

SECTION 4. – COMPENSATION (Bills you owe or bills you have paid)

Type of crime-related assistance you are requesting which resulted in personal injury, including physical or mental trauma or death to the victim: Medical Dental Lost Income Funeral Expenses
 Counseling Security System Relocation Other _____

SECTION 5. – CRIME INFORMATION (Please fill out this section as completely as possible)

Type of crime: Assault Sexual Assault Robbery with Injury Domestic Violence Stalking DUI
 Homicide Child Physical Abuse/Neglect Child Pornography Human Trafficking Kidnapping
 Other Vehicular Crimes Terrorism Other (describe) _____

Date of crime | Town/City/County where crime occurred

Date crime was reported to police | Police department to which crime was reported

Name of assisting officer(s) | Phone number

Has an arrest(s) been made? Yes No Unknown | _____
Name of offender(s), if known

Has the offender been charged in court? Yes No Unknown | _____
If yes, court location

Did the victim know the offender? Yes No If yes, in what way | _____

Where is the offender now? _____

Name of: Prosecuting Attorney _____ Victim/Witness Advocate _____

SECTION 6. – MEDICAL/COUNSELING INFORMATION

Are you applying for compensation of unreimbursed:

- Medical expenses Yes No
- Dental expenses Yes No
- Mental health expenses Yes No

If applicable, list all providers that provided treatment, including hospital, doctors, dentists, mental health counselors, ambulance, radiology and prescriptions (drugs and eyeglasses). Attach additional sheets if necessary. If available, please enclose copies of bills.

Provider's Name	Address	Telephone

SECTION 7. – FUNERAL INFORMATION

Are you applying for compensation for funeral expenses? Yes (please complete below) No

Name of Funeral Home	Telephone number		
Address	City	State	Zip code

Have any funeral expenses been paid or will any funeral expenses be paid by any of the following sources? Yes No

- | | |
|--|---|
| Burial Insurance <input type="radio"/> Yes <input type="radio"/> No | Veteran's Benefits/Insurance <input type="radio"/> Yes <input type="radio"/> No |
| Life Insurance <input type="radio"/> Yes <input type="radio"/> No | Donations <input type="radio"/> Yes <input type="radio"/> No |
| Public Assistance <input type="radio"/> Yes <input type="radio"/> No | Other _____ |

Please note: If you have checked yes to any of the above, funeral bills must be submitted to that source before Victims' Compensation can consider reimbursement.

SECTION 8. – EMPLOYMENT INFORMATION

Were you employed at the time of the crime? Yes No If yes, are you applying for lost wages? Yes No

If yes, complete the following section, and submit copies of your pay stubs. If you were self-employed at the time of the crime, please submit a copy of your tax return documentation for the year before the crime. If you have missed more than two weeks of work, please provide a doctor's statement verifying length of time you were unable to work.

_____ Name of employer		_____ Telephone number	
_____ Address	_____ City	_____ State	_____ Zip code
_____ Hours worked per week	_____ Wage per hour	_____ Tips, bonuses per week	
Dates absent from work		_____ From	_____ To

SECTION 9. – RESTITUTION AND CIVIL ACTION

Did the crime involve motor vehicles? Yes No
(If yes, please provide your automobile insurance policy declarations page.)

Did the court order the defendant to make restitution? Yes No
 If yes, what is the amount? _____

Have you filed or do you intend to file a civil action? Yes No
(If yes, please complete below.)

_____ Name of attorney		_____ Name of firm/telephone number	
_____ Address	_____ City	_____ State	_____ Zip code

Does your attorney know you have filed a claim with the Victims' Compensation Program? Yes No

SECTION 10. – INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION

Have bills been paid or will bills be paid by any of the following sources?

- | | | | | | |
|--------------------------|---------------------------|--------------------------|------------------------------|---------------------------|--------------------------|
| Yourself | <input type="radio"/> Yes | <input type="radio"/> No | Veteran’s Administration | <input type="radio"/> Yes | <input type="radio"/> No |
| Private Health Insurance | <input type="radio"/> Yes | <input type="radio"/> No | Life Insurance | <input type="radio"/> Yes | <input type="radio"/> No |
| Medicare/Medicaid | <input type="radio"/> Yes | <input type="radio"/> No | Worker’s Compensation | <input type="radio"/> Yes | <input type="radio"/> No |
| Social Security Program | <input type="radio"/> Yes | <input type="radio"/> No | Unemployment Compensation | <input type="radio"/> Yes | <input type="radio"/> No |
| Sick/Vacation Time | <input type="radio"/> Yes | <input type="radio"/> No | Public or General Assistance | <input type="radio"/> Yes | <input type="radio"/> No |
| Other Employer Benefits | <input type="radio"/> Yes | <input type="radio"/> No | (including Welfare) | | |

If you have selected yes to any of the above sources, please provide the name of the person, company, agency or organization, including mailing address and police number:

SECTION 11. – AFFIRMATION OF INFORMATION PROVIDED

1. The crime occurred in New Hampshire. Yes No
2. The crime resulted in personal injury (including mental trauma or death) Yes No
3. The crime occurred on or after November 2, 1989 Yes No
4. The crime was reported to law enforce within 5 days Yes No
5. This claim is being filed within 2 years of the crime Yes No
6. The out-of-pocket loss or liability is greater than \$100.00 Yes No

*If you have answered **No**, please explain why*

How did you find out about the New Hampshire Victims’ Compensation Program?

- | | | | |
|--|------------------------------------|---|--|
| <input type="radio"/> community advocate | <input type="radio"/> Infoline/211 | <input type="radio"/> County Attorney’s Office/Advocate | <input type="radio"/> police |
| <input type="radio"/> medical provider | <input type="radio"/> hospital | <input type="radio"/> family member/friend | <input type="radio"/> mental health provider |
| <input type="radio"/> webpage | <input type="radio"/> brochure | <input type="radio"/> other _____ | |

SECTION 12. – STATEMENT OF FACTS AND AUTHORIZATION

The undersigned certifies that the information herein is true to his or her best knowledge, information and belief and hereby authorizes any hospital, physician(s) or other person(s) who attended or examined (name of victim or family member's name), _____; any funeral director or other person who rendered services, any employer(s) of the victim; any police or other local governmental agency, including state and federal revenue services; any insurance company or organization having knowledge thereof, to furnish to the NH Victims' Compensation Program, or it's representative, any and all information with respect to the incident leading to the victim's personal injuries and the victim's or family member's application made for compensation. A photocopy of this authorization will be considered as effective and valid as the original.

If any of the Victim/Claimant's crime-related expenses claimed in this application may be fully or partially covered by any public or commercial health, disability, life, automobile, homeowner's or other insurance; the hospital's free-care program; worker's or unemployment compensation; sick, vacation or personal leave; union or fraternal benefits; pensions or retirement funds, restitution, civil suit judgments or any other resource; please explain in full on a separate piece of paper and attach it to this application. Include the complete names, addresses and phone numbers of your resources and of your private attorney, if any, if you do not have any resources to assist you, and you have applied for assistance from Medicaid, Medicare, the Free- Care program at the hospital and any of the public assistance program, but were determined to be ineligible, attach copies of the documents that show your ineligibility for public assistance.

I understand that any recovery of my losses through legal action shall entitle the state of New Hampshire to reimbursement to the extent of any compensation awarded to me. I also understand that my providers may be reimbursed directly for debts that I owe. I declare, under penalty of perjury, that I have read all the questions in the claim form and to the best of my knowledge and belief, all of my answers are true, correct and complete. I also declare, under penalty of perjury, that the expenses and losses claimed in this application have not, will not and cannot be covered by any other resource of public assistance program.

Applicant Signature *(parent or guardian must sign if victim is a minor or an incompetent adult)*

Date

Please return completed application to:

New Hampshire Victims' Compensation Program
Department of Justice
33 Capitol Street
Concord, N.H. 03301-6397

Questions?

Call 1-800-300-4500 (Toll free compensation line – NH only)
or 603-271-1284

Email: victimcomp@doj.nh.gov

Victims of crime may also receive help from other programs, such as:

- Domestic Violence – NH Statewide Domestic Violence Hotline – 1-866-644-3474;
www.nhcadsv.org
- Sexual Assault – NH Statewide Sexual Assault Hotline – 1-800-277-5570; www.nhcadsv.org
- New Hampshire 211; www.211.nh – For everyday needs and difficult times. A connection to thousands of resources available in New Hampshire

