**U.S. Department of Justice**
Office of Justice Programs
*Office for Victims of Crime*

OMB Number 1121-0309
Expiration: 09/30/2014

# Supplemental Sheet F: MEDICAL EXPENSES

**If necessary, please attach additional sheets using this format.**

**Medical Expense** *Please list each medical expense for which you are seeking reimbursement*

| Describe the Medical Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred | |
|---|---|---|---|
| Name of Service Provider | Contact Person's Name: | E-mail | Telephone: |
| Provider's Address | City | State | Zip Code |

**Medical Coverage** *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

| Coverage Source's Name | Policy # - Acct # - Claim # | Contact Person's Name: |
|---|---|---|
| Coverage Source's Address | Source's Telephone | Source's E-mail/Fax |

**Medical Expense** *Please list each medical expense for which you are seeking reimbursement*

| Describe the Medical Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred | |
|---|---|---|---|
| Name of Service Provider | Contact Person's Name: | E-mail | Telephone: |
| Provider's Address | City | State | Zip Code |

**Medical Coverage** *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

| Coverage Source's Name | Policy # - Acct # - Claim # | Contact Person's Name: |
|---|---|---|
| Coverage Source's Address | Source's Telephone | Source's E-mail/Fax |

**Please attach supporting documentation for each expense such as insurance statements, invoices, copies of receipts, credit card statements, Explanation of Benefits, etc.**

*For assistance call 1-800-363-0441 or e-mail itverp@ojp.usdoj.gov*

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# Supplemental Sheet G: MENTAL HEALTH EXPENSES

**If necessary, please attach additional sheets using this format.**

**Mental Health Expense** *Please list each mental health expense for which you are seeking reimbursement*

| Describe the Medical Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred | |
|---|---|---|---|
| Name of Service Provider | Contact Person's Name: | E-mail | Telephone: |
| Provider's Address | City | State | Zip Code |

**Mental Health Coverage** *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

| Coverage Source's Name | Policy # - Acct # - Claim # | Contact Person's Name: |
|---|---|---|
| Coverage Source's Address | Source's Telephone | Source's E-mail/Fax |

**Mental Health Expense** *Please list each mental health expense for which you are seeking reimbursement*

| Describe the Medical Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred | |
|---|---|---|---|
| Name of Service Provider | Contact Person's Name: | E-mail | Telephone: |
| Provider's Address | City | State | Zip Code |

**Mental Health Coverage** *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

| Coverage Source's Name | Policy # - Acct # - Claim # | Contact Person's Name: |
|---|---|---|
| Coverage Source's Address | Source's Telephone | Source's E-mail/Fax |

**Please attach supporting documentation for each expense such as insurance statements, invoices, copies of receipts, credit card statements, Explanation of Benefits, etc.**

*For assistance call 1-800-363-0441 or e-mail itverp@ojp.usdoj.gov*

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# Supplemental Sheet H: PROPERTY LOSS EXPENSES

**If necessary, please attach additional sheets using this format.**

*Please list in detail, your specific items below.*

| Item Name | Detailed Description | Cost at time of purchase | Was the item insured? | Attached Supporting Documentation |
|---|---|---|---|---|
| **Example:** *Digital Camera* | *1 Canon PowerShot S95 Camera with 10 megapixels, 4x zoom, 3" LCD display and SD memory card slot.* | *$865.00* | *no* | *Receipt* |
| | | | | |
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**Please attach supporting documentation for each expense such as copies of receipts, credit card statements, pictures of the items, etc.**

*For assistance call 1-800-363-0441 or e-mail itverp@ojp.usdoj.gov*

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## Supplemental Sheet I: FUNERAL & BURIAL EXPENSES

**If necessary, please attach additional sheets using this format.**

*Please list in detail, your requested expenses below:*

| Type of Expense | Detailed Description | Total Cost at time of purchase | Amount covered by other sources | Purpose of Expense | Attached Supporting Documentation |
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**For each expense you must attach copies of supporting documentation.**

**Third Party Contributions:** Has any other person(s) such as a family member or friend, paid for part of the out-of-pocket funeral and/or burial expenses for which you are seeking reimbursement? If so, complete the chart below.

| Person Who Paid | Contact Information for Person(s) Who Paid | Relationship Between Claimant and Who Paid | Amount Paid | For What Expense |
|---|---|---|---|---|
| Name | Address, e-mail and telephone | | | |
| Name | Address, e-mail and telephone | | | |
| Name | Address, e-mail and telephone | | | |

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**Please attach supporting documentation for each expense such as copies of receipts, credit card statements, etc.**

## Supplemental Sheet J: MISCELLANEOUS EXPENSES

**If necessary, please attach additional sheets using this format.**

*Please list your specific expenses below.*

| Type of Expense | Detailed Description | Cost at time expense was incurred | Amount covered by other sources | Purpose of Expense | Attached Supporting Documentation |
|---|---|---|---|---|---|
| *Example:* *Phone bill* | *Phone charges from India to Knoxville, TN while in India attending to victim's affairs – June/July 2004* | *$384.28USD* | *no* | *Putting victim's affairs in order* | *Phone bill* |
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**For each expense you must attach copies of supporting documentation.**

**Third Party Contributions:** Has any other person(s) such as a family member or friend, paid for part of the out-of-pocket funeral and/or burial expenses for which you are seeking reimbursement? If so, complete the chart below.

| Person Who Paid | Contact Information for Person(s) Who Paid | Relationship Between Claimant and Who Paid | Amount Paid | For What Expense |
|---|---|---|---|---|
| Name | Address, e-mail and telephone | | | |

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| Name | Address, e-mail and telephone | | | |
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