bids, and/or Contracts

**Section 7: Amount of Your Claim**

- You do not need to wait until all medical bills are received before completing this section.
- Enter amounts for the bills currently received that are related to the crime.

1. Total of Hospital Bills	\$
2. Total of Doctors' Bills	\$
3. Ambulance Cost	\$
4. Total of Prescription (drug) Bills <i>(Other than those billed at the Hospital)</i>	\$
5. Mental Health Expenses	\$
6. Funeral Expenses	\$
7. Lost Wages	\$
8. Other Expenses <i>(i.e., Crime Scene Clean Up)</i>	\$
<b>Total Amount</b>	\$

Will there be additional medical bills?  Yes  No  Unknown

**Section 8: Medical Compensation Request**

*Does the victim have coverage or benefits available from any of the following? Check all applicable boxes.*

Does the victim have coverage or benefits available from any Sources of Compensation below?

Yes *(below, check all that apply)*  No

**Source of Compensation:**

Health Insurance  Medicaid  Medicare  Worker's Compensation

Other *(please specify)* \_\_\_\_\_

Has the victim received any money from the above Sources of Compensation to pay for expenses related to the crime?

Yes  No

If answering Yes to coverage or benefits, please enter the applicable information below:

Health Insurance Company/Number

Medicaid Plan/Number

Medicare Plan/Number

Worker's Compensation Information (Who should CVR contact?)

Other *(please specify)*

## Nebraska Crime Victim's Reparations Program Authorization to Release Information

This authorization is an integral part of your application and must be **signed and dated by the victim or claimant** before any action will be taken on your claim.

### **AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize any hospital, physician, medical facility, mental health provider or other person who attended or examined the victim; any funeral home or other person who rendered services; any employer of the victim; any law enforcement or other state/federal governmental agency; and any insurance company or organization having knowledge, to furnish the Nebraska Crime Victim's Reparations program or its representative, confidential information with respect to the incident leading to the victim's personal injury or death and the claim made herewith for compensation. Per 45 CFR 164.506, The Nebraska Crime Victim's Reparations program is a potential payor and this release of information will be used to determine eligibility for the purpose of adjudicating claims. A photocopy of this signed release is as effective and valid as the original.

I furthermore understand that any recovery of my losses through restitution/reimbursement from the offender, a civil suit, insurance or from any other governmental or private agency shall entitle the Nebraska Crime Victim's Reparations program to be reimbursed for any compensation awarded me by the Nebraska Crime Victim's Reparations program. The undersigned swears or affirms the information contained herein is true to his/her best knowledge. **I understand that the filing of false information is an offense punishable by law.**

\_\_\_\_\_  
**Victim or Claimant Signature**

(Parent/Guardian if victim/Claimant/dependent is a minor)

\_\_\_\_\_  
**Victim or Claimant Printed Name**

(Parent/Guardian if victim/Claimant/dependent is a minor)

\_\_\_\_\_  
**Date**



**UNITED STATES CITIZENSHIP ATTESTATION**

**For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:**

I am a citizen of the United States.

**-OR-**

I am a qualified alien under the federal Immigration and Nationality Act **AND** I agree to provide a copy of my USCIS documentation. (Enter Immigration Status and Alien Number below)

**My immigration status is:** \_\_\_\_\_

**My alien number is:** \_\_\_\_\_

**I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.**

**PRINT NAME:** \_\_\_\_\_  
(First, Middle, Last)

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_