VICTIM WITNESS ASSISTANCE PROGRAM

Serving Catoosa, Chattooga, Dade and Walker Counties

Chris Arnt,
District Attorney

DISTRICT ATTORNEY'S OFFICE

LOOKOUT MOUNTAIN JUDICIAL CIRCUIT

The District Attorney's Victim & Witness Assistance program provides services and support to victims of crime. You were identified as a victim in this case. We are sorry for any pain or loss you have suffered as a result of this crime.

As a victim, you have rights. You have the right to notice of court proceedings if you make a request in writing. I have enclosed a Victim's Request for Notification form. Please complete and return it to our office within two (2) weeks if you wish to receive notification. We must have valid contact information to provide notice. You must update the information if it changes. If not, you will not receive notification. For example, if the defendant is in custody and requests bond, you have a right to be notified and to be present for the hearing but we must be able to reach you.

Your input on sentencing is your right as a victim. Please fill out the enclosed *Victim Impact Statement.* Describe how this crime has affected you and what you would like see happen in the criminal justice system.

You have the right to seek restitution for any financial loss due to this crime. The enclosed Request for Restitution Form documents this. **Include copies of bills or estimates for any out-of-pocket expenses** you may have incurred. If you received injuries, please describe those injuries and include medical treatment records. This information will be public record. The Primary & Secondary Contact form which aids us in contacting you for restitution purposes will not.

You may be eligible for Georgia's Crime Victim's Compensation Program if you have incurred any medical, counseling or funeral expenses. If you wish to fill out an application, please contact our office. Your application must be submitted within one (1) year of the date on which the crime occurred. You may also call the State's Victim Compensation Program directly at (404) 657-1956. If you apply directly, please furnish our office with a copy of the application.

If you had any property taken as evidence, you may be able to have that property returned. However, if the defendant is convicted any evidence introduced at trial cannot be released until the appeals process is completed. To request the return of property, please contact the law enforcement agency that handled your case.

As the victim, or the parent of a minor victim, you also have the sole right to choose whether or not you (or your minor child) consent to be contacted or interviewed by anyone on behalf of the defendant. Please review the enclosed form.

I've also enclosed an Informational Guide. The guide explains each stage of the judicial process and your rights. It also provides important contact information for various services which may be available to you and your family.

Please do not hesitate to contact the county office if you have any questions or if we can be of assistance.

Restitution Form

CASE INFORMATION:

Victim Name	Defendant(s) Name(s)	Case Number and/or Charge(s)

When ordered by the court, restitution is paid by the defendant(s). In order that your loss may be adequately presented to the court, please complete this form and return to the District Attorney's Office via mail or FAX within two (2) weeks of receiving this letter. Be specific as possible when listing the damages you suffered and/or the items you lost. **You must enclose copies of bills, receipts, estimates, employer statement verifying missed work days, and any other documents that will assist the court.** Attach additional sheets if necessary. If additional help is needed, please contact your Victim Advocate.

Are you Seeking Restitution? ☐ **Yes** ☐ **No**

Did you incur costs for any of the following as a result of this crime? **Attach RECEIPTS for out of pocket expenditures. Please provide as much documentation as possible.*		
1.	☐ **Lost Wages** (May include, but is not limited to; work missed due to court hearings, meeting with District Attorney's Office, medical/counseling appointments, etc.)	Total Amount: $ _____
2.	☐ **Medical Expenses** **Have you applied for Georgia Crime Victim's Compensation?** ☐ **Yes** ☐ **No**	Total Amount: $ _____
3.	☐ **Mental Health, Counseling, Therapy**	Total Amount: $ _____
4.	☐ **Financial Loss** (This may include stolen cash, forged checks, monies lost from financial transaction card fraud)	Total Amount: $ _____
5.	☐ **Stolen and/or Damaged Property** (Attach receipts or documents to support claim) Were any of these items recovered? ☐ Yes ☐ No Were any of the items recovered damaged? ☐ Yes ☐ No	Total Amount: $ _____ Value of items **NOT** recovered: $_____ Repair cost $ _____
6.	☐ **Funeral Expenses**	Total Amount: $ _____
7.	☐ **Other** (Please specify)	
	1.	Amount: $ _____
	2.	Amount: $ _____
	3.	Amount: $ _____
	Total of Other:	Total Amount: $ _____
8.	☐ **For additional comments, please include details on additional paper**	Total Amount: $ _____
	9. Total (add lines 1-8):	

DID YOU FILE AN INSURANCE CLAIM: ☐ **Yes** ☐ **No** ☐ **Plan to File a Claim**
If yes, please include copies of claim forms to support your claim.

Name of Insurance Company: _____

Phone Number: _____ Policy Number: _____

Amount Paid by Insurance: $ _____ Your Deductible: $ _____

Remaining Expenses NOT covered by Insurance: $ _____
Attach documentation for out-of pocket expenditures NOT covered by insurance or by any other means.

10.	DO YOU ANTICIPATE ADDITIONAL COST AND/OR BILLS? ☐ Yes ☐ No If yes, what do you anticipate the **TOTAL** additional cost to be?	Total Amount: $ _____
	11. Total (add lines 9 & 10):	

I verify that to the best of my knowledge all the information provided by me on this form is true and correct.

Victim Name (Print): _____ Victim Signature: _____

Victim Address: _____

Victim Phone #: _____ Date: _____

If completed by someone other than the victim, please indicate your relationship to the victim: _____

PLEASE NOTE: some cases are resolved very quickly. Therefore, failure to return this form with the necessary documentation may result in loss of due restitution. Immediately notify the District Attorney's Office of additional bills/expenses received after this form is submitted.

APPLICATION AND INSTRUCTIONS

CRIME VICTIMS COMPENSATION PROGRAM

INSTRUCTIONS
To expedite the processing of your application, please submit a **Complete Application Packet,** which includes items 1 thru 3 below.

1.

Please complete the entire application, printing clearly. Sign every place where an original signature is requested.

2.

Provide us with a police or incident report that lists the victim or witness name, and a summary of the incident.

3.

The State Accounting Office who handles all payments for the CVCP may request a W-9 form for new payees to certify your identity. Submitting a completed W-9 form with your Complete Application Packet will assist with processing of your approved payments.

4.

Mail the complete application packet to
Criminal Justice Coordinating Council,
Crime Victims Compensation Program
104 Marietta Street NW, Suite 440
Atlanta, GA 30303

You can also register to apply online, by visiting victimscompportal.cjcc.ga.gov.
If you would like help completing your application, or if you have questions, please call us. We have Program Advocates available to assist you.

Office (404) 657-2222
Toll Free (800) 547-0060
TTY (404) 463-7650
Fax (404) 463-7652

GEORGIA CRIME VICTIMS COMPENSATION PROGRAM
CRIMINAL JUSTICE COORDINATING COUNCIL
www.crimevictimscomp.ga.gov

The Georgia Crime Victims Compensation Program (CVCP) may be able to ease the financial burden incurred by innocent victims and witnesses of crime, when other resources are exhausted.

Eligible program applicants can receive compensation of up to $25,000 to help with medical and dental care, counseling, economic support, crime scene sanitization, and funeral expenses when the costs are not covered by other sources.

BENEFITS COVERED

Medical and Dental Expenses..... UP TO $15,000

Lost Wage Expenses..... UP TO $10,000

Loss of Support Expenses..... UP TO $10,000

Funeral Expenses..... UP TO $6,000*

Counseling Expenses..... UP TO $3,000**

Crime Scene Sanitization Expenses..... UP TO $1,500

* A death certificate must be submitted with your application for funeral benefits. For crimes prior to May 6, 2015, the categorical cap is $3,000.
** Please refer to our website for the counseling benefits fee schedule.

PLEASE NOTE

- If you do not have some or all of the required documentation (such as an itemized bill or police report), you may still submit a signed application to begin the claim review process. Your claim will be incomplete and we will follow up with you for the additional documents that are needed.
- You may also submit an application even if there is no known offender. While the incident must be reported to law enforcement or an investigative agency (DFCS, APS, the courts, medical authorities, or the school system), arrest and/or prosecution of an offender is not a program or eligibility requirement.
- You may be asked to complete a medical release form when requesting medical or counseling benefits. Submitting the release with your Complete Application Packet may expedite processing.
- We are the payor of last resort. We cover expenses not paid by insurance, including Medicaid/Medicare or other monetary resources.
- Benefits received are based on actual eligible expenses and itemized bills must be submitted with your application for review.

CRIME VICTIMS COMPENSATION APPLICATION

104 Marietta Street
Suite 440
Atlanta, GA 30303

Office (404) 657-2222
Fax (404) 463-7652
Toll Free (800) 547-0060
TTY (404) 463-7650

GEORGIA CRIME VICTIMS COMPENSATION PROGRAM
CRIMINAL JUSTICE COORDINATING COUNCIL
www.crimevictimscomp.ga.gov

SECTION 1. VICTIM / WITNESS INFORMATION	Please provide information on the individual who was killed or injured as a result of a violent crime, or who witnessed a violent crime.

Victim/Witness Name (First, Middle, Last)	Gender ☐ Male ☐ Female	Date of Birth (MM/DD/YY) / /	Social Security Number (or TIN)
Street Address (including apartment #)	City	State	Zip Code
Best Contact Phone Number	Alternate Phone Number	E-Mail Address	

How would you like to receive claim updates? ☐ Email ☐ Mail

Demographic Data (For Statistical Use Only)

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian and Other Pacific Islander ☐ White/Non-Latino/Caucasian ☐ Hispanic/Latino ☐ Other Race_____

If 17 or older, is the victim a veteran? ☐ Yes ☐ No Is the victim disabled? ☐ Yes ☐ No If yes, is the disability as a result of the crime? ☐ Yes ☐ No

SECTION 2. SECONDARY CONTACT INFORMATION	If your contact information above changes, please provide information for a person we can contact to reach you about your claim. **Please Note:** We will not disclose any information about the claim to your secondary contact.

Victim/Witness Name (First, Middle, Last)	Best Contact Phone Number	Alternate Phone Number

SECTION 3. CLAIMANT INFORMATION	Complete this section if you are filing on behalf of the deceased victim, minor victim, incapacitated adult victim, or if you are not the victim but are paying bills on behalf of the victim.

Claimant Name (First, Middle, Last)	Gender ☐ Male ☐ Female	Date of Birth (MM/DD/YY) / /	Social Security Number (or TIN)
Street Address (including apartment #)	City	State	Zip Code
Relationship to Victim /Witness	Best Contact Telephone Number	Alternate Telephone Number	Email Address

How would you like to receive claim updates? ☐ Email ☐ Mail

Demographic Data (For Statistical Use Only)

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian and Other Pacific Islander ☐ White/Non-Latino/Caucasian ☐ Hispanic/Latino ☐ Other Race_____

Are you a veteran? ☐ Yes ☐ No Are you disabled ☐ Yes ☐ No

SECTION 4. BENEFITS REQUESTED	Please complete this section by checking all the benefits you are applying for and submit itemized bills for services related to the crime. **Please Note:** a death certificate is required for funeral benefits.

☐ **Medical**	☐ **Loss of Income**	☐ **Loss of Support**	☐ **Counseling**	☐ **Funeral/Burial**	☐ **Crime Scene Sanitization**

Please Note: If applying for loss of income, you cannot be reimbursed if your wages were fully covered (e.g., sick or annual leave, vacation, disability etc.) while you were out due to the crime. If eligible, you can only be reimbursed when you missed work and were not paid, or your wages were only partially covered.

Was the victim or witness gainfully employed at the time of the crime? ☐ Yes ☐ No
If yes, please provide the date(s) the victim or witness was out of work due to the crime:

Please check if you have requested/filed for: ☐ Restitution ☐ Workers Compensation ☐ Civil Action/Lawsuit

If benefits are awarded, please indicate if you would like to receive Direct Deposit (ACH Payment) or a Check ☐ Direct Deposit (ACH payment)* ☐Check
***Please note: Your first payment will be made by check as additional information is needed to set up Direct Deposit/ACH.**

SECTION 5. MEDICAL RECORDS/INFORMATION AUTHORIZATION	Some medical and counseling reimbursement may require a medical release form. While not required Submitting a medical release with your completed application packet may expedite processing later, if needed.

Please check the applicable box:
☐ **I am submitting the Medical/Information Authorization form, along with medical and/or counseling bills, with this application.**
☐ **I opt to complete the Medical/Information Authorization Form at a later time, if needed.**

SECTION 6. INSURANCE INFORMATION	Please provide us your insurance information, including Medicaid/Medicare.

Do you have insurance, including Medicaid/Medicare? ☐ Yes ☐ No If yes, Name of Insurance Company:

SECTION 7. **CRIME INFORMATION**	Completing the below section is optional if you include a police report or incident report with your application. We will accept a report from law enforcement, child/adult protective services, the school system, the courts, medical authorities or any other official governmental investigative agency.	
County of Crime	Date of Crime (MM/DD/YY) / /	Date Crime Reported (MM/DD/YY) / /
Agency Crime Reported to	Law Enforcement Agency Case Number (if known)	

SECTION 8. **GOOD CAUSE**	Please provide us information about when the crime was reported to the proper authorities and when you submitted your application.

Was the crime reported to the proper authorities within 72 hours: ☐ Yes ☐ No
If no, to prevent delay of your application, please explain why not:

Is this application being submitted within one year (or 3 years for crime occurring on or after 7/1/14) from the date of the crime? ☐ Yes ☐ No
If no, to prevent delay of your application, please explain why not:

Section 9. **REFERRAL INFORMATION**	Please tell us who referred you and/or assisted you in applying to the Crime Victims Compensation Program	
Name of Referring Agency or Office **Lookout Mountain Judicial Circuit**	Name of Contact person from Referring Agency or Office	Agency Phone Number

Please check which one applies:
☐ **The Referring Agency helped me with completing and/or submitting the required application and documents.**
☐ **The Referring Agency only told me about the Program or shared materials with me.**

Section 10. **RELEASE FOR DA'S OFFICE**	Please read this section carefully and let us know if you consent to allow the DA's office with jurisdiction over the crime for which you are applying access to view your claim. NOTE: This authorization can be revoked at any time.

I hereby authorize the release of information associated with this application to the District Attorney's Office, or any representative thereof, with jurisdiction over the crime for which this application is based. My signature allows the DA's office to view my claim and assist with obtaining required information. I understand that I can contact the Victims Compensation Program by phone or in writing to revoke this authorization at any time, except to the extent that the DA's office has already acted based on this Authorization. I understand this authorization is voluntary and will not affect my eligibility for benefits or payment thereof.

I Do Consent: X_____ I Do Not Consent: X _____

Section 11. **SUBROGATION AGREEMENT ACKNOWLEDGEMENT**	Please read this section carefully. The person who is signing this application, either as the victim/witness or the claimant, **must be 18 years of age.**

By signing this section, I certify to date that I have not received any compensation as a result of this crime. I also acknowledge that if I recover any money by legal judgment, settlement, or restitution resulting from this crime, based on the recovery agreement, I may be responsible for repaying some or all the amounts awarded to me, or on my behalf, by the Georgia Crime Victims Compensation Program. As such, I hereby agree that in consideration of an award by the Georgia Crime Victims Compensation Program, I assign, transfer and subrogate all claims, interest and rights of action that I may have against other parties or authorities up to the amount awarded by the Program.

X _____ _____
Victim/Witness/Claimant Signature (Original Signature Required) **Date**

Section 12 **CRIMINAL HISTORY & MEDICAL ACKNOWLEDGEMENT**	Please read this section carefully. The person who is signing this application, either as the victim/witness or the claimant, **must be 18 years of age.**

A criminal history report will be completed on all victims/witnesses and claimants 18 years of age and older. I hereby authorize and understand that a criminal history report will be analyzed to determine eligibility for the Georgia Crime Victims Compensation Program; I also authorize any hospital, physician, medical facility, insurer or any other person or law enforcement agency that has knowledge relative to my claim to furnish information to the Georgia Crime Victims Compensation Board. If psychiatric assistance is requested, a separate authorization form may be required.

X _____ _____
Victim/Witness/Claimant Signature (Original Signature Required) **Date**

Section 13. **ACKNOWLEDGEMENT OF UNDERSTANDING**	Please read this section carefully. The person who is signing this application, either as the victim/witness or the claimant, **must be 18 years of age.**

I hereby acknowledge that the Georgia Crime Victims Compensation Program will only award compensation if all of the programs eligibility requirements are met. I also acknowledge that the Georgia Crime Victims Compensation Program is the payor of last resort. As such, my benefits will be reduced by any monies I receive from any other source as a result of the crime, including insurance, restitution, and civil suit settlements.

X _____ _____
Victim/Witness/Claimant Signature (Original Signature Required) **Date**

REQUEST FOR NO CONTACT BY DEFENDANT, DEFENDANT'S ATTORNEY OR AGENTS

Under the Constitution, every person charged with a crime has the right to be represented by counsel. As a victim, or the parent of an underage victim, you have certain rights, too. You have the right to refuse to submit to an interview by the accused, the accused's attorney or any agent acting on behalf of the accused, such as an investigator, but it is equally your right to consent to an interview if you so choose. O.C.G.A.§17-17-8.1.

If you do choose to be interviewed, you may set conditions for such interview, such as the time, date and place of the interview. You may also choose to have other persons present, such as the prosecuting attorney or someone from our office. You may wish to have security arrangements for the interview. You may also agree, or not, to a recording of the interview. Furthermore, if you consent to an interview, you may stop the interview at any time and refuse to answer any question during the interview.

If you do choose to be interviewed, you may request a copy of any statement or recording you make, and, if you so choose, you may show it to the prosecuting attorney.

Please understand that this office has a duty to make you aware of these rights, but in no way does this office intend to suggest or recommend to you what decision you should make. The final decision, as to any and all of these things, is entirely up to you and no one else. No one in the District Attorney's Office may give you any advice other than what is contained in this written form.

If your decision is to exercise your right to have no contact, directly or indirectly, by the accused, the accused's attorney or an agent of the accused, we will convey that decision to the appropriate person. At that point, the law prohibits contact with you by the accused, the accused's attorney or an agent of the accused. Without a clear expression of a desire not to be interviewed, the accused, the accused's attorney or an agent of the accused may contact you in a reasonable manner for the purpose of interviewing you.

EXERCISE OF RIGHTS

AS A VICTIM OR PARENT OF A MINOR VICTIM IN THIS CASE, I REQUEST THAT NO CONTACT BE MADE WITH ME OR MY FAMILY. ANY CONTACT MAY BE MADE THROUGH THE DISTRICT ATTORNEY'S OFFICE. I DO NOT WISH TO BE CONTACTED BY THE DEFENDANT, THE DEFENDANT'S ATTORNEY OR ANY AGENT OR ANYONE ACTING ON BEHALF OF THE DEFENDANT IN THIS MATTER. I UNDERSTAND I CAN WITHDRAW THIS DECISION AT ANY TIME. I FURTHER STATE THAT NO COMMENTS, WORDS OR ACTIONS BY ANYONE IN THE DISTRICT ATTORNEY'S OFFICE HAS LED ME TO MAKE THIS DECISION.

DEFENDANT(S): CASE #:

VICTIM NAME:

VICTIM SIGNATURE: DATE:

Original Signature Required

CRIME VICTIM IMPACT STATEMENT

(Use additional sheets if needed)

Victim's Name:

Defendant's Name:

1. How has this crime affected you emotionally? _____
_____
_____
_____
_____
_____

2. How has this crime affected you physically? _____
_____
_____
_____
_____
_____

3. How has this crime affected you financially? _____
_____
_____
_____
_____
_____

4. What do you think should be the sentence given to the defendant for this crime? _____
_____
_____
_____
_____
_____

Signature of Victim: _____

Date: _____

VICTIM'S REQUEST FOR NOTIFICATION

Defendant's Name: _____

Victim's Name: _____

Mailing Address: _____

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

I authorize the District Attorney's office to contact me via the following methods:

Preferred (choose one)	**Secondary** (check all that apply)	**Contact type**	
		Text	
		Telephone contact	
		Email	Email Address:

In order to be notified of hearings concerning this case, I understand it is my responsibility to complete and return this form to the Office of the District Attorney. I understand that failure to maintain a current address and telephone number with the Office of the District Attorney will result in no notification.

Signature: _____ Date: _____

Primary & Secondary Contact

In accordance with O.C.G.A. § 17-17-8 (c) (3) the information contained herein "…shall be treated as confidential and shall not be disclosed to any person outside of the disclosure provided by this subsection; such information shall not be subject to Article 4 of Chapter 18 of Title 50, relating to open records, or subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding."

Victim Contact Information

Full Legal Name: _____
First Middle Maiden Last

Mailing Address: _____

_____, _____, _____
City State Zip Code

Telephone Numbers: _____ _____ _____
Home Work Cell

E-Mail Address: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____
Month Day Year

SECONDARY CONTACT

IF NECESSARY, WHO MAY WE CONTACT TO HELP LOCATE YOU**?** (Not in your household)

Full Legal Name: _____
First Middle Maiden Last

Mailing Address: _____

_____, _____, _____
City State Zip Code

Telephone Numbers: _____ _____ _____
Home Work Cell

E-Mail Address: _____

Date of Birth: _____/_____/_____
Month Day Year

Relationship: _____

Disclosure Information: Pursuant to O.C.G.A.17-17-8 (c) (2) "The prosecuting attorney shall transmit the information collected in paragraph (1) of this subsection to the Department of Corrections, Department of Juvenile Justice, or the State Board of Pardons and Paroles, as applicable, if an order of restitution is entered."