VICTIM CLAIM FORM

Northampton County Juvenile Probation Department

In the matter of: _____ Probation Officer: _____ Incident Date: _____ Incident: _____

PERSONAL PROPERTY LOSS

(Please attach estimates, bills or receipts to substantiate claim)

Victim's current address:	DESCRIPTION OF LOSS	AMOUNT
\$ \$ \$		\$
\$ \$ <td< td=""><td></td><td>\$</td></td<>		\$
\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ Victim's Name: \$ Victim's current address: \$ Victim's current telephone number: \$ Above loss covered by insurance: Yes No In part Date of Loss: Amount of Claim presented to Insurance Company \$ Amount of Claim paid by the Insurance Company \$ What is your deductible? \$ Insurance Co.: Claim Representative: Address: \$ Telephone #: Policy Holder: Policy #: Claim #: The FACTS SET FORTH IN THE FOREGOING ARE TRUE AND CORRECT TO THE BEST OF THE UNDERSIGNED'S KNOWLEDCE, INFORMATION AND BELIEF AND ARE VERIFIED SUBJECT TO THE PRALTIES FOR UNSWORN FALSEFICATION TO AUTHORNITIES UNDER IS PAC.S & \$4994		\$
\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ TOTAL \$ Victim's Name: \$ Victim's current address: \$ Victim's current telephone number: \$ Above loss covered by insurance: Yes No In part Date of Loss: \$ Amount of Claim presented to Insurance Company \$ \$ \$ \$ Amount of Claim paid by the Insurance Company \$ \$ \$ \$ Insurance Co.: Claim Representative: \$ \$ \$ \$ Insurance Co.: Policy Holder: \$		\$
\$ \$ \$ \$ \$ \$ \$ \$ TOTAL \$ Victim's Name: Victim's current address: Victim's current telephone number:		\$
\$ \$ \$ \$ \$ \$ TOTAL \$ Victim's Name: \$ Victim's current address: Victim's current telephone number: Victim's current telephone number: Date of Loss: Above loss covered by insurance: Yes [] No [] In part [] Date of Loss:		\$
\$ \$ S \$ TOTAL \$ Victim's Name: \$ Victim's current address: ````````````````````````````````````		\$
\$ \$ Yictim's Name:		\$
\$ TOTAL \$ TOTAL \$ Victim's Name:		\$
TOTAL \$ Victim's Name:		\$
Victim's Name:		\$
Victim's current address:	TOTAL	4 \$
Above loss covered by insurance: Yes No In part Date of Loss:	Victim's Name: Victim's current address:	
Amount of Claim presented to Insurance Company \$	Victim's current telephone number:	
Amount of Claim paid by the Insurance Company \$	Above loss covered by insurance: Yes No No In part Date of Loss:	
What is your deductible? \$	Amount of Claim presented to Insurance Company \$_	
Insurance Co.:	Amount of Claim paid by the Insurance Company \$_	
Address:	What is your deductible? \$_	
Telephone #: Policy Holder: Policy #: Claim #: The facts set forth in the foregoing are true and correct to the best of the undersigned's knowledge, information and belief and are verified subject to the penalties for unsworn falsification to authorities under 18 pa.c.s.§4904	Insurance Co.: Claim Representative: _	
Policy #: Claim #: THE FACTS SET FORTH IN THE FOREGOING ARE TRUE AND CORRECT TO THE BEST OF THE UNDERSIGNED'S KNOWLEDGE, INFORMATION AND BELIEF AND ARE VERIFIED SUBJECT TO THE PENALTIES FOR UNSWORN FALSIFICATION TO AUTHORITIES UNDER 18 PA.C.S.§4904	Address:	
THE FACTS SET FORTH IN THE FOREGOING ARE TRUE AND CORRECT TO THE BEST OF THE UNDERSIGNED'S KNOWLEDGE, INFORMATION AND BELIEF AND ARE VERIFIED SUBJECT TO THE PENALTIES FOR UNSWORN FALSIFICATION TO AUTHORITIES UNDER 18 PA.C.S.§4904	Telephone #: Policy Holder:	
AND BELIEF AND ARE VERIFIED SUBJECT TO THE PENALTIES FOR UNSWORN FALSIFICATION TO AUTHORITIES UNDER 18 PA.C.S.§4904	Policy #: Claim #:	
DATE: SIGNATURE:		
	DATE: SIGNATURE:	

IMPORTANT Restitution may not be ordered, if no reply within 30 days from