LOSS OF SUPPORT

Who <u>may</u> 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 #I:

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**

Names and Ages of Dependents	Relationship of Dependents *to Victim*	Relationship of Dependents *to Claimant*	Dependents Eligible for SSI Yes or No ?	Dependents Eligible for Pension Plans: Yes or No?

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

CVR NUMBER:

VICTIM:

VICTIM SSN:

CLAIMANT:

ADDRESS:

DATE OF CRIME:

CLAIMANT INSTRUCTIONS:
1) Ask the victim's employer to complete and return this form to you.
2) Give completed form to your claim investigator.

EMPLOYER INSTRUCTIONS:
1) A claim is being made for wages lost as a result of an injury of the victim referenced to the left, and caused by a crime on the date shown.
2) Complete this form, verifying the actual earnings lost and return to the claimant.

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 _____ = $ _____
Wkly Income Wks/Out of Wk

($ _____) (Less: Wkrs. Comp, Social Security, etc.)

= $_____ **Lost Wages** (Adjusted)

VERIFYING SIGNATURE

_____ _____
AUTHORIZED SIGNATURE DATE

_____ (____)_____
PRINTED NAME PHONE

_____
TITLE

Revised: August 13, 2014