Victim/Witness Assistance Program of Adams County

Support Services for Victims of Crime

JUVENILE COURT VICTIM IMPACT STATEMENT

Juvenile: _____Case Number:_____

Print Name of Victim _____ 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 may be given to the defense counsel. Therefore, the juvenile may it as well.

1. 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 endured. Attach additional pages if necessary.

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2. Which of these outcomes closely reflects your beliefs about an appropriate sentence? Check all that apply.

____ Probation Supervision

____ Detention

____ Special Conditions (Circle all that apply): Drug/Alcohol Treatment, Anger Management, No Contact w/Victim(s), Psychological Treatment, Victim Awareness Program

3. If the juvenile is eligible for the **Consent Decree Disposition**, and successfully completes the program, the juvenile's charges will be expunged (removed from record). The requirements of this program may include: court costs, restitution paid in full, victim awareness program, community service, recommended counseling, and a period of probation. The decision to accept or deny enrollment into the Consent Decree Disposition is at the discretion of the District Attorney, Probation, and the Judge.

However, your position and input are greatly considered. _____ Approve _____ Object

RETURN TO: Victim/Witness Assistance Program, 117 Baltimore Street, Gettysburg, PA 17325

Phone: 717-337-9844 | Fax: 717-334-3859

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RESTITUTION FORM

Defendant: _____ **Case Number:** _____

Name of Victim_____ **Phone Number**_____

As the victim of a crime, you have the right to submit a restitution request for any direct financial loss as a result of this crime. This statement is not confidential and may be given to the defense counsel. Therefore, the defendant may see it as well.

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. FINANCIAL (forgery, bad checks, credit/debit card misuse, etc.)

Were you reimbursed? ___No ___Yes If yes, how much? $_____ **Total amount of out of pocket loss $**_____

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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