

CONFIDENTIAL

VICTIM IMPACT CONTACTINFORMATION

CONFIDENTIAL INFORMATION SHEET

OFFENSE INFORMATION: To be completed by the Victim Assistance Coordinator.

Offense:		Offense Date:
Defendant:		
County:	Case No.:	Division: I or II

Please complete lwrf cvg the following information. This information will be used only by our office to contact you throughout the process. IF YOU MOVE OR CHANGE ANY OF YOUR CONTACT INFORMATION, PLEASE CALL OUR OFFICE TO ADVISE OF SUCH.

Victim's Name:		
Date of Birth:	Age:	MALE FEMALE
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		
Person Submitting this Information:		Relationship to Victim:

Please provide the contact information of someone who will always know how to reach you.

Name:		
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

Signature: _____

Date:_____



VICTIM IMPACT STATEMENT

OFFENSE INFORMATION: To be completed by the Victim Assistance Coordinator.

Offense:	Offense Date:		
Defendant:			
County:	Case No.:	Divi	sion: I or II

The information in this statement will show the impact the crime has on the victim, the parents, guardians or close relative of the victim or other family members of the victim. It may be used at each phase of the criminal justice process: from the prosecution of the offense to incarceration. **Please answer only as many questions as you wish.** If you need more space, feel free to use additional sheets of paper and attach them to this Victim Impact Statement.

Victim's Name:

EMOTIONAL/PSYCHOLOGICAL IMPACT. Use this section to discuss your feelings about what has happened to you as a result of the crime and how it has affected your general well-being. Please check all the reactions you have experienced.

Loss of sleep	Lack of concentration	Fear of strangers	Marital problems
Nightmares	Fear of being alone	Anger	Loss of security/control
No trust in anyone	Anxiety	Cry more easily	Thoughts of suicide
Serious change in appetite	Job stress	Family not as close	Feelings of helplessness
Depression	Want to be alone	School stress	Fear of leaving home
Other: (Please explain.)	 	 	

PHYSICAL INJURY. Use this section to discuss what physical injuries or symptoms were suffered as a result of this crime. You may want to write about the extent of the injuries, how long your injuries lasted, and if you received and/or where you received medical treatment for your injuries. If more space is required, please use additional pages.

INDICATE MEDICAL TREATMENT RECEIVED. Attach a doctor's statement if you wish.

Other: (Please explain.)

ECONOMIC LOSS. Use this section to record the extent of economic and financial loss as a result of this crime. You may want to begin a journal of economic loss as soon as possible after the crime occurred. In the event of a conviction, this information may be used later to determine any **restitution owed by the defendant**.

Estimate of Economic Loss	Cost to Date	Future Expected Costs
Property loss or damage	\$	\$\$
Doctor/hospital bills	\$	\$
Moving expenses	\$	\$
Funeral expenses (If applicable)	\$	\$\$
Other (Please explain)	\$	\$\$
Amount covered by insurance: (-)	\$	\$\$
TOTAL OUT OF POCKET EXPENSE:	\$	\$

Please to attach copies of receipts, bills, and canceled checks. Are copies attached?□ Yes□ NoHave you applied for Crime Victims' Compensation through the Attorney General's Office?□ Yes□ No

- If you have not, you may contact the Crime Victims Compensation Board office at: 800-469-2120 or 502-573-2290
- If you have, please provide your claim number: _______

VICTIM IMPACT INFORMATION. To be completed by the victim, parent/guardian or close relative of the victim. Please give <u>any other information</u> you believe is important about the effect of this crime on you and your family. Please do not relate any information about the crime itself; those facts are available already in other reports.

THOUGHTS AND/OR SUGGESTIONS ON FINAL DISPOSITION OF CASE

What sentence do you feel should be imposed upon the defendant?

1. PRISON /JAIL	\Box Yes	\square No
2. TREATMENT/COUNSELING:	\Box Yes	\square No
3. RESTITUTION:	\Box Yes	\square No
Do you wish to be present at all scheduled hearings?	\Box Yes	\square No

The information in this Victim Impact Statement is true and correct to the best of my knowledge.

Print Name	Name Signat				Date
Information submitted by:	□ Victim	□ Parent/Guardian	Close Relative	□ Other	

Submit to: Leticia Newton, P.O. Box 27, Campbellsville Kentucky, 42719 or Lnewton@kyprosecutors.com