

MARYLAND CRIMINAL INJURIES COMPENSATION BOARD (CICB)
APPLICATION FOR CRIME VICTIM COMPENSATION

6776 Reisterstown Rd, Ste. 206, Baltimore, MD 21215 | Office: (410) 585-3010 | Fax: (410) 764-3815
 goccp.maryland.gov/victims/cicb

SECTION 1: VICTIM INFORMATION

Victim's Full Name:					Social Security Number:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: / /	Primary Language:	Marital Status:	Safe Telephone Number:	Email Address:
Current Address:					County:

VICTIM STATISTICAL INFORMATION (OPTIONAL)

Race/Ethnicity: <input type="checkbox"/> White, Non-Latino/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Multiple Races <input type="checkbox"/> Some Other Race: _____ Birthplace, if not the United States: _____					
Are you a person living with a disability?: <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes" is the disability: <input type="checkbox"/> Physical <input type="checkbox"/> Mental <input type="checkbox"/> Developmental					
Who referred you to the Criminal Injuries Compensation Board?: <input type="checkbox"/> Hospital <input type="checkbox"/> States Attorney's Office <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Victim Service Program <input type="checkbox"/> Poster/Brochure <input type="checkbox"/> Attorney <input type="checkbox"/> Other: _____					

SECTION 2: CLAIMANT INFORMATION

Claimant's Full Name:			Relationship:	Social Security Number (*See Pg 2):	
Relationship to Victim (<i>Check all that apply</i>): <input type="checkbox"/> Parent of a Minor Child <input type="checkbox"/> Legal Guardian of Victim <input type="checkbox"/> Secondary Victim <input type="checkbox"/> Person Responsible for Crime-Related Expenses <input type="checkbox"/> Other (please provide here) _____					
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: / /	Primary Language:	Marital Status:	Safe Telephone Number:	Email Address:
Current Address:					County:

SECTION 3: CRIME INFORMATION

Date of Crime: / /	Time: : <input type="checkbox"/> AM <input type="checkbox"/> PM	Date Reported to Authorities: / /	Time: : <input type="checkbox"/> AM <input type="checkbox"/> PM
Address Where Crime Occurred (<i>If Known</i>):			
City/Town:	County:	State:	
Police Department:	Detective Name:	Phone Number:	Police Report No. :
Offender/Suspect Information (<i>If the suspect(s) has/have no relation to the victim please put "N/A"</i>) Name: _____ Relation: _____ Court Case Number: _____ Court: _____ Name: _____ Relation: _____ Court Case Number: _____ Court: _____			
Description of Crime: (<i>If necessary, attach separate paper</i>)			
Did the crime involve a motor vehicle or vessel? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did the crime happen at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 4: REQUESTED EXPENSES

Check all that apply for the type of financial assistance that you are seeking. Please include with your application the items needed.	
<input type="checkbox"/> MEDICAL <input type="checkbox"/> COUNSELING <input type="checkbox"/> LOSS OF SUPPORT <input type="checkbox"/> FUNERAL/BURIAL ASSISTANCE <input type="checkbox"/> CRIME SCENE CLEAN UP <input type="checkbox"/> DISABILITY <input type="checkbox"/> LOSS OF EARNINGS <input type="checkbox"/> BEREAVEMENT LEAVE	
Dates Absent From Work: ___/___/___ To ___/___/___ Employer: _____	
Address: _____	Phone: _____

SECTION 5: FINANCIAL BENEFITS INFORMATION

Please check any financial benefits that may be applied towards the reported crime indicated above.

PRIVATE MEDICAL INSURANCE	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING	LIFE INSURANCE	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING
MEDICAID (<i>Medical Assistance</i>)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING	AUTOMOBILE OR BOAT INSURANCE	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING
MEDICARE	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING	HOME OWNERS/RENTERS INSURANCE	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING
SOCIAL SECURITY DISABILITY	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING	CHARITY OR DONATIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING
SOCIAL SECURITY SURVIVOR BENEFITS	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING	COURT ORDERED RESTITUTION	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING
WORKERS' COMPENSATION	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING	CIVIL JUDGMENT	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PENDING

SECTION 6: AUTHORIZATIONS AND AGREEMENTS**REPRESENTATION BY OTHERS**

Name of Representative: <input type="checkbox"/> Attorney <input type="checkbox"/> Victim Service Provider		Name of Firm or Organization:	
Street Address:		City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:	

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**PERMISSION FOR USE OF SOCIAL SECURITY**

*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.

ACKNOWLEDGEMENT AND AUTHORIZATIONS

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.
- Any police record or record of another governmental entity, including State and Federal taxing authorities, pertaining to the crime 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**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



INSTRUCTION SHEET FOR CRIME VICTIM COMPENSATION

MARYLAND CRIMINAL INJURIES COMPENSATION BOARD

6776 Reisterstown Rd, Ste. 206, Baltimore, MD 21215

Office: (410) 585-3010 ▪ Fax: (410) 764-3815 ▪ Email: cicb.info@maryland.gov

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The Maryland Criminal Injuries Compensation Board (CICB) is a state agency with the purpose of compensating victims of crime for losses sustained from their victimization. (See benefits listing below)

Application Instructions:

- Fully complete the enclosed two (2) page application
- Write legibly; or complete the fillable Online Application (see webpage above for fillable app.)
- Authorization Signatures on Page 2 of the application (Failure to sign **will** result in the application being returned and not filed)
- Mail, Email, or and deliver the completed application to the CICB office

CICB Eligibility Requirements:

- The Crime **must** be reported to authorities within 48 hours (exceptions may apply).
- Application must be filed within three (3) years of date of discovery of crime (exceptions may apply).
- The crime must have occurred in the state of Maryland (exceptions may apply).
- Claimants must be at least 18 years of age (parents or guardians must apply for those under 18).
- The victim must have suffered a physical or psychological injury.
- The victim must have incurred a financial loss of at least \$100.00 resulting from the crime.
- **Not covered by CICB:** property loss, mileage, lock changes, relocation, child care, pain and suffering, and all other losses not listed below
- **CICB is the Payor of Last Resort:** All other reimbursement options must be exhausted before CICB

What May Make An Application 'Ineligible':

- The victim contributed to and/or proximately caused their injury; the victim initiated, consented to, provoked, participated in, or unreasonably failed to avoid a confrontation with the offender
- The victim was participating in a crime or delinquent act during time of incident.
- Failure to cooperate with law enforcement.
- Failure to provide documentation required and requested by CICB.

Benefits & Required Documentation: CICB is required to verify all losses. Below is a list of benefits and documents that may be required. **Other documentation may be required.**

- All claims: Police report or police report number. Report to judicial authority may also be considered.
- Medical/Dental: Itemized bills; letter from a doctor or medical documentation relating the injury to the crime and the treatment; treatment plan; & medical insurance. If the claimant has no private insurance, CICB requires the claimant to apply for Medicaid.
- Counseling: Letter from a therapist documenting treatment related to crime; itemized statements; receipts if paid out of pocket by claimant.
- Lost Wages/Disability: Employer information; W-2 and/or pay stubs; letter from a doctor certifying inability to work. Permanent disability may necessitate additional documents.
- Bereavement: A parent/child/spouse of a homicide victim may receive up to two (2) weeks.
- Funeral/Burial: Funeral/burial bill or receipts; death certificate; life insurance information.
- Crime scene clean-up: Itemized bill or receipts.
- Loss of Support: Depending on relationship of parties, CICB may require: proof of cohabitation; employment: or financial contribution by the decedent to support the claimant.