

# 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?
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?

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

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 \$6,000.00)
- 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**

**APPLICATION FOR REPARATION AND AUTHORIZATION**  
**NEW MEXICO CRIME VICTIMS REPARATION COMMISSION**  
 Telephone: (505) 841-9432 Fax: (505) 841-9437

**DO NOT USE PENCIL**

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<b>SECTION I: VICTIM DATA</b>		Victim's Full Name:			Home Phone #: ( )
Mailing Address:		City:	State:	Zip	Cell or Message #: ( )
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: / /	Age at Incident:	<input type="checkbox"/> Single <input type="checkbox"/> Separated	<input type="checkbox"/> Married <input type="checkbox"/> Widow	<input type="checkbox"/> Divorced  Social Security #: / /
Dependents: (Name/Age):					

<p><b>Is the victim:</b> <input type="checkbox"/> Deceased (Submit a death certificate) <input type="checkbox"/> Incapacitated (Submit a power of attorney) <input type="checkbox"/> Or a minor,  <b>IF SO, COMPLETE SECTION II</b></p>
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<b>SECTION II: CLAIMANT DATA</b>		Claimant's Full Name:			
Date of Birth: / /	Social Security #: / /	Relationship to Victim:			Cell or Message #: ( )
Mailing Address:		City:	State:	Zip:	Home Phone #: ( )

<b>SECTION III: CONTACT DATA</b> Someone who doesn't reside with the victim or claimant if we are unable to contact you.		Contact's Full Name:			Relationship to Victim:
Mailing Address:		City:	State:	Zip:	Home Phone #: ( )

<b>SECTION IV: CRIME INFORMATION</b> Attach police reports if available		Date of Crime: / /	Date Crime Reported: / /	Police Agency Reported To:	
Name of Officer or Detective:	Crime Location (Street Address):		City:	County:	
Briefly Describe What Happened:	Injuries:	Name of Suspect(s) if Known:			
		Is Victim related to Suspect(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, how? _____			

<b>SECTION V: LOSS OF WAGES</b>	If Self-Employed, we require Income Tax Returns from both the year prior to incident and year of incident.
Did the <b>VICTIM</b> take time off from work due to the incident? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is the <b>VICTIM</b> applying for loss of wages? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Employer at the time of incident: _____ Job Title: _____ Work Phone: _____	
Address: _____ City: _____ State: _____ Zip Code: _____	
Did the <b>CLAIMANT</b> take time off from work due to the incident? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is the <b>CLAIMANT</b> applying for loss of wages? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Employer at the time of incident: _____ Job Title: _____ Work Phone: _____	
Address: _____ City: _____ State: _____ Zip Code: _____	

<b>SECTION VI: FUNERAL EXPENSES</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO	Name of Funeral Home:		
Date of Death: / /	Names on Funeral Contract:		Amount of Burial Expense: \$		
Address of Funeral Home:		City:	State:	Zip:	Phone #: ( )

<b>SECTION VII: INSURANCE</b>		Is insurance available? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Policy Holder's Name:		Policy Holder's SS#: / /	Policy #:	Insurance Phone #: ( )	
Name of Insurance Company:	Address:		City:	State:	Zip:

**If the incident involved a motor vehicle, please provide the following information:**

Victim's car insurance:	Policy #:	Insurance Phone #: ( )	
Address:		City:	State: Zip:

<b>SECTION VIII: COLLATERAL SOURCES</b>	Please indicate with a check mark in the YES or NO box if any of the following sources could pay for your expenses.		
1) MEDICARE: <input type="checkbox"/> YES <input type="checkbox"/> NO	2) I H S: <input type="checkbox"/> YES <input type="checkbox"/> NO	3) DISABILITY: <input type="checkbox"/> YES <input type="checkbox"/> NO	
4) SOCIAL SECURITY: <input type="checkbox"/> YES <input type="checkbox"/> NO	5) MEDICAID: <input type="checkbox"/> YES <input type="checkbox"/> NO	6) WORKER'S COMP: <input type="checkbox"/> YES <input type="checkbox"/> NO	
7) INDIGENT FUNDS: <input type="checkbox"/> YES <input type="checkbox"/> NO	8) VETERAN'S BENEFITS: <input type="checkbox"/> YES <input type="checkbox"/> NO		
9) EMERGENCY FUNDING: <input type="checkbox"/> YES <input type="checkbox"/> NO	10) HOME OWNER'S OR RENTER'S INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO		
11) Did the victim receive payments/donations or insurance settlements from any other source due to incident? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If so, please list source and amount: Source: _____ \$ _____			

<b>SECTION IX: MEDICAL/DENTAL/MENTAL HEALTH EXPENSES</b>	<b>You must provide insurance information to all providers.</b>		
Have you done this? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Name of Provider/Hospital	Provider Address & Phone #:		

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

<b>SECTION X: CIVIL ATTORNEY INFORMATION</b>	If a settlement is received, you must reimburse CVRC for amount paid.		
Have you hired an attorney for a civil suit? <input type="checkbox"/> YES <input type="checkbox"/> NO	Attorney's Name:	Phone #: ( )	
Address:	City:	State:	Zip:

<b>SECTION XI: INFORMATION REQUIRED BY THE FEDERAL GOVERNMENT</b>	Country of Birth:
Ethnic Group of Victim: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander	
<input type="checkbox"/> Native American Native American residency within the last six months: <input type="checkbox"/> Rural <input type="checkbox"/> Pueblo <input type="checkbox"/> Reservation <input type="checkbox"/> City	
Any prior existing disability of victim? <input type="checkbox"/> YES <input type="checkbox"/> NO Describe: _____	

Who referred you to the compensation program?

<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Department of Justice	<input type="checkbox"/> Hospital	<input type="checkbox"/> Media (TV, Radio, Website, etc.)
<input type="checkbox"/> District Attorney	<input type="checkbox"/> Victim/Witness Group	<input type="checkbox"/> Other _____	

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 NMCVRC, to the extent of any reparation I am awarded if I receive restitution from the offender, monetary recovery from a civil lawsuit (including a judgment or settlement), or other collateral source, such as an insurance company, further, I hereby authorize the NM Corrections Department to directly send to the NMCVRC any restitution collected by the NM Corrections Department from the offender related to the incident for which I received reparations, to the extent of any reparations I am awarded.

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 \_\_\_\_\_

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 (i) 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 \_\_\_\_\_

\*\*\*\*\* This section is to be signed in front of a Notary Public\*\*\*\*\*

\_\_\_\_\_  
SIGNATURE (Must be 18 years of age & over)

\_\_\_\_\_  
Social Security Number of Person Signing

\_\_\_\_\_  
Print VICTIM'S name

\_\_\_\_\_  
Your relationship to the victim

\_\_\_\_\_  
Date

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

SEAL

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

<b>This box is to be completed by VICTIM ADVOCATE only.</b>	
Name: _____	
Organization: _____	
Phone Number: _____	
Signature: _____	Date: _____