RESTITUTION INFORMATION

Name _____

Address _____

Telephone _____

Defendant:

Date of Offense:

Charges:

Type of Damages: (Please provide receipts, estimates, or other documentation)

☐Property Damaged or Stolen ☐Fraudulent Check ☐Unauthorized Purchases

☐Medical/Dental Expenses ☐Counseling Expenses ☐Lost Wages

☐Other Losses ☐No Losses ☐I do not wish to claim any losses

Description of Loss	Value	Recovered: Y/N	Dollar Amount

(Use back of page if needed)

Insurance

☐I filed an insurance claim ☐I **did not** file an insurance claim

☐I paid an insurance deductible : $_____

Total Loss: $_____

Crime Victim Compensation Program

This program reimburses victims for medical/dental expenses, counseling expenses, lost wages, replacement of home security items, and crime-related travel. (This program does not pay for property damage)

You must apply in addition to filling out this form. Please call (800) 373-5044 or www.iowaattorneygeneral.gov

☐I have already applied to this program

☐I plan to apply to this program

To the best of my knowledge, the information on this form is true and correct.

_____ _____ _____

Signature Printed Name Date