

RESTITUTION CLAIM FORM

This form, along with all supporting documentation should be returned to:

**Office of the Commonwealth's Attorney
Victim Witness Assistance Program
9300 West Courthouse Road#102
Manassas, VA 20110
(703)792-8220**

Defendant _____ **Court Date** _____

Name of Person Completing Form **Relationship to Victim**

Name of Victim

ECONOMIC LOSS

A. Financial Loss

- 1. Property Loss. List the property lost as a result of this crime. This is property that has not been and is not expected to be recovered. (Attach copies of any relevant receipts)**

Cost \$ _____

\$ _____

- 2. Property Damage. List property damage as a result of this crime and attach copies of bills for repair or replacement.**

Cost \$ _____

- 3. Medical/Hospital Costs, to include current or future expenses (Attach copies of any bills or receipts)**

\$ _____

4. Other Economic Losses/Costs-both current and future
(Lost wages and/or income-please specify type of loss) \$ _____

SUBTOTAL A: Property Loss+Property Damage+Medical/Hospital+Other=

TOTAL \$ _____

B. Reimbursement Received

1. Name and Address of Property Insurance Company

Total amount received/reimbursed \$ _____

2. Name and Address of Hospital/Medical Insurance Company

Total amount received/reimbursed \$ _____

3. Restitution Received \$ _____
Explain _____

4. Other Reimbursements Received \$ _____
Explain _____

SUBTOTAL B: Sum of Reimbursements TOTAL \$ _____

C. Economic Loss NOT Reimbursed

SUBTOTAL A Minus SUBTOTAL B = TOTAL \$ _____

NOTE: This amount represents your total out of pocket unreimbursed financial losses. The total MUST be CLEARLY indicated to ensure the Court addresses restitution.

Signature of Person Completing Form

Date

Daytime Telephone Number _____