Who may be eligible for Lost Wage Claim Reimbursement:

1. In the case of a homicide of an innocent victim, his/her dependent children who are under 18. Claimant must show proof of custody.

2. The dependent spouse, as long as she is not remarried.

3. Any relative who was a financial dependent of the victim at the time of death of the victim.

4. A minor victim of sexual assault where the offender was the parent, is now incarcerated, and had gainful employment immediately prior to the incarceration.

The following must be included to file a claim for Loss of Support:

1. Claim Form for Loss of Support
   a) All questions must be answered
   b) Form must be signed by claimant
   c) The dependents being listed on the claim form must also be listed on the victim's tax return or there must be a copy of a court document listing the claimant as the dependent's guardian.

2. Employment Verification Form from Victim's former employer must be completed and signed by the person authorized to verify the amount of income earned.

3. Proof of income
   a) Two or three payroll check stubs immediately prior to the crime.
   b) A copy of the previous year's federal income tax return, including W-2s.

4. Social Security approval or denial of benefits letter.
CLAIM FORM FOR LOSS OF SUPPORT

THIS FORM IS TO BE COMPLETED BY THE CLAIMANT

CVR NUMBER: CLAIMANT: VICTIM:

You claim investigator is: Phone #:

STEP 1. REVIEW AND ANSWER THESE QUESTIONS ABOUT LOSS OF SUPPORT.

NOTE: A. You may only claim “Loss of Support” expenses if the victim is deceased and you are one of the following:
   1) Spouse of the victim
   2) OR -- a dependent of the victim
   3) OR -- the guardian of the victim’s dependents

B. You must provide evidence that the victim supported you or the dependent(s) listed below.

If you are the spouse, complete the following:
1) Have you ever worked outside the home? [ ] Yes [ ] No
   If yes, when/what was that last job? _______________________________________________________________
2) Do you have any disabilities or physical limitation that prevent you from working? [ ] Yes [ ] No
   If yes, please explain: __________________________________________________________________________
3) Do you have any other limitations that prevent you from supporting yourself? [ ] Yes [ ] No
   If yes, please explain: __________________________________________________________________________

STEP 2. EXPLAIN RELATIONSHIP BETWEEN DEPENDENT AND VICTIM and/or CLAIMANT

<table>
<thead>
<tr>
<th>Names and Ages of Dependents</th>
<th>Relationship of Dependents to Victim</th>
<th>Relationship of Dependents to Claimant</th>
<th>Dependents Eligible for SSI Yes or No?</th>
<th>Dependents Eligible for Pension Plans: Yes or No?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

STEP 3. OBTAIN THE NECESSARY DOCUMENTATION. Check off documents as they are attached. Explain if not.

1. [ ] Letter of approval/denial of benefits from Social Security Office about SSI benefits
2. [ ] Copy of Victim’s last tax return (must show evidence of dependence). Include W-2s where possible.
3. [ ] Copy of EMPLOYMENT VERIFICATION FORM from VICTIM'S former employer
4. [ ] Copies of court documents and/or tax return show evidence of dependence. If not available, please explain:
   ____________________________________________________________________________________________
   ____________________________________________________________________________________________

STEP 4. CLAIMANT SIGNATURE: ____________________________ DATE: ____________________________

PRINT NAME: ____________________________

SEND THIS FORM AND THE REQUIRED ATTACHMENTS TO YOUR CLAIM INVESTIGATOR.

Revised: August 13, 2014
# EMPLOYMENT VERIFICATION FORM

**THIS FORM IS TO BE COMPLETED BY THE VICTIM’S EMPLOYER**

<table>
<thead>
<tr>
<th>CVR NUMBER:</th>
<th>CLAIMANT INSTRUCTIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>VICTIM:</td>
<td>1) Ask the victim’s employer to complete and return this form to you.</td>
</tr>
<tr>
<td>VICTIM SSN:</td>
<td>2) Give completed form to your claim investigator.</td>
</tr>
<tr>
<td>CLAIMANT:</td>
<td>EMPLOYER INSTRUCTIONS:</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>1) A claim is being made for wages lost as a result of an injury of the</td>
</tr>
<tr>
<td>DATE OF CRIME:</td>
<td>victim referenced to the left, and caused by a crime on the date shown.</td>
</tr>
<tr>
<td></td>
<td>2) Complete this form, verifying the actual earnings lost and return to the</td>
</tr>
<tr>
<td></td>
<td>claimant.</td>
</tr>
</tbody>
</table>

Name of Business: _______________________________________
Victim’s Job Title: _______________________________________
Business Address: _______________________________________
Victim’s Supervisor: _______________________________________
Phone #: (____) ___________________________
Victim employed: [ ] FULL TIME  [ ] PART TIME  [ ] OTHER  HOW LONG EMPLOYED? _____________________ (Years/Months)
Days a week victim worked: [ ] Monday; [ ] Tuesday; [ ] Wednesday; [ ] Thursday; [ ] Friday; [ ] Saturday; [ ] Sunday; [ ] Schedule varies
Victim absent from work: FROM: _____/_____/_______ TO: _____/_____/_______ = _____________________ Total weeks out of work
Date returned to work: _____/_____/_______ [ ] Did not return to work

**INCOME/EARNINGS CALCULATION**

Please check one:

RATE OF PAY: $ ______________ per: [ ] Hour  [ ] Week  [ ] Month  [ ] Other _________________

How many days does employee work a week? ____________  How many hours does employee work each day? ____________

OVERTIME/COMMISSION: $ ______________ per [ ] Week  [ ] Month  [ ] Other _________________

Was employee paid for time off from work? [ ] Yes  [ ] No  DISABILITY INCOME: $ _______________

WORKMEN’S COMP: $ ______________ BEGINNING DATE ___________________ ENDING DATE ___________________

LOST WAGE INCOME: $ _______________ X Wks/Out of Wk = $ _______________

(Wkly Income) (Less: Wkrs. Comp, Social Security, etc.)

= $______________ Lost Wages (Adjusted)

**VERIFYING SIGNATURE**

____________________________________________________________  (____) ___________________________
AUTHORIZED SIGNATURE                                      PHONE

____________________________________________________________
PRINTED NAME

____________________________________________________________
TITLE

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Revised: August 13, 2014