NEW HAMPSHIRE VICTIMS' COMPENSATION PROGRAM

APPLICATION FORM

SECTION 1. – VICTIM INFORMATION

Name of victim _____ Address _____

City _____ State _____ Zip _____ Birth date _____ ○ Male ○ Female

Primary language of victim _____ Preferred telephone number _____

Marital Status: ○ Single ○ Married (name of spouse): _____ ○ Widowed ○ Separated ○ Divorced

Dependent Name, Relationship and Age: _____

Would you like to be contacted via email? ○ Yes ○ No Email _____

SECTION 2. – CLAIMANT INFORMATION (Complete if different from victim)

Name _____ Address_ _____

City _____ State _____ Zip _____ Birth date _____ ○ Male ○ Female

Primary language of victim _____ Preferred telephone number _____

Would you like to be contacted via email? ○ Yes ○ No Email _____

Claimant's relationship to victim: _____

SECTION 3. – COMPENSATION (Bills you owe or bills you have paid)

Type of assistance you are requesting: ○ Medical ○ Dental ○ Lost income ○ Funeral expenses ○ Counseling ○ Security system ○ Relocation ○ Other: (describe) _____

SECTION 4. – 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 5. – MEDICAL/COUNSELING INFORMATION

Are you applying for compensation of unreimbursed medical, dental and/or mental health counseling? ○ Yes ○ No (If yes, please complete below.)

List all providers that gave treatment, include 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 6. – FUNERAL INFORMATION

Are you applying for compensation for funeral expenses? ○ Yes ○ No (If yes, please complete below.)

Name of Funeral Home _____ Telephone number _____

Address _____ State _____ Zip _____

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

Burial Insurance ○ Yes ○ No

Life Insurance ○ Yes ○ No

Public Assistance ○ Yes ○ No

Veteran's Benefits/Insurance ○ Yes ○ No

Donations ○ Yes ○ 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 7. – 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. If you were self-employed at the time of the crime, please submit a copy of your tax return and documentation (W-2 form, 1099 form, etc.) 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 _____

Address _____ State _____ Zip _____ Hours worked per week _____

Wage per hour _____ Tips, bonuses per week _____

Dates absent from work due to _____ From _____ To _____ Total hours absent

SECTION 8. – INSURANCE & OTHER COLLATERAL SOURCE INFORMATION

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

Yourself	○ Yes	○ No	Veteran's Administration	○ Yes	○ No
Private Health Insurance	○ Yes	○ No	Life Insurance	○ Yes	○ No
Medicare/Medicaid	○ Yes	○ No	Worker's Compensation	○ Yes	○ No
Social Security Program	○ Yes	○ No	Unemployment Compensation	○ Yes	○ No
Sick, Vacation or Other Employer Benefits	○ Yes	○ No	Public or General Assistance (Including Welfare)	○ Yes	○ No

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

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

SECTION 10. – STATISTICAL INFORMATION

How did you find out about the crime victims' compensation program?

○ community advocate ○ Infoline/211 ○ County Attorney's Office/advocate ○ medical provider ○ police

○ hospital ○ family member/friend ○ mental health provider ○ webpage ○ brochure

Submission of information regarding race/ethnic background or disabilities is voluntary.

○ Black/African American ○ American Indian/Alaska Native ○ Asian ○ Pacific Islander

○ White Non-Latino/Caucasian ○ Hispanic or Latino ○ other_____

Were you disabled prior to the crime? ○ Yes ○ No

SECTION 11. – 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**

_____ | _____ | _____

FOR OFFICE USE ONLY **CLAIM NUMBER** **DATE RECEIVED**

Please return completed form 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