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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 ☐Male ☐ 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) ☐ Parent of a Minor Child ☐ Legal Guardian of Victim ☐ Person Responsible for Crime-Related Expenses ☐ Secondary Victim					
Gender ☐Male ☐ 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 ___/___/___ (MM/DD/YY) TIME ☐AM ☐PM		Date and Time Reported to Authorities ___/___/___ (MM/DD/YY) TIME ☐AM ☐PM	
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) _____Relation: _____ _____Relation:_____ _____Relation:_____ _____ ___ Relation: _____			Did the crime happen at work? ☐ Yes ☐ No	Did the crime involve a motor vehicle? ☐ Yes ☐ No
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** ☐ **No**
Crime-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:

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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? ☐ Yes ☐ No Amount Paid:

Did you or do you expect to receive life insurance benefits? ☐ Yes ☐ No

Carrier: Policy Number: Amount Paid:

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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 ☐ No
If 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: In filing this claim? ☐ Yes ☐ No In a civil lawsuit related to this crime? ☐ Yes ☐ No In an insurance action related to this claim? ☐ Yes ☐ No In the criminal justice system? ☐ Yes ☐ No			**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?** ☐ Yes ☐ 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? ☐ Yes ☐ 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**

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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**