STATE OF NEW MEXICO
CRIME VICTIMS REPARATION COMMISSION

You may qualify for financial assistance through New Mexico Crime Victims Reparation Commission, if you answer "YES" to the following questions:

- Have you been a victim of a violent crime?
- Did the crime take place in New Mexico?
- Was the crime reported to law enforcement within 30 days?
  (Exceptions for minors, victims of sexual assault, and victims of domestic violence)
- Did the crime occur within the last two years?
- Did you cooperate fully with law enforcement?

If you answered "YES" to all of the above questions, please fill out the attached application and submit via e-mail, fax or US Postal Service. If you need help filling out the application please call New Mexico Crime Victims Reparation Commission at: (505) 841-9432 or toll free, (800) 306-6262. You have **two years** from the date of the crime to file an application.

State of New Mexico Crime Victims Reparation Commission
6200 Uptown N.E., Suite 210
Albuquerque, New Mexico 87110
Telephone (505) 841-9432 / Fax (505) 841-9437
Toll free 1-800-306-6262
Email: cvrc@state.nm.us
Applications may be accepted by FAX, EMAIL or US Postal Service

The maximum amount of compensation that can be awarded on any application is $20,000.00.
Potentially eligible expenses include:

- Medical
- Dental
- Ambulance
- Funeral (Up to $6,000.00)
- Counseling
- Loss of Wages
- Eyeglasses (Up to $350.00)
- Medically Necessary Devices

There is NO award for loss or damage to property or for pain and suffering.

Expenses incurred as a result of the incident must first be submitted to all readily available collateral sources, such as your insurance company, local indigent program, Medicare, and Medicaid for payment. Those expenses not fully covered by collateral sources will be potentially eligible for payment.

www.cvrc.state.nm.us

NM CRIME VICTIMS REPARATION COMMISSION APPLICATION

6200 Uptown NE Suite 210
Albuquerque, NM 87110
Phone: 505-841-9432 Fax: 505-841-9437
E-mail: cvrc@state.nm.us
Web: www.cvrc.state.nm.us

DO NOT USE PENCIL

Section 1. VICTIM INFORMATION

First Name:	Middle Initial:	Last Name:
Mailing Address:		
City:	State:	Zip Code:
E-mail Address:		
Home Phone #:	Cell or Message #:	
Date of Birth:	Age at Incident:	Social Security #:
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced	

IF THE VICTIM IS:
☐ DECEASED (Submit copy of death certificate) ☐ INCAPACITATED (Submit a power of attorney) ☐ A MINOR
PLEASE COMPLETE SECTION 2 (CLAIMANT INFORMATION)

Section 2. CLAIMANT INFORMATION

First Name:	Middle Initial:	Last Name:
Relationship to Victim: ☐ Spouse ☐ Parent ☐ Sibling ☐ Child ☐ Grandparent ☐ Friend ☐ Other_____		
Mailing Address:		
City:	State:	Zip Code:
E-mail Address:		
Home Phone #:	Cell or Message #:	
Date of Birth:	Social Security #:	

Section 3. ADDITIONAL CONTACT PERSON

PLEASE LIST SOMEONE WHO DOES NOT RESIDE WITH THE VICTIM/CLAIMANT AS AN ALTERNATE CONTACT PERSON IF WE ARE UNABLE TO CONTACT YOU

First Name:	Middle Initial:	Last Name:
Relationship to Victim: ☐ Spouse ☐ Parent ☐ Sibling ☐ Child ☐ Grandparent ☐ Friend ☐ Other_____		
Mailing Address:		
City:	State:	Zip Code:
Home Phone #:	Cell or Message #:	

Section 4. CRIME INFORMATION (Provide copy of police report if available)

Date of Crime:	Date Crime was Reported:	Police Case #:
Police Agency:	Detective:	
Crime Location (Street Address):		
City:	County:	
Brief Description of Crime:		
Injuries:		
Any prior existing disabilities of victim? ☐ Yes ☐ No Describe:		
Name of Suspect:	Suspect 2:	

Section 5. COLLATERAL SOURCES

☐ Health Insurance: _____ ☐ Medicaid ☐ Medicare ☐ IHS ☐ Auto Insurance ☐ Social Security ☐ Donations: $_____ ☐ Other: _____
Hired an attorney for a civil suit? ☐ Yes ☐ No
Attorney's Name: Phone #:

Section 6. POTENTIALLY ELIGIBLE EXPENSES (List all providers and check those expenses that are applicable)

☐ Ambulance	☐ Prescriptions	☐ Radiology (x-rays)
☐ Eyeglasses/Contacts/Hearing Aids	☐ Travel	☐ Crime Scene Cleanup
Medical Provider(s):		
Dental Provider(s):		
Counseling Provider(s):		
Funeral Home:		
LOSS OF WAGES: Did the ☐ VICTIM ☐ CLAIMANT take time off from work due to the incident? ☐ Yes ☐ No		
Name of Employer:		
Mailing Address:		
Work Phone:	Contact Person:	

Section 7. PLEASE PROVIDE THE FOLLOWING STATISTICAL INFORMATION

Country of Birth:
Race/Ethnicity of Victim: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White Non-Latino/Caucasian ☐ Multiple Races ☐ Decline to Answer
American Indian residency within the last six months: ☐ Rural ☐ Pueblo ☐ Reservation ☐ City

Who helped you complete this application?	
Name:	Organization:

Acknowledgement and Authorization

This authorization is part of your application and must be completed and signed in order to process this application.

BY YOUR SIGNATURE BELOW YOU AGREE TO THE FOLLOWING TERMS.

Authorization for Release of Information: I hereby authorize any financial institution, social service agency, government agency, hospital, physician, mental health facility, counselor, psychologist, psychiatrist, employer, insurer or any other person with information relating to my financial, health or employment status to release information concerning this application for benefits to the employees of the New Mexico Crime Victims Reparation Commission, as needed to process this application. This information includes, but is not limited, to criminal, medical (relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection or other sexually transmitted diseases, behavioral health services/psychiatric care, and treatment for alcohol, drug abuse test results), financial, and employment information.

Subrogation Agreement: In accordance with NMSA 1978, Section 31-22-12 of the Crime Victims Reparation Act, I agree to notify the Commission before I file a lawsuit against another party as a result of this crime. If I recover or anticipate recovery, of any money at any time, by judgment, settlement, restitution, collateral source or any other income as a result of the incident that gave rise to this application, I agree to notify the Commission. I acknowledge that I may be responsible for repayment to the Commission for any and all amounts that the Commission has awarded to me. I hereby authorize the New Mexico Corrections Department to directly send to the Commission any restitution collected by the New Mexico Corrections Department from the offender related to the incident for which I received reparations.

Authorization: I understand and agree that if false, misleading or intentionally incomplete information is provided, my application for compensation may be denied and I may be subject to criminal punishment, pursuant to NMSA 1978, Section 31-22-20 of the Crime Victims Reparation Act.

VICTIM	
Printed Name:	Date of Birth:
Signature:	Date:

CLAIMANT	
Printed Name:	Date of Birth:
Signature:	Date: