NEW HAMPSHIRE DEPARTMENT OF JUSTICE
VICTIMS' COMPENSATION PROGRAM
APPLICATION FORM

SECTION 1. – VICTIM INFORMATION

Name of Victim _____ Address _____

City _____ State _____ Zip Code _____ Telephone Number _____

Date of Birth: _____ ○ Male ○ Female
(Submission of date of birth and gender is voluntary.)

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

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

Dependent Name(s), Relationship and Age(s) _____

SECTION 2. – CLAIMANT INFORMATION (Complete if you are <u>not</u> the primary victim)

Name of Victim _____ Address _____

City _____ State _____ Zip Code _____ Telephone Number _____

Date of Birth: _____ ○ Male ○ Female
(Submission of date of birth or gender is voluntary.)

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

Claimant's relationship to victim _____

SECTION 3. – STATISTICAL INFORMATION

Submission of information regarding date of birth, race/ethnic background, gender 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

Revised 10/5/22

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	◯ Yes	◯ No	Veteran's Benefits/Insurance	◯ Yes	◯ No
Life Insurance	◯ Yes	◯ No	Donations	◯ Yes	◯ No
Public Assistance	◯ 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 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	○ 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 Time	○ Yes	○ No	Public or General Assistance	○ Yes	○ No
Other Employer Benefits	○ Yes	○ 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 policy 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 <u>No</u>, please explain why

_____

_____

_____

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

○ community advocate	○ Infoline/211	○ County Attorney's Office/Advocate	○ police
○ medical provider	○ hospital	○ family member/friend	○ mental health provider
○ webpage	○ brochure	○ 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