CRIME VICTIM'S REPARATION CLAIM FORM INSTRUCTIONS

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

1. The claim for compensation must be thoroughly and accurately completed.
2. The signature on the compensation form must be notarized.
3. The attestation form (page 8) must be completed.
4. If you are claiming compensation for medical expenses, itemized copies of medical bills related to the incident should be included with the claim form.
5. If you are claiming compensation for funeral expenses, an itemized copy of the funeral bill and a copy of the death certificate should be included with the claim form.
6. If you are the victim, and you are claiming loss of wages, the following must be submitted with the claim form:
    a. A copy of the doctor's release stating the exact date you were released to return to work
    b. Copies of the three payroll stubs from just prior to the incident
    c. Statement from your employer providing
        i. Your hourly wage
        ii. Number of hours you work each week
        iii. Dates of work you missed due to the incident
        iv. Any type of compensation you received (i.e. sick leave, vacation, unemployment, etc.)
    d. If you are self-employed, a copy of the previous year's income tax return

To expedite the processing of your claim, be sure to submit the required information listed above. 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.

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.

If you have a change of address, you must notify the Crime Victim's Reparations program at (402) 471-2828 or write to:

Nebraska Crime Victim's Reparations Program
PO Box 94946
Lincoln, NE 68509-4946

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

If at any time you have a question, please call (402) 471-2828.

COMPLETE INFORMATION ON NEXT PAGE

NEBRASKA CRIME VICTIM'S REPARATIONS COMMITTEE CLAIM FOR COMPENSATION

Section 1. VICTIM INFORMATION (All applicants MUST complete this section)

Name (Last) (First) (Middle Initial)			Social Security Number
Street or Other Mailing Address		City	State Zip Code
Telephone Number ( )	Date of Birth	Age at Time of Incident	Sex: ☐ Male ☐ Female
Occupation at Time of Incident		Place of Employment at Time of Incident	
Marital Status	If Married, Spouse's Name		Number of Dependents

FEDERAL CIVIL RIGHTS INFORMATION: The Department of Justice requires us to collect the following data and it is needed to comply with Federal regulations. This information is used for statistical purposes only and will remain confidential.

(Information relates to victim only)

Ethnic Group:

_____ American Indian/ Alaskan Native

_____ Asian

_____ Black/African American

_____ Hispanic or Latino

_____ Native Hawaiian or Other Pacific Islander

_____ White Non-Latino/Caucasian

_____ Some Other Race

National Origin: _____ (Country of Birth)

Was the victim handicapped before this crime occurred? ☐ No ☐ Yes (Explain)	Is the victim handicapped as a result of this crime? ☐ No ☐ Yes (Explain)
Deceased victim's place of death (City/State)	Date of Death (Send Copy of Death Certificate)

COMPLETE INFORMATION ON NEXT PAGE

Section 2. CLAIMANT INFORMATION

Complete this section if **YOU** are filing the claim 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.

Your Name (Last) (First) (Middle Initial)			Your Social Security Number
Your Street or Other Mailing Address		City	State Zip Code
Your Telephone number ( )	Your Date of Birth	Your Marital Status	Your Sex: ☐ Male ☐ Female
Your Occupation		Your Place of Employment	
Your relationship to the victim: ☐ Spouse ☐ Parent ☐ Child ☐ Other (Explain)			
Are you dependent on the victim for: ☐ Principal Support ☐ Child Support ☐ Not Dependent on Victim ☐ Other (Explain)			

COMPLETE INFORMATION ON NEXT PAGE

Section 3. INFORMATION ABOUT THE MINOR and/or DEPENDENT OF VICTIM

Is this claim being made for a minor or dependent of the victim? ☐ Yes ☐ No

If the claim is being made for a **minor** or loss of support for a dependent of the victim please complete this section.

If there are multiple minors/dependents of the victim, a separate claim form is needed for each minor/dependent.

In addition, a copy of the victim's income tax return for the previous year is needed.

Name (Last) of Minor/Dependent (First) (Middle Initial)			Social Security Number of Minor/Dependent
Current Street or Other Mailing Address of Minor/Dependent City			State Zip Code
Current Telephone Number of Minor/Dependent ( )	Date of Birth of Minor/Dependent	Marital Status of Minor/Dependent	Sex of Minor/Dependent: ☐ Male ☐ Female
Relationship of Minor/Dependent to Victim: ☐ Child ☐ Parent ☐ Other (Explain)			
Name, Address, and Telephone Number of person having legal custody:			
What other benefits were and are being received for the support of the minor/dependent(s): ☐ Welfare for child/dependent ☐ Social Security ☐ Supplemental Security Insurance (SSI) ☐ Medicare ☐ Medicaid Other_____			

Section 4. ATTORNEY INFORMATION

Attorney, if any:	
Attorney's Business Address City State Zip Code	
Attorney's Telephone Number	Attorney's Social Security Number or Tax ID #

COMPLETE INFORMATION ON NEXT PAGE

Section 5. CRIME INFORMATION (All applicants must complete this section)

Date of Crime	Place & Time of Crime	Date Reported	Who Reported Crime?

Type of Crime (Please check)

_____ Sexual Assault
_____ Child Sex Abuse
_____ Child Physical Abuse
_____ Domestic Assault
_____ Assault
_____ Murder/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

Please provide a brief description of the crime in your own words. (Use additional sheet of paper if necessary)

Law enforcement agency crime was reported to:

Who committed the crime, if known?	Please include names & addresses of any witnesses to the crime, if known.

COMPLETE INFORMATION ON NEXT PAGE

Section 6. LOSS OF WAGE INFORMATION

Are you the victim? ☐ Yes ☐ No Are you claiming loss of wages? ☐ Yes ☐ No

If **yes to both** questions, complete the following and enclose **three** payroll stubs and a copy of your doctor's release.

Number of days or hours missed due to crime		Date released from doctor's care (Attach copy of doctor's release)	
Name of victim's employer		Employer's telephone number ( )	
Employer's business address	City	State	Zip Code
Dates absent from work due to crime related injuries: From _____ To: _____			
NOTE: If you are self-employed, you must furnish us with copies of estimates, bids, contracts, or your tax return from last year to accurately determine lost wages. **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:			

COMPLETE INFORMATION ON NEXT PAGE

Section 7. AMOUNT OF YOUR CLAIM (All applicants MUST complete this section)

Note: You do not need to wait until you receive all medical bills before you complete this section. Enter total amounts for the bills you currently have which are related to the crime.

You must submit **itemized copies** of medical and/or funeral bills. If claiming loss of wages see instruction sheet. If claim is approved you will be reimbursed **only** for those expenses incurred which are not paid by another source such as insurance.	
1. Total hospital bills	$ _____
2. Total doctor's and ambulance bills	$ _____
3. Total prescription (drug) bills (Other than those prescribed in hospital)	$ _____
4. Funeral expenses (Include copy of death certificate)	$ _____
5. Amount of income lost as a result of the incident	$ _____
6. Other expenses not covered above (Explain) (**Property loss and Pain & Suffering are not covered)**	$ _____
TOTAL AMOUNT OF CLAIM	$ _____
Will there be additional medical bills? ☐ Yes ☐ No ☐ Unknown	

Section 8. All applicants seeking compensation for medical bills must complete the following information.

Have you received any money from the following sources to pay for expenses related to the crime?

Source of Compensation	Yes	No	Unknown	Name of Insurance Company/Policy Number
Private Insurance				
Group Insurance				
Medicaid (Title 19)				
Medicare				
Worker's Compensation				
Other (please specify)				

Have you applied for any other public assistance? ☐ Yes ☐ No

If yes, explain:

COMPLETE INFORMATION ON NEXT PAGE

Section 9. IMPORTANT - READ CAREFULLY

This authorization is an integral part of your application and must be **completed, signed, and notarized** 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. 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)

SWORN BEFORE ME THIS _____ DAY OF _____ , 2 _____

NOTARY PUBLIC: _____

Return this form to:

Nebraska Crime Victim's Reparations Program
PO Box 94946
Lincoln, NE 68509-4946

Telephone:
(402) 471-2828 or (402) 471-2194

Location:
Nebraska Crime Commission
301 Centennial Mall South
14th & M Streets
Lincoln, NE

CHECKLIST

1. Did you complete all sections of the application form which related to your claim?
2. Have you included itemized copies of bills for which compensation is being claimed?
3. If you are claiming loss of wages, have you included a copy of your doctor's release stating the exact day you could return to work? Have you included the 3 check stubs prior to the incident or last year's income tax form?
4. If you are claiming funeral expenses, have you included a copy of the death certificate?
5. Have you signed the application form and has the application been notarized?

If you need help or have questions, please call (402) 471-2828.

COMPLETE INFORMATION ON NEXT PAGE

UNITED STATES CITIZENSHIP ATTESTATION FORM

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, my immigration status and alien number are as follows _____
and I agree to provide a copy of my USCIS documentation upon request.

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 _____