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| Minnesota Pollution Control Agency (MPCA), 520 Lafayette Road North, St. Paul, MN 55155-4194 | Application for Compensation for Personal Injury  Harmful Substance Compensation Program  Superfund Program  *Doc Type: Application* |

## **Instructions:** Complete this form to apply for financial aid for personal injury caused by harmful chemical substances. If you have questions regarding the form or your application, please contact Jennifer Haas at 651-757-2401 or [jennifer.haas@state.mn.us](mailto:jennifer.haas@state.mn.us).

## **Email** an electronic copy of the completed form and attachmentsto [jennifer.haas@state.mn.us](mailto:jennifer.haas@state.mn.us).

## **Send a hardcopy** of the completed formand attachments to**:**

Jennifer Haas, Superfund Section, Minnesota Pollution Control Agency, 520 Lafayette Road North, St. Paul, Minnesota 55155-4194.

## **Tennessen warning:** It is possible that some of the information that you are being asked to provide on the attachments associated with this form may be classified as private data on individuals (as described in Minn. R. 1205.0200, subp.9, Minn. R. 1205.0400 and Minn. Stat. § 13.02, subd. 12). You are being asked to provide this information to assist the Minnesota Pollution Control Agency (MPCA) in assessing your eligibility for reimbursement from the Harmful Substance Compensation Fund. You are not legally required to provide the requested information. If you supply the requested information, it will be used to assist the MPCA in processing your application and in assessing your eligibility for reimbursement from the Harmful Substance Compensation Fund. If you do not supply the requested information, it may be difficult for the MPCA to process your application and to assess your eligibility for reimbursement from the Harmful Substance Compensation Fund. The not public data that you provide will be available only to those personnel whose work assignments reasonably require access and to those entities/persons authorized by court order or law.

## **Claimant**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | | | | |
| Address: |  | | | | Phone number: |  |
| City: |  | | State: |  | Zip code: |  |
| Email address: | |  | | | | |

## **Address at the time of personal injury** Same as above

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Address: |  | | | County: | |  |
| City: |  | State: |  | | Zip code: |  |

## **Claimant’s Representative (if any)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | | | | | | |
| Address: |  | | | | | | Phone number: |  |
| City: |  | | | State: | |  | Zip code: |  |
| Email address: | |  | | | | | | |
| Relationship to claimant (e.g., attorney, parent, guardian): | | | | |  | | | |
| If attorney, name of law firm: | | |  | | | | | |

## **Exposure to harmful substances**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| List harmful substance(s) to which you were exposed: | | | | | | | | | | |  | | | | | | | | | | |
| What was the source (facility name and location)? | | | | | | | | |  | | | | | | | | | | | | |
| How did you become aware of the presence of harmful substances? | | | | | | | | | | | | | |  | | | | | | | |
| What government agency did you contact about the harmful substance? | | | | | | | | | | | | | | |  | | | | | | |
| When did you become aware of the exposure (mm/dd/yyyy)? | | | | | |  | | | | | How long do you believe that you were exposed? | | | | | | |  | | | |
| Where were you exposed? (location: e.g., home) | | | | | | | |  | | | | | | | | | | | | | |
| How were you exposed to the harmful substance? (e.g., via drinking water, breathing indoor air, etc.) | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| What disease, illness or disability resulted from exposure to the harmful substance(s)? | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| Who diagnosed the condition? | | | |  | | | | | | | | | | | | Date diagnosed (mm/dd/yyyy): | | | | |  |
| Name of medical facility: | |  | | | | | | | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | Phone number: | | |  | | |
| City: |  | | | | | | | | State: | |  | | | | | Zip code: | | |  | | |
| Were you hospitalized for the condition? | | | | | | | Yes  No | | | | | | Dates of hospitalization: | | | | | |  | | |
| Name and location of hospital: | | | | |  | | | | | | | | | | | | | | | | |
| Why do you believe the exposure to the harmful substance(s) caused or contributed to your condition? | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |

## **Compensation**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| What unreimbursed medical expenses have you incurred because of your condition? | | |  | |
| If wages were lost, list amount: |  | | | |
| List the date(s) the wages were lost (mm/dd/yyyy): | |  | |  |

## **Employer**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name of company: | |  | | | | | |
| Supervisor (or HR staff that can verify employment): | | | |  | | | |
| Address: |  | | | | | Phone number: |  |
| City: |  | | State: | |  | Zip code: |  |

|  |  |  |
| --- | --- | --- |
| Have you received compensation from any of the following for your losses? | | |
|  | The party responsible for the release of the harmful substance(s) | |
|  | Insurance | |
|  | Federal, state or local government programs | |
|  | Other compensation source (please specify): |  |

## **Certification**

I certify that all statements in this application are true and complete to the best of my knowledge:

|  |  |  |  |
| --- | --- | --- | --- |
| Print name: |  | | |
| Signature: |  | Date (mm/dd/yyyy): |  |

**Notary signature**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Subscribed and sworn to before me this: | | | | |
|  | day of |  | , |  |
|  | | | | |
| County | | | | |
|  | | | | |
| My Commission Expires | | | | |
|  | | | | |
| Notary Signature | | | | |

## **Consent Form**

If you are applying for compensation for personal injury, this form must be signed and returned with your claim form.

Pursuant to Minnesota Statutes 115B.25 to 115B37, I hereby voluntary consent and authorize the Minnesota Pollution Control Agency (MPCA) or its representatives to examine medical records, including records in existence on the date of signature and after this date. I authorize any hospital, physician, medical practitioner, supplier, facility, insurance company, or employer to release to the MPCA any information concerning medical care, advice, treatment or supplies. I also give the MPCA or its representatives permission to discuss with health care providers, any information or opinion which may be relevant to the claim.

I agree to undergo medical examination or testing which may reasonably be required by the MPCA.

I further authorize the examination of employment records, records of unemployment or disability benefits, insurance benefits, and other information concerning my financial status or the status of my spouse and/or dependents, including all governmental or private benefits received, and waive all legal privileges pertaining to such as would otherwise apply. I agree to supply federal tax data when requested.

I understand this information will be used solely by the MPCA and its staff to determine compensation. This authorization is granted until the MPCA issues a final determination of the claim. A photocopy of this authorization shall be as valid as the original

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| --- | --- | --- |
|  |  |  |
| Signature of claimant |  | Printed name of claimant |
| *(Parent or guardian if claimant is a minor)* |  |  |
|  |  |
|  |  | Date (mm/dd/yyyy) |