Manitoba Compensation for Victims of Crime Program

Manitoba Justice

1410 – 405 Broadway
Winnipeg MB R3C 3L6

Ph: (204) 945-0899
Fax: (204) 948-3071
Toll Free: 1-800-262-9344

Application for Compensation

Claim Number: (Office Use Only) _____

1(a) Victim's Personal Information (Please print clearly and in ink)

Last Name	First Name	Middle Initial
Address	City	Province / Postal Code
Phone Number(s) / Home #	Work or Other #	Social Insurance Number
Date of Birth: Month / Day / Year	Age	Gender: Male ❑ Female ❑	Personal Health I.D. No.
Name of Band (if applicable)	Treaty Card # or Metis Card # (if applicable)
Marital Status: ❑ Single ❑ Married ❑ Common-Law ❑ Separated ❑ Divorced ❑ Widowed	

1(b) Applicant's Personal Information (Please complete this section if you are applying for the victim)

Last Name	First Name	Middle Initial
Address	City	Province / Postal Code
Phone Number(s) / Home #	Work or Other #	Social Insurance Number
Date of Birth: Month / Day / Year	Age	Gender: Male ❑ Female ❑	Personal Health I.D. No.
Name of Band (if applicable)	Treaty Card # or Metis Card # (if applicable)
Your Relationship To the Victim	
Is the Victim Deceased? ❑ Male ❑ Female	If yes, date of death: Month / Day / Year	Location of Death

If the victim is deceased, please list the full names of all the people who relied on the victim for financial support

Full Name	Date of Birth	Age	His or Her Relationship to the Victim

If the victim is not deceased, please tell us why the victim could not complete this application on his or her own and what authority you have to fill it in for the victim. For example, the victim is under 18 years old.

_____

_____

_____

2 Details of the Crime

Date the Crime Occurred	Month / Day / Year	Location of the crime (City, town, community, etc.)	Middle Initial
Which Police Force was the crime reported to?		Date reported to police Month / Day / Year	Police Incident #

Please describe the crime in your own words. (If you need more space, please add another piece of paper.)	
List name(s) of offender(s), if known.	Victim's relationship to offender(s), if any.
List the names of any witnesses to the crime.	

3 Injuries (Please list all the physical and/or emotional injuries that you received)

Did the offender use a weapon? ❑ Yes ❑ No	If yes, what was used?	Was alcohol involved in the crime? ❑ Yes ❑ No

4 Victim's Medical Information (List all the doctors, dentists, therapists, etc. that the victim saw because of the injury)

Doctor or Dentist Name	Hospital or Medical Facility	Address

5 Estimate of Expenses (Please provide details and receipts if you have them)

Expenses being Claimed	Details	Estimated Cost
❑ Ambulance Bills		
❑ Medical Expenses (prescription costs, crutches, etc.)		
❑ Dental Treatment		
❑ Eye Glasses		
❑ Damaged Clothing		
❑ Counselling Costs		
❑ Travel Costs		
❑ Wage Loss		
❑ Funeral Expenses		
❑ Death Benefit for Dependants		
❑ Other (please specify)		

6 Source of Income at Time of Crime

❑ Employed	❑ Employment Insurance Benefits	❑ Employment and Income Assistance
❑ Self Employed	❑ Workers Compensation	❑ Child (under age 12)
❑ Unemployed	❑ Canada Pension	❑ Student (age 12 and over)
❑ Support from spouse	❑ Other (Please Specify) _____	

7 Employment Information

Name of Employer			
Company Address	City	Province	Postal Code
Name of Company Contact Person	Phone #	Fax #	
Date last worked before the crime Month / Day / Year		Date returned to work Month / Day / Year	
Please provide us with details about your wages	I earn: $_____ per hour (gross) I earn: $_____ per week (gross)	I normally work: _____ hours/day _____ hours/week	
How long have you been employed with this company? _____ years, _____ months			

8(a) Money or Benefits available from Other Sources because of the Victim's Injury or Death

Benefit (please check box)	Details	Amount to be Received
❑ Insurance Plan		
❑ Disability Plan		
❑ Sick Leave		
❑ Worker's Compensation		
❑ Employment Insurance		
❑ Employment & Income Assistance		
❑ Canada Pension Plan		
❑ Indian Affairs / Band Allowance		
❑ Funeral Expenses		
❑ Death Benefit for Dependants		
❑ Other (please list)		

8(b) Restitution and Civil Action

Have you applied to the Court for money from the offender? ❑ Yes ❑ No	
If yes, what expenses did you ask to be covered?	Amount Awarded by the Judge: $_____ Amount you have already received: $_____
Are you considering a lawsuit against the offender? ❑ Yes ❑ No	If yes, give us the name and address of your lawyer or law firm

9 Referrals

How did you hear about the Compensation for Victims of Crime Program?	
Have you ever filed a Victim's Compensation Claim before? ❑ Yes ❑ No	If yes, when did you last file?

10 Information Authorization (This is needed to assess your claim and to make decisions about benefits)

I authorize:

a) the doctor, dentist, therapist and/or staff of the medical facility the victim went to, to give the Compensation for Victims of Crime Program reports about the victim's injuries;

b) the police to furnish the Compensation for Victims of Crime Program with a copy of any statement or any other information related to the crime;

c) employer(s), Human Resources Development Canada, Canada Pension, Canada Customs & Revenue Agency, Manitoba Health, Manitoba Employment & Income Assistance, The Workers Compensation Board, Manitoba Public Insurance Corporation and/or any other federal or provincial program or private insurance company to give the Compensation for Victims of Crime Program any report relevant to this claim; and

d) the Compensation for Victims of Crime Program to give out information when needed, as long as it respects information disclosure laws.

This authorization or a photocopy of it, gives the program full and sufficient permission to obtain or provide this information for a period of two calendar years from the date signed, but may be revoked by me at any time by written request. All information will be used and disclosed as stated on this form.

Date: _____ **Signature of Victim:** _____

_____

Victim's full name and address (Please PRINT)
If you have signed this on behalf of the victim, please print your full name and tell us your relationship to the victim.

Name: _____ **Relationship:** _____

11 Declaration of Understanding

I understand that:

a) It is the victim's responsibility to report the crime to the police.

b) The Compensation for Victims of Crime Program may tell the people mentioned above about this application and they may give them information about any part of this application or about any decisions made on this claim.

c) I may be required, by the Compensation for Victims of Crime Program, to have an independent medical examination for the purpose of assessing this claim.

d) If I do not provide the Compensation for Victims of Crime Program with the information that they have requested, staff may deny my eligibility or refuse or reduce any benefits payable.

e) I may cancel any of the above authorizations, in Section 10, at any time by telling the Compensation for Victims of Crime Program in writing. However, I understand that if they are cancelled, it may affect the ability of staff to make a decision on my claim.

f) I have the right to receive benefits and at the same time start a civil action or lawsuit against the person or party who is responsible for the victim's injuries or death.

g) If I choose not to take legal action, the Compensation for Victims of Crime Program may take legal action, on my behalf.

h) Compensation may be reduced or denied if I, at any time, receive money from a lawsuit or from any other person or party responsible for the victim's injuries or death. I further understand that if I am eligible for coverage under another benefit plan or program, that money will be deducted from the amount to be received from the Compensation for Victims of Crime Program.

i) Making a false or misleading statement in this application is an offence and if any information is found untrue, I will forfeit my application and must immediately give back any money that I have already received.

I declare that I have read, understand and agree to the conditions listed above and that the information in this application is true.

Date: _____ **Signature:** _____