# NEBRASKA CRIME VICTIM'S REPARATIONS
# CLAIMANT COMPENSATION REQUEST

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 investigated 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** program by phone or mail.

**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
P 402.471.2828
F 402.471.2837
**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) Statement from your employer providing:
            - Your hourly wage
            - Number of hours you work each week
            - Dates of work you missed due to the incident
            - Any type of compensation you receive (i.e. sick leave, vacation, unemployment, etc.)
        4) 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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| **Section 1: Victim Information** | | | |
|---|---|---|---|
| **Full Name** *(First, Middle Initial, Last)* | | | **SSN** |
| **Address** | | **City & State** | **Zip** |
| **Telephone Number** | **Date of Birth** | **Sex of Victim** ☐**Male** ☐**Female** ☐**Other** | |
| **Occupation at Time of Incident** *(if unemployed, enter "UNEMPLOYED")* | | **Place of Employment at Time of Incident** *(Enter "N/A" if unemployed)* | |
| **Marital Status** | **If Married, Spouse's Name** | | **Number of Dependents** |

**Federal Civil Rights Information:**

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.

***This information relates to the victim only.***

**Ethnic Group:**

☐ **American Indian/Alaska Native** ☐**Asian** ☐ **Black/African American** ☐ **Hispanic/Latino**

☐ **Native Hawaiian/Other Pacific Islander** ☐**White Non-Latino/Caucasian** ☐ **Some Other Race**

**Country of Birth:** _____

| **Was the victim disabled prior to this crime?** | **Is the victim disabled as a result of this crime?** |
|---|---|
| ☐ **Yes** ☐ **No** | ☐ **Yes** ☐ **No** |
| **If deceased, victims place of death** *(City & State)* | **Date of Death** *(submit copy of Death Certificate)* |

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** | | | **Claimant SSN** |
|---|---|---|---|
| **Claimant Address** | | **City & State** | **Zip** |
| **Claimant Telephone Number** | **Claimant Date of Birth** | **Claimant Sex** ☐**Male** ☐**Female** ☐**Other** | |
| **Claimant Marital Status** | **Claimant Occupation** | **Claimant Place of Employment** | |

**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** |
|---|---|---|---|
| **Minor/Dependent Address** | | **City & State** | **Zip** |
| **Minor/Dependent Telephone Number** | **Minor/Dependent Date of Birth** | **Minor/Dependent Marital Status** | **Sex of Minor/Dependent** ☐**Male** ☐**Female** |

**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** |
|---|---|---|
| **Custodian's Address** | **City & State** | **Zip** |

**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*): _____

COMPLETE INFORMATION ON NEXT PAGE

| **Section 4: Attorney Information** ***(if applicable)*** | | |
|---|---|---|
| **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** **AM / PM** | **Where did crime occur? (City and approximate location)** |
| **Date Crime Reported** | | **Name of Who Reported the Crime** |
| **Police Report and/or Incident Report#** (*if available*) | | **What Law Enforcement Agency was the Crime Reported to?** |

**Crime Type**

☐ **Sexual Assault** ☐ **Child Sexual Abuse** ☐ **Child Physical Abuse** ☐ **Domestic Assault**

☐ **Assault** ☐ **Homicide** ☐ **DUI/DWI** ☐ **Other** (*please specify*) _____

**Was the crime committed by a family member or person living with the victim?** ☐ **Yes** ☐ **No**

**Was the crime related to any of the following:**

☐ **Bullying** ☐ **Domestic Violence** ☐ **Elder Abuse/Neglect** ☐ **Hate Crime** ☐ **Mass Violence** ☐ **N/A**

**Who Committed the Crime** (*if known)*

COMPLETE INFORMATION ON NEXT PAGE

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

**Provide a brief description of the crime in your own words:**

**Section 6: Loss of Wage Information**

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

| **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**<br>**Start Date:** **End Date:** | **Number of Days or Hours Missed**<br>_____ **Hours** _____ **Days** | **Date Released from Doctor's Care** *(attach doctor's release)* |
|---|---|---|

**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:**

**To accurately determine loss of wage, attach these *REQUIRED* documents:**

**1) Doctor's Release Note**

***AND***

**2) *THREE* most recent Payroll Stubs from your Place of Employment**

***OR***

**If Self-Employed, submit Corresponding Year's Tax Return, Copies of Estimates, Bids, and/or Contracts**

COMPLETE INFORMATION ON NEXT PAGE

**Section 7: Amount of Your Claim**

- *Do not need to wait until all medical bills are received before completing this section.*
- *Enter Total 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** | **$** |
| **4. Total of Prescription (drug) Bills** (Other than those billed at the Hospital) | **$** |
| **5. Mental Health Expenses** | **$** |
| **6. Funeral Expenses** | **$** |
| **7. Lost Wages** | **$** |
| **8. Other Expenses** | **$** |
| **TOTAL AMOUNT OF CLAIM :** | **$** |

**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 Yes, update Source of Compensation information below:**

| | |
|---|---|
| **Health Insurance Company Name** | **Health Insurance Policy Number** |
| **Medicaid** | **Medicaid Number** |
| **Medicare** | **Medicare Number** |
| **Worker's Compensation** | **Worker's Compensation Claim Number** |
| **Other** (*please specify*) | |

COMPLETE INFORMATION ON NEXT PAGE

## 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**

COMPLETE INFORMATION ON NEXT PAGE

## 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:** _____

COMPLETE INFORMATION ON NEXT PAGE