VICTIM RESTITUTION ESTIMATE

Mail or fax this completed form and documentation to:
Victim/Witness Unit, Grant County Prosecutor's Office, PO Box 37, Ephrata, WA 98823
Fax: (509) 754-3449

State of Washington vs. _____
Grant County Superior Court No._____

A. PROPERTY LOSS/DAMAGE: *All losses listed must be a direct result of this crime.* You *must* include copies of bills, receipts, repair estimates, proof of wages/salary for time lost, etc. that support your stated value of loss. Restitution cannot be sought on items returned or in evidence that are not damaged. You should contact law enforcement to inspect any items in evidence for damage.

Item Description - Damaged or Unrecovered Items	**Cost to repair or replace**
1.	
2.	
3.	
4.	
5.	

B. MEDICAL COSTS: *All medical expenses listed must be a direct result of this crime.* You *must* include copies of all medical bills or invoices, counseling receipts, etc.

Treatment Provider: Name/Address Phone	**Description of Injury/Treatment**	**Cost**
1.		
2.		
3.		
4.		
5.		

C. INSURANCE COVERAGE: *Applies to property and medical losses.*

Was this loss/injury submitted to your insurance? ❒ Yes ❒ No *If yes, please complete the following:*

Name of insurance company_____

Address_____ Phone No: _____

Agent_____ Claim and/or Policy Number_____

Deductible $_____ Total paid by insurance $_____

Was this injury submitted to Crime Victims Compensation? ❒ Yes ❒ No CVC Claim No:_____

D. WAIVER OF RESTITUTION *If you are **NOT** requesting restitution, please mark the appropriate box:*

❒ **Restitution has already been made to my satisfaction**

❒ **No restitution is requested**

Name: _____

Address:_____ City, State, Zip_____

I declare under penalty of perjury that the above is true and correct to the best of my knowledge.

_____

Signature Date Phone