New Mexico Crime Victims Reparation Commission

You may qualify for financial assistance through New Mexico Crime Victims, if you answer "YES" to the following six questions:

1. Have you been the victim of a violent crime?
2. Did the crime take place in New Mexico?
3. Was the crime reported to law enforcement within 30 days?

(There are exceptions for minors, victims of sexual assault, and victims of domestic violence)

4. Did the crime occur within the last two years?
5. Did you cooperate fully with law enforcement?
6. Do you have expenses as a result of the crime?

If you answered YES to all of the above questions, please fill out the attached application and mail it to the address below. If you need help filling out the application please call your local District Attorney's Office or call Crime Victims Reparation Commission at: (505) 841-9432. You have **two years** from the date of the crime to file an application. (There are exceptions for minors regarding abandonment or abuse of a child, and sexual assault).

The maximum amount of compensation that can be awarded on any one application is $20,000.00. The type of expenses we cover include:

- Medical
- Dental
- Hospital
- Funeral (Up to $3,500.00)
- Counseling
- Loss of Wages
- Eyeglasses (Up to $350.00)
- Or other medically necessary devices

There is NO award for loss or damage to property or for pain and suffering.

Expenses incurred as a result of the incident must first be submitted to all readily available collateral sources, such as your insurance company, local indigent program, Medicare, and Medicaid for payment. Those expenses not fully covered by collateral sources will be considered for payment.

If you answered NO to any of the above six questions, please contact your local District Attorney's victim advocate for additional referrals.

State of New Mexico Crime Victims Reparation Commission
8100 Mountain Road N.E., Suite - 106
Albuquerque, New Mexico 87110
Telephone (505) 841-9432 / Fax (505) 841-9437
Toll free 1-800-306-6262
cvrc@state.nm.us

STATE OF NEW MEXICO CRIME VICTIMS REPARATION COMMISSION
Telephone: (505) 841-9432 Fax: (505) 841-9437

DO NOT USE PENCIL

SECTION I: VICTIM DATA	Victim's Full Name:			
Address:	City:	State:	Zip:	Home Phone: ( )
❑ Male ❑ Female	Date of Birth: \ \	Age at Incident:	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow	Social Security #: \ \
Dependents: Name/Age/Address:				

Is the Victim: ❑ Deceased ❑ Incapacitated ❑ A Minor if so, THEN COMPLETE SECTION II

SECTION II: CLAIMANT DATA	Claimant's Full Name:			
Date of Birth: \ \	Relationship to Victim:		Social Security #: \ \	
Address:	City:	State:	Zip:	Home Phone: ( )

SECTION III: CONTACT DATA Someone other than the victim or claimant if we are unable to contact you	Contact's Full Name:		Relationship to Victim:
Address:	City:	State:	Zip:	Home Phone: ( )
Employer:	Address:			Work Phone: ( )

SECTION IV: CRIME INFORMATION Attach Police Reports if available	Date of Crime: \ \	Date Crime Was Reported: \ \	Police Agency Reported To:
Name of Officer or Detective:	Crime Location (Street address):	City:	County:
Briefly Describe What Happened:	Name of Suspects if Known:		
Injuries	Is Victim Related to Suspects? ❑ YES ❑ NO If so, how?_____ Has Restitution Been Ordered? ❑ YES ❑ NO How Much? $_____		

SECTION V: LOSS Of WAGES

Please indicate if the victim/claimant will be applying for Loss of Wages.

Is the **VICTIM** applying for loss of wages? ❑ YES ❑ NO Did the **VICTIM** take time off work? ❑ YES ❑ NO

Employer at time of incident: _____ Job Title:_____ Work Phone _____

Address: _____ City: _____ State: _____ Zip Code: _____

Is the **CLAIMANT** applying for loss of wages? ❑ YES ❑ NO Did the **CLAIMANT** take time off work? ❑ YES ❑ NO

Employer at time of incident: _____ Job Title:_____ Work Phone _____

Address: _____ City: _____ State: _____ Zip Code: _____

If Self-Employed, we require Income Tax Returns from both the year prior to incident and year of incident

SECTION VI: FUNERAL EXPENSES

Name of Funeral Home:

Date of Death: \ \

Names on Funeral Contract:

Amount of Burial Expense: $

Address of Funeral Home:

City:

State:

Zip:

Phone: ( )

SECTION VII: Insurance

Complete Sub-Section B if the incident involves a motor vehicle

A

Policy Holder's Name:

Policy Holder's SS #: \ \

Policy #:

Insurance Phone: ( )

Name of Insurance Company:

Address:

City:

State:

Zip:

B

Victim's Car Insurance:

Policy #:

Insurance Phone: ( )

Insurance Address:

City:

State:

Zip:

Third Party's Car Insurance:

Policy #:

Insurance Phone: ( )

Suspect's Car Insurance:

Policy #:

Insurance Phone: ( )

SECTION VIII: COLLATERAL SOURCES

Please indicate with a checkmark in the YES or NO box if any of the following sources could pay for your expenses.

1) MEDICARE: ❑ YES ❑ NO **2)** I H S: ❑ YES ❑ NO **3)** DISABILITY: ❑ YES ❑ NO

4) SOCIAL SECURITY: ❑ YES ❑ NO **5)** MEDICAID: ❑ YES ❑ NO **6)** WORKER'S COMP: ❑ YES ❑ NO

7) INDIGENT FUNDS: ❑ YES ❑ NO **8)** VETERAN'S BENEFITS: ❑ YES ❑ NO

9) EMERGENCY FUNDING: ❑ YES ❑ NO **10)** HOME OWNER'S OR RENTER'S INSURANCE: ❑ YES ❑ NO

11) Did the victim receive payments/donations from any other source due to incident? ❑ YES ❑ NO
If so, please list source and amount: Source: _____ $ _____

SECTION IX: Medical/Dental/Mental Health Expenses

Attach additional sheets if necessary. Please provide copies of bills, receipts, or cancelled checks.

Name of Provider/Hospital	Amount Charged	Paid by Insurance	Paid by Victim/Claimant

SECTION X: Civil Attorney Information

If a settlement is received, you must reimburse CVRC for amount paid

Have you hired an attorney for a civil suit? ❑ YES ❑ NO

Attorney's Name:

Phone: ( )

Address:

City:

State:

Zip:

SECTION XI: Information required by the Federal Government

National Origin of Victim:

Ethnic Group of Victim: ❑ White ❑ Black ❑ Hispanic ❑ Asian or Pacific Islander

❑ Native American Native American residency within the last six months: ❑ Rural ❑ Pueblo ❑ Reservation ❑ City

Any prior existing disability of victim? ❑ YES ❑ NO Describe:_____

Who referred you to the compensation program?

❑ Law Enforcement ❑ Department of Justice ❑ Hospital ❑ Media (TV, Radio, etc)
❑ District Attorney ❑ Victim/Witness Group ❑ Other _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____
Name (PLEASE PRINT)
have read the foregoing application form before signing it and hereby swear, under oath, that all the information I have given is true and correct. I promise to repay the New Mexico Crime Victims Reparation Commission if I receive payment from the offender, restitution, civil action, or other collateral source resulting from this incident.

_____
Please initial

I authorize any hospital, physician, or person who attended, examined, acted as an undertaker, or any person who rendered service, to furnish the New Mexico Crime Victims Reparation Commission, or its representatives, any and all information with respect to personal injury or death.

_____
Please initial

I authorize my current and /or previous employer to comply with any request submitted by New Mexico Crime Victims Reparation Commission for information of the following types, concerning my employment: job title(s), days and hours of employment, pay rate(s), dates of absence(s), category of absence(s) (vacation, holiday, etc.), and verification of disability benefits.

_____
Please initial

Pursuant to Section 29-10-6 A of the New Mexico Arrest Record Information Act, I hereby appoint the Crime Victims Reparation Commission as an authorized agent for me for the purpose of inspecting any arrest record information or any other information concerning me maintained by the Law Enforcement Agencies within the State of New Mexico. This authorization includes the United States Attorney's Office and investigation information they have regarding the crime for which I am applying for assistance.

To the custodian of the records in question, I hereby direct you to release such information to the Crime Victims Reparation Commission. A copy of this release form will be valid as an original hereof even though that copy does not contain an original writing of my signature.

I hereby release the custodian(s) of such records and the Department of Public Safety, the State of New Mexico, or any other Municipal or County Police Department within the State of New Mexico, including any of their agents, employees or representatives in any capacity, from any and all claims of liability or damage of whatever kind or nature, which at any time could result to me, my heirs, assigns, associates, personal representative(s) of any nature because of compliance by said custodian(s) with this Authorization for Release of Information and my request contained herein for this release or because of any use of these records. This release is binding, now and in the future, on my heirs, assigns, associates, or personal representative(s) of any nature.

I also authorize the Social Security Administration to release information about myself to the Crime Victims Reparation Commission for the purposes of collateral source assessment. The information to be released would include all information pertaining to the Social Security Benefits. This consent is indefinite until I withdraw my authorization. I am the individual to whom such records pertain. I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5000.00 or (1) year in prison.

This authorization will have no limitations placed on dates, history of illness or diagnostic and therapeutic information, including any treatment for counseling and/or psychiatric consultation, alcohol and drug abuse.

_____
Please initial

I hereby authorize you to disclose my medical records, including, but not limited to, the results of a Human Immunodeficiency Virus Test (HIV), to the New Mexico Crime Victims Reparation Commission. I hereby waive, to the extent specified above, any right to confidentiality as to the results of my HIV test. I understand that disclosure of HIV testing information is protected by the NM Human Immunodeficiency Virus Test Act, NMSA 24-2B-1 et. seq., that my test results will be released only pursuant to the provisions of this Act and that any disclosure of my test results will be made with the following disclosure:
"This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by law."

_____
Please initial

_____ _____
SIGNATURE (Must be 18 years of age & over) **Social Security Number of Person signing**

_____ _____ _____
Print **VICTIM'S** name Your relationship to the victim **Date**

********** **This portion is to be completed by a Notary Public**********

SUBSCRIBED AND SWORN TO before me this _____day of _____, 20_____.

SEAL

Notary Public: _____

My Commission Expires:_____

This box is to be completed by VICTIM ADVOCATE only.

Name:_____

Organization:_____

Phone Number:_____

Signature:_____Date:_____