Victim/Witness Assistance Program of Adams County

Support Services for Victims of Crime

VICTIM IMPACT STATEMENT

Defendant: _____ **Case Number:** _____

Print Name of Victim _____

Print Name of Parent or Guardian _____ **Date** _____

As the victim of a crime, you have the right to submit a **Victim Impact Statement (VIS)** to describe how this crime has affected you, and those close to you. This is a voluntary statement and you are under no obligation to fill out this form. This statement is not confidential and will be given to the defense counsel. Therefore, the defendant may see it as well.

The **VIS** is not a retelling of the incident, but a description of how your life and the lives of your loved ones have been changed by this crime. Please include any emotional changes, physical injuries, lifestyle changes, and/or financial burdens that you may have experienced. Writing Impact Statements can be challenging and emotional, please be patient with yourself as you process your memories and feelings. Take a break if you need to and come back to it when you feel you are ready. A Victim Advocate would be happy to assist you with this process. *(use extra paper if needed)*

1. How would you introduce/describe in your own words your loved one?

2. What have you lost in the way of companionship with your loved one (holidays, family events, special milestones)?

3. What are the consequences of the loss to yourself and other family members?

4. What do you think would be an appropriate sentence for the Defendant?

5. Is there anything else you feel is important for the court to know?

RETURN TO: Victim/Witness Assistance Program, 117 Baltimore Street, Gettysburg, PA 17325
Phone: 717-337-9844 | Fax: 717-334-3859

RESTITUTION FORM

1. PHYSICAL INJURY AND/OR COUNSELING (medical, counseling, prescription, etc.)

Is your treatment completed? _____Yes _____No Have you received all bills? _____Yes _____No

Please list any and all medical and/or counseling out of pocket losses. Please attach all bills and/or receipts. *Use additional pages if necessary.*

Date of service	***Provider (doctor, hospital, counselor, prescription, co-pay)***	***Amount***
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

Insurance type: ___None ___Auto ___Medical ___Work Benefit ___Other **Total amount insurance paid $_____**

Total amount of personal out of pocket loss $_____

2. PROPERTY (damaged, lost, or stolen)

Please list the item, its value and check whether insurance covered any loss. Please attach all bills, estimates, receipts, and/or proof of value. *Use additional pages if necessary*.

Item	***Value***	***Insurance***
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____

Total amount of out of pocket loss $_____

Insurance type: ___None ___Auto ___Homeowner ___Renter ___Defendant ___Other

Did you pay a deductible? _____No _____Yes If yes, how much? $_____

Total amount of out of pocket loss (with deductible) $_____

3. OTHER: Costs for crime scene clean-up? ___Yes ___ No Funeral expenses? ___ Yes ___ No
If yes, your advocate will be in touch with you regarding these expenses.

4. If there is **NO RESTITUTION** owed to you, please check this box and return the form to us. ☐

Signature of Victim _____ Date _____

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