CARBON COUNTY
DISTRICT ATTORNEY'S OFFICE
4 BROADWAY · PO BOX 36
JIM THORPE, PENNSYLVANIA 18229
TELEPHONE: (570) 325-2718
FAX: (570)325-3525

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VICTIM IMPACT STATEMENT

Please complete & return this statement to the District Attorney's Office within ten (10) days, including any proof of loss.
Mail to: DA's Office, Attn: Victim/Witness, PO Box 36, Jim Thorpe, PA 18229
or e-mail to SARAHREESER@CARBONCOUNTY.NET

COMMONWEALTH VS. ___________________________________ **NO.** _____________________

VICTIM'S NAME: ____

VICTIM'S ADDRESS: ____

VICTIM'S TELEPHONE NUMBER: (H) _______________________ **(C)** ____________________________

VICTIM'S EMAIL ADDRESS: ____

The District Attorney's Office is required to provide specific information to you about the case. These include notices regarding potential reduction or dropping of charges, changing of a plea, notice of disposition hearings, notice of sentencing and final disposition and notice of release from a state correctional facility and/or mental health facility.

Please indicate the following:

____ I DO NOT wish to be contacted further regarding this case.

____ Please MAIL my notices to the address above

____ Please E-MAIL my notices to the e-mail address above

____ A voicemail MAY be left on the phone number(s) above

____ A voicemail MAY NOT be left on the phone number(s) above

Under Act 1992-155, Section 479.10, "The information provided shall not be disclosed to a person other than law enforcement or corrections agency… without prior consent of the victim."

Please notify this office of any changes to address or phone number promptly to ensure you are notified of all information related to your case. Addresses, phone numbers and any other identifying information is kept confidential within our office.

AS A RESULT OF THIS INCIDENT:

1. Were you physically injured? Yes No
   If yes, what were the extent of your injuries?

   ____

   ____

   ____

2. Did you receive medical treatment? Yes No
   If yes, briefly describe type and dates of service of treatment(s).

   ____

   ____

   ____

3. Have you incurred any out-of-pocket medical expenses? (Charges not covered by insurance – copay, coinsurance, deductible, etc.) Yes No
   If yes, please attach itemized bills from each provider showing the amount paid/due. Copies of bills are <u>required</u> to substantiate your claim.

4. Did you have any medical bills that were covered by your insurance carrier? Yes No

   If yes, do you have Medical Assistance? Yes No

   If you have MA, information below MUST be completed:
   Federal law requires the Department of Human Services to seek reimbursement and requires that you cooperate in identifying and recovering funds. In order to determine if the DHS is entitled to reimbursement, you will need to provide your Social Security number ____________________________, Date of Birth _________________________ and Medical Assistance ID number ____________________.

   I, (Print Name:)_____________________________, hereby give permission for the Carbon County District Attorney's Office to obtain copies of all bills related to this incident from the Department of Human Services. I understand this permission can be revoked at any time in writing by contacting the DA's Office.

   Signature ____ Date ___________________

5. Has this incident affected you emotionally or psychologically?
   Yes No If yes, please explain:

   ____

   ____

   ____

6. Have you received or are you currently receiving counseling and/or therapy related to this incident?

Yes No

If yes, please describe the length of time you have been or will be undergoing counseling or therapy.

____

____

____

7. Have you incurred any out-of-pocket expenses as a result of counseling and/or therapy?

Yes No

If yes, out-of-pocket amount $ ____________________

*If yes, please attached itemized statements showing dates of service and amount paid/due

8. How much, if any, of these expenses were reimbursed by insurance? Amount $ ______________

9. Has this incident affected your ability to earn a living?
Yes No
If yes, please describe your employment and specify how and to what extent your ability to earn a living has been affected:

____

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____

10. How was your life changed as a result of the incident?

____

____

____

11. Have you suffered any financial loss as a result of this incident? Yes No
All losses must have attached documentation substantiating your loss

LOSS	AMOUNT	
Out-of-Pocket Medical	$ ______________	*Itemized bills required
Lost wages:	$ _____________	*Proof of wages must be attached (Paystub, W2)
Personal Property:	$ ______________	***
Valuables:	$ _____________	***
Damages to Home:	$ ______________	***
Other:	$ ______________	***

TOTAL: $__________________

Please specify loss:

____

____

Was any of the above loss covered by auto or home owner's insurance Yes No Partially

Amount of Claim presented to Insurance Company $ ____________________

Amount of Claim paid by Insurance Company $ ____________________

Amount of Deductible $ ____________________

Total Not Covered by Insurance Company $ ____________________

Name of Insurance Company ____

Local Agent ____

Address ____

Telephone No. ___________________________ Email ________________________________

Policy No. ______________________________ Claim No. ______________________________

Date of Claim: ____________________

12. Do you have any additional comments regarding <u>SENTENCING</u> which you would like the Assistant District Attorney to present to the Court? If you require more space, please attach your statement.

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13. There is information regarding the Victim's Compensation Assistance Program (VCAP) in the enclosed brochure titled "Rights and Services for Crime Victims and Witnesses."
Do you need assistance applying for these benefits if you believe you qualify? Yes No

Signature ____ Date _______________________

VICTIM IMPACT STATEMENT – FINANCIAL LOSSES

COMMONWEALTH VS. ____ **NO.** ____________

VICTIM'S NAME: ____

VICTIM'S ADDRESS: ____

VICTIM'S TELEPHONE NUMBER: ____

NOTICE: If you do not file the "Victim Impact Statement" with our agency within ten (10) days, the information will not be included in any pre-sentence investigation presented to the presiding Judge handling this case and will not be eligible for restitution.

DESCRIPTION OF LOSS: (Indicate net financial loss suffered by you as a result of the incident. Attach a **copy** of estimates, bills, or receipts to substantiate your loss).

1. ____ $ ______________

2. ____ $ ______________

3. ____ $ ______________

4. ____ $ ______________

5. ____ $ ______________

6. ____ $ ______________

Total Amount of Loss **$** ________________

Loss covered by Insurance: Yes No Partially

Amount of loss presented to Insurance Company $ ______________

Amount of loss paid by Insurance Company $ ______________

Deductible Amount Paid $ ______________

Name of Insurance Company ____

Address ____

Telephone Number: __________________________ Email: ________________________________

Policy Number ______________________________ Claim Number ____________________________

Please use the back of this sheet for any additional information including, but not limited to: physical or psychological harm related to the incident.

Signature:____ Date: ____________

YOUNG ADULT VICTIM IMPACT STATEMENT

Read this first! Completion of this form is completely voluntary – if you're not comfortable talking about the incident, you don't need to fill this out. This form gives YOU the chance to tell the JUDGE exactly how you feel and how this incident has affected you. You also get to tell the judge what you think should happen to the person who committed the crime. You can have an adult help you complete the form or call Sarah Reeser, the Victim Witness Coordinator at (570) 325-2718.

What is your name? ____

How old are you? ________________ **What grade are you in?** ____________________

How do you feel about what happened to you?

____

____

Is anything different at home, at school, in your neighborhood or with your friends because of what happened?

____

____

How do you feel about the person who did this to you?

____

____

If you were the Judge, how would you sentence this person? What would YOU like to see happen to them?

____

____

Is there anything else you think the Judge should know about the crime or how you feel now?

____

____

____

Sometimes, people feel better when they write a story, poem or draw a picture about how they feel. If you want the judge to read or see anything artistic you have created to help you with your feelings, please attach it to this form.

COMMONWEALTH VS. ________________________ **NO.** ________________

PARENT/GUARDIAN VICTIM IMPACT STATEMENT

COMMONWEALTH VS. ___________________________________ NO. ____________________

Parents, Completion of this form is completely voluntary. Please fill out the first page of this Victim Impact Statement regarding how this incident has affected your child. This will allow the judge to understand the impact this has had on your child and your family. The second page is for your child to fill out and is also completely voluntary. If you require assistance or have additional questions, please call Sarah Reeser, Victim/Witness Coordinator at (570) 325-2718.

Parent Completing this Form: ____

Child(ren)'s Name(s): ____

Has your child been emotionally affected by this incident? Have you noticed changes in behavior at home or school? Has there been a change in their attitude toward friends, family or authoritative figures?

____

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Was your child physically injured as a result of this incident? If yes, what were the injuries, how long was the child under medical care and what type of treatment was required? (Please attach any unpaid medical bills)

____

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Has this incident affected your family or those close to you? For example, are you able to work? Do you enjoy family activities in the same manner as before the incident?

____

____

____

Please provide any additional comments you would like known regarding the incident

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COMMONWEALTH VS. ______________________________ NO. ________________

CHILD VICTIM IMPACT STATEMENT

This is a special form for the Judge to know how YOU feel about what happened. You only fill this out if you WANT to. Sometimes people feel better when they write a story or draw a picture. You can send a picture or story for the Judge to see too!

What's your name? ____

How old are you? ____

Do you go to school? Yes No What grade are you in? __________

How do you feel about what happened to you?

5	Rage, Furious	
4	Angry, Mad	
3	Frustrated, Confused, Annoyed, Sad	
2	Nervous, Worried, Anxious	
1	Happy, Calm, Satisfied, Pleased, Okay	

If you were the Judge, what would you do to ________________________?

Circle your choices!

Go to Jail

Talk to a Doctor

Stay away from ME!

Do Chores in the Community

Write an apology

Pay Back Money

Nothing

Put your Own Idea Here:

____

____

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