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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