Nebraska Crime Victim's Reparations
Application for Crime Victim Compensation

The Crime Victim's Reparations Program helps victims and their families through the emotional and physical aftermath of a violent crime by easing the financial impact. The CVR Program may be able help with certain out-of-pocket expenses resulting from the crime.

ELIGIBILITY REQUIREMENTS: (Exceptions may apply)

- The violent crime occurred in Nebraska
- Injuries resulted from a violent crime
- The crime was reported to law enforcement within five days
- The victim cooperated with law enforcement and prosecution
- The victim's expenses were incurred as a direct result of the crime
- The application was filed within two years from the date of the crime *some exceptions may apply for minors and good cause exception may be considered
- The victim's behavior did not contribute to the crime

If eligible, you may be awarded compensation for the following crime-related expenses (Monetary limits apply):

Medical or Dental	Counseling
Loss of Wages	Funeral and Burial
Loss of Support for dependent(s) of a deceased victim	Crime Scene Clean-up

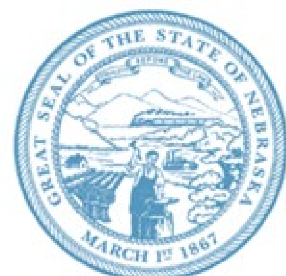
Return the completed/signed application and documentation to the below address:

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

Phone: 402.471.2828
Fax: 402.471.2837

OR Scan & Send it to:

ncc.cvr@nebraska.gov



Jim Pillen, Governor

CRIME VICTIM'S REPARATIONS CLAIM FOR COMPENSATION

Section 1: Victim Information (*The victim is the person who was physically injured or killed due to the crime.)*

Full Name *(First, Middle Initial, Last)*			**Social Security Number**
Address		**City & State**	**Zip**
Telephone Number	**Date of Birth**	☐ **Male** ☐ **Female** *or* **Other/ Preferred Pronouns:**	
Email		**Preferred Method of Contact:** ☐ **Email** ☐ **Phone**	

Federal Reporting

To comply with Federal regulations, The Department of Justice requests 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.

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

☐ **Native Hawaiian/Other Pacific Islander** ☐ **White Non-Latino/Caucasian** ☐ **Multiple Races** ☐ **Other**

Was the victim disabled prior to this crime? ☐ **Yes** ☐ **No**	**Is the victim disabled as a result of this crime?** ☐ **Yes** ☐ **No**

Section 2: Claimant Information

Complete this section if ***you*** *(a claimant different than the victim in section 1) 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 *(First, Middle Initial, Last)*			**Claimant Social Security Number**
Claimant Address		**City & State**	**Zip**
Claimant Telephone Number	**Claimant Date of Birth**	☐ **Male** ☐ **Female** **Other/Preferred Pronouns:**	
Email			

Alternative Contact

If CVR Staff cannot get a hold of you, do you have an alternative contact that we can call or email and ask them to relay a message to call us?
(For example, a relative, trusted friend, or victim advocate)

Name: ____________________ **Phone:**____________________ **Email:**__________________________

Section 3: Crime Information	
Date of Crime	**Where did crime occur? (City or County)**
Date Crime Reported	**Did the crime occur in Nebraska?** ☐ **Yes** ☐ **No**
Police Report and/or Incident Report # (*if known*)	**What Law Enforcement Agency was the Crime Reported to?**
Crime Type ☐ **Sexual Assault** ☐ **Domestic Assault** ☐ **Assault** ☐ **Homicide** ☐ **DUI/DWI** ☐ **Child Physical Abuse** ☐ **Child Sexual Abuse** ☐ **Other** (*please specify*)____	
Who Committed the Crime (*if known)*	
This space is available to provide a brief description of the crime and/or injuries sustained. ***This is not required.***	

If needed, utilize additional space:

Section 4: Expenses

Please check the type of expenses you are requesting.

Attach copies of crime related bills and any paid receipts.

☐ Medical and/or Dental Expenses (Complete Section # 5)

☐ Funeral or Burial Expenses (A copy of the death certificate will need to be provided.)

☐ Counseling Expenses (Complete Section # 5)

☐ Loss of Wages (Complete Section # 6)

☐ Loss of Support for Dependents of Homicide (Additional forms will be sent to you.)

☐ Crime Scene Clean-up Expenses

Please note that additional information may be requested from CVR Staff.

Section 5: Medical, Dental, or Therapy Providers and Insurance Information

Does the victim have coverage or benefits available from any of the following? Check all applicable boxes.

Does the victim/claimant 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 answering Yes to coverage or benefits, please enter the applicable information below:

Health Insurance Company/Policy Number

Medicaid Plan/Policy Number

Medicare Plan/ Policy Number

Section 6: Loss of Wage Information

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

Please note that the Program will contact your employer to verify lost wages due to the crime.

Loss of Wage will only be considered if more than seven (7) consecutive days are missed from work.

Name of Victim's Employer	Employer's Telephone Number and Email address	
Employer's Business Address	**City & State**	**Zip**

☐ Please do not contact my employer directly. (If checked CVR Staff will determine good cause exception of contacting employer in rare situations.)

Please include, or be prepared to submit:

- **Copy of pay stubs or an earning statement for the pay period(s) for missed work as a result of the incident.**

  If Self-Employed: submit the most recent federal tax returns including the schedule C form, Copies of Estimates, Bids, and/or Contracts.

- **A Doctor's release back to work.**
- **Note: CVR will request a licensed medical provider to complete a Loss Wages form.**

Section 7: Attorney Information ***(not required)***

Attorney Name		
Attorney Business Address	**City & State**	**Zip**
Attorney Email	**Attorney Phone #**	

The next two forms are important. Please ensure you print your name, sign, and date them.

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 signature if victim is a minor)

____

Victim or Claimant Printed Name
(Parent/Guardian printed name if victim is a minor)

____

Date

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:____

SIGNATURE:____

DATE:____