Restitution Request Form

Commonwealth v. _____

If you have suffered financial loss and/or physical and psychological harm because of the Defendant's activities, please complete this form. Restitution is the part of the sentence given by a Judge to reimburse victims for their direct losses as the result of the crime. Generally, property losses, monetary losses, medical and counseling bills can be included. To ensure your input and information is included in the case file, this form must be returned to this office as soon as possible. If you have questions, call 570-946-4053 and ask to speak to the Victim Witness Coordinator. Please return this form to the Sullivan County District Attorney's Office, PO Box 157, 245 Muncy Street, Laporte, PA 18626. **Protect your restitution claim by returning this form quickly.**

Restitution is only collectible after conviction by plea, trial or settlement and is collected and disbursed by the Sullivan County Probation Office.

Name: _____	Day Telephone #: _____
Address: _____	Evening Telephone#: _____
City, State, Zip: _____	Cell #: _____
Preferred method of contact: _____	Email Address: _____

1. Did you have any cash or property taken or damaged because of this crime? _____
   If yes, please include copies of receipts, estimates, bills, insurance claim forms or other information to support your claim. Please send us this information even if you have already given it to the police.

Description of Loss or Damage Value of Loss, Cost/Estimate of Repairs

_____ $_____

_____ $_____

_____ $_____

_____ $_____

_____ $_____

Attach additional sheets, if necessary. Total $_____

2. Did insurance pay for some of your damage/losses? _____
   If yes please give us this information:

Insurance type: Auto_____ Homeowner ____ Defendant's Insurance ____ Other _____

Name: _____Agent's Name: _____

Address: _____

Telephone #: _____Claim #: _____Policy #_____

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

3. Do you have bills for medical treatment and/or counseling because of the crime? _____
   If yes, please include copies of bills.
   - **a.** Is your treatment completed? _____
   - **b.** Have you received all the bills? _____

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Dates Hospital/Doctor/Prescription/Counselor Amount

_____ _____ $_____

_____ _____ $_____

_____ _____ $_____

_____ _____ $_____

_____ _____ $_____

Attach additional sheets, if necessary. Total $_____

4. Did insurance or medical assistance pay some of your medical/counseling bills _____
If yes please give us this information:

Date of Birth: _____

Insurance type: Auto_____ Medical_____ Work Benefit_____ Other_____

Company Name: _____ Agent's Name: _____

Address: _____

Telephone #: _____ Claim #: _____ Policy #: _____

Your deductible or co-pays: $_____ Amount insurance paid: $_____

5. Did you lose money because of forgery, bad checks, credit card/debit card misuse or another financial crime? _____

a. Type of Loss: _____

b. Amount of Loss: $_____

c. If your money was returned by a bank or a credit card company who took the loss, please give us this information:

Name of Bank/Company: _____ Amount paid: $_____

Address: _____ Telephone #: _____

6. Have you applied for Victim's Compensation Assistance? _____

a. If no, would you like assistance applying for Victim's Compensation Assistance? _____
Victim's Compensation Assistance may help you to pay medical, counseling, loss of wages, and travel expenses. It does not cover property losses.

The information I have provided is true and correct. I give my permission to release information to the District Attorney's office about bills related to this case that were paid for me.

Signature: _____ Date: _____