

(please detach - keep the above for your records)

office use only \_\_\_\_\_

Maryland Criminal Injuries Compensation Board  
Suite 206, Plaza Office Center ♦ 6776 Reisterstown Road ♦ Baltimore, MD 21215-2340  
410-585-3010 or 1-888-679-9347 fax 410-764-3815 http://www.dpscs.state.md.us/victimservs/vs\_cicb.shtml

**Crime Victim Compensation Application**  
(Please print clearly and fill out both sides in blue/black ink)

Victim: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
(First) (Middle) (Last)

Address: \_\_\_\_\_  
City and State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Claimant: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
(If victim is a minor or deceased)

Address: \_\_\_\_\_  
City and State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Relationship to Victim: \_\_\_\_\_

Date of Crime: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

Location: \_\_\_\_\_

Name of Offender (if known): \_\_\_\_\_ Relationship to Offender (if any) \_\_\_\_\_

Brief description of crime: \_\_\_\_\_

Date crime was reported to police: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

If crime not reported within 2 days, explain why: \_\_\_\_\_

Which Police Department: \_\_\_\_\_ Police Complaint Number: \_\_\_\_\_

Has the offender been arrested? Yes/No Has a warrant for arrest been issued? Yes/No

Has prosecution begun? Yes/No Name of Court: \_\_\_\_\_ Case Number: \_\_\_\_\_

Disposition: \_\_\_\_\_

Restitution if any and how much paid to date: \_\_\_\_\_

If applying for lost wages: \_\_\_\_\_

Employer's Business Name \_\_\_\_\_ Contact person/Phone Number \_\_\_\_\_

Street Address \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_

Lost time: From \_\_\_\_\_ To \_\_\_\_\_

Do/Did you receive any type of support (sick/annual leave, vacation, disability, workman's comp, etc.)? \_\_\_\_\_

**PLEASE ATTACH COPIES OF MOST RECENT PAYSTUBS AND W2s**

Description of Injuries: \_\_\_\_\_

List names of hospitals, doctors, dentists, etc. who gave treatment. (Send copies of all bills if available)

Name	Address	City/State/Zip
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In cases of homicide, enclose a copy of the death certificate and itemized funeral bills and provide the following:

Funeral Home \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Total funeral expenses: \_\_\_\_\_ Amount paid by claimant: \_\_\_\_\_

Amount paid by others: \_\_\_\_\_ Amount still due funeral home: \_\_\_\_\_

Did you receive any other financial benefits as a result of the death of the victim? Yes/No

If "yes", please describe: \_\_\_\_\_

Indicate whether the claimant/victim was covered by any of the following:

Medical Insurance	Yes/No	Carrier: _____	Policy No. _____
Medical Asst/Medicare	Yes/No	Account No.: _____	_____
Social Services Benefits	Yes/No	_____	_____
Life Insurance	Yes/No	Carrier: _____	Amount _____
Social Security	Yes/No	Amount payable to survivors (if any) _____	_____
Other	Yes/No	_____	_____

For loss of support for a child, attach a copy of the birth certificate and if applicable, Social Security Survivor Benefits statement. For a spouse, attach a copy of the marriage certificate.

Dependents Name	Date of Birth	Relationship	Guardian (if minor)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If applying for lost wages: Income available to claimant/victim (including spouse)

Wages/Salaries \$ \_\_\_\_\_  
Self-employment income \$ \_\_\_\_\_  
Child Support \$ \_\_\_\_\_  
Other \_\_\_\_\_

Optional:

The following victim information is used for statistical purposes only. It is to be used only to comply with federal regulations.

Race:  White  Black  Hispanic  American Indian  Asian/Pacific Islander  Other  
Name of country where born \_\_\_\_\_

Who referred you?  Police  Prosecutor  Victim Svcs.  Hospital  Attorney  Poster/Brochure  Other

Attorney Representation: (Complete only if represented by an attorney for this claim)

Attorney's name (Last, First and Middle) \_\_\_\_\_

Phone Number and Fax Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

The claimant affirms that **no release or compromise** has been or will be given by the claimant to any third party who may be liable in damages to the claimant based on the incident described in this claim. If the claimant receives an award from the Criminal Injuries Compensation Board as a result of this application and later recovers damages or other payments from a third party, the claimant agrees to **repay** to the said Board the amount of such award to the extent of such recovery.

The claimant authorizes any health care provider, employers of the claimant or victim, law enforcement authorities, courts, insurance companies, financial institutions, State or Federal Government agencies, or other persons or organizations having pertinent information to **release** to the Criminal Injuries Compensation Board such information as may be relevant in evaluating this claim. The authorization duration shall be until the completion of all steps in processing and determining a claim, including any appeals to any other agency or court. The claimant also agrees that statistics and information relevant to the claim may be released as needed for reporting, for processing, for response to federal and/or state legislative, executive and/or judicial units consistent with the limitations of law. Claimant specifically waives any requirement that he or she be given notice of any request being made to any information provider.

The claimant consents to the payment of any award for outstanding indebtedness of the claimant arising from this claim to be paid **directly** to health care providers, funeral homes, or attorneys, as appropriate.

I hereby **declare and affirm**, under the penalties of perjury, that the information and statements given in this claim form are true and correct to the best of my knowledge, information and belief.

Signature of claimant \_\_\_\_\_ Date \_\_\_\_\_