NEW MEXICO CRIME VICTIMS REPARATION COMMISSION
CRITICAL INCIDENT APPLICATION

DATE OF INCIDENT: _____

LAW ENFORCEMENT AGENCY: _____

VICTIM DATA:

VICTIM'S FULL NAME:_____ DOB:_____

ADDRESS: _____(City/State/Zip):_____

MALE:_____FEMALE: _____ SSN: XXX-XX- _____ PHONE: _____

EMAIL: _____

CLAIMANT DATA:

CLAIMANT'S FULL NAME: _____ DOB: _____

ADDRESS: _____(City/State/Zip):_____

MALE:_____FEMALE: _____ SSN: XXX-XX- _____ PHONE: _____

EMAIL: _____

ALTERNATE CONTACT NAME: _____PHONE NUMBER:_____

POTENTIAL EXPENSES:

MEDICAL: _____ MENTAL HEALTH: _____ FUNERAL/BURIAL: _____

DENTAL: _____ LOSS OF WAGES: _____ OTHER: _____

COLLATERAL SOURCES:

HEALTH INSURANCE: _____ MEDICAID: _____ MEDICARE:_____

PREPARED BY (PLEASE PRINT): _____

AGENCY: _____

NOTES:

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