Claim No. _____

VICTIM ASSISTANCE AND SEXUAL ASSAULT PROGRAM
Department of Health and Human Services
Behavioral Health and Crisis Services

COMPENSATION AND PROPERTY REPLACEMENT APPLICATION

1) **Victim's Name** _____ 2)_____
Last First M.I. *Social Security Number*

3) Address _____
Street City/Town State Zip

Telephone: Home: _____ Work: _____

4) Victim's Date of Birth _____/_____/_____ 5) _____Male _____Female

6) Race/Ethnic Identification ___Black (Not Hispanic Origin) ___American Indian or Alaskan Native
___ Hispanic ___Asian or Pacific Islander
____White (Not Hispanic Origin) ___ Other

7) **Claimant's Name** _____
(if victim is a minor or deceased) *Last First M.I.*

Address _____
Street City/Town State Zip

Telephone: Home: _____ Work:_____

CRIME INFORMATION

a. Date of Crime _____
b. Type of Crime _____
c. Date Reported to Police _____
d. Name of Department _____ _____
Report #

EMPLOYMENT

Current Employer: _____
Employer's Address: _____
Contact Person/Phone Number: _____

IF UNEMPLOYED

Most Recent Employer: _____
Employer's Address: _____
Contact Person/Phone Number: _____

Description of Incident _____

_____

_____

_____

Continue on back page if necessary

CLAIM INFORMATION

Medical Expenses $_____

Explain _____

_____

_____

_____

Value of Property Stolen or Damaged $_____

Explain _____

_____

_____

_____

Cost of Repairs $_____

Explain _____

_____

_____

_____

Lost Wages $_____

Explain _____

_____

_____

_____

Amount Reimbursed or Paid to Date $_____

Source: _____

Insurance Company, Employer, Offender, Etc.

TOTAL AMOUNT OF CLAIM **$_____**

INCOME INFORMATION

Total Annual Gross Family Income $_____ **or** Monthly Income $ _____

Sources: Wages _____ Public Assistance _____

Retirement Income _____ Alimony _____

Social Security _____ Child Support _____

Disability Income _____ Other _____

DEPENDENTS

Names	Relationships	Ages

DECLARATION

I hereby affirm that the compensation or property replacement requested is not available from any other source such as insurance and other grant programs. I understand that any recovery of my losses through legal action (Restitution or Civil Action) for which I have received compensation shall be reimbursed to Montgomery County. I declare that information provided and statements made to the Victim Assistance and Sexual Assault Program are true and based on personal knowledge.

Claimant's Signature* _____ **Date** _____

*If the claimant is a minor, claim must be signed by his/her parent or guardian.

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who attended or examined:

_____

(Place Your Name Here)

or other person who rendered services; any employers of the victim; any police or other municipal authority or agency, or public authority; any insurance company or organization, having knowledge thereof, to furnish to the Montgomery County Department of Health and Human Services, or its representatives, any and all information with respect to this incident leading to the victim's personal and/or property loss, and the claim made herewith for benefits. A photocopy of this authorization will be considered as effective and valid as the original.

_____ _____

Claimant's Signature **Date**

Description of Incident (Continued)

Use this space for any additional information you would like the Victim Assistance and Sexual Assault Program to know.

Return Form to: **VICTIM ASSISTANCE & SEXUAL ASSAULT PROGRAM**
1301 Piccard Drive, Suite 4100
Rockville, Maryland 20850
Telephone: 240/777-1355
TTY: 240/777/1347
www.montgomerycountymd.gov/vasap