JUVENILE COURT
Victim Impact Statement

VICTIM-WITNESS ASSISTANCE PROGRAM
197 Carl Griffin Drive
Savannah, Georgia 31405
(912) 652-6702
or
(912) 652-6735
(912) 644-4042 Fax

MEG HEAP
DISTRICT ATTORNEY
Eastern Judicial Circuit

The District Attorney's office would like to know how this crime affected you. If you are a victim and have additional information regarding the crime please complete this form and return it to the above address. If you are requesting restitution for medical bills or any other out-of-pocket expenses suffered as a result of this crime please include copies of bills, estimates and/or pictures. You may attach additional pages if you need more space.

If you have been injured, you may also be eligible for crime victim compensation. If you would like to apply, please contact our office for more information and an application.

Completing this form will help the Assistant District Attorney better prepare for successful prosecution of your case.

The Assistant District Attorney assigned to your case will need to review this information before the court date; therefore, please mail or fax this form to the address or fax number above as soon as possible. If you have any questions, comments, or concerns regarding this form or your case do not hesitate to contact your assigned advocate - Monday thru Friday 8:00 a.m. - 5:00 p.m.

PLEASE COMPLETE INFORMATION ON THE REVERSE SIDE

PLEASE MAIL THIS FORM BACK PROMPTLY Defendant's Name _____
Case Number R _____

Victim's Name_____
Address_____City_____State_____Zip code_____
Phone Number (H)_____(W)_____(O)_____
Cellular, neighbor, close friend

INJURIES

1. Did you receive any injuries as a result of the crime?____yes___no If yes, please explain:

_____

_____
(use additional paper, if needed)

2. Did the police observe these injuries?___yes____no

3. Did you receive medical treatment?___yes___no If yes, at what medical facility?_____

4. Were your expenses covered by insurance?___yes___no Amount of deductible $_____

5. Do you have receipts/statements for services rendered?___yes ___no If yes, attach copies.

6. What are the cost of medical bills to date? $_____ Do you expect further medical treatment?____yes___no
If yes, how much? $_____

PROPERTY

7. Was any of your property stolen or damaged as a result of the crime?___yes___no
Was it insured?___yes___no Amount of deductible $_____

8. List the items and the value of the items when they were stolen or damaged. Serial numbers and receipts would be helpful.

ITEMS	AMOUNT	CIRCLE ONE
_____	$_____	damage or stolen
_____	$_____	damage or stolen
_____	$_____	damage or stolen

CRIMINAL CASE

9. In the event that the defendant enters a guilty plea or is found guilty, the judge will decide the punishment(sentence). Sentencing conditions can include all or a combination of the following: financial restitution, probation, imprisonment, drug and alcohol counseling, fines, community service, or domestic violence treatment program. Please be advised that final sentencing is at the sole discretion of the Judge. What are your thoughts?

_____

_____

_____
(use additional paper, if needed)

10. What other information is important for the Assistant District Attorney to know?

_____

_____
(use additional paper, if needed)

I am prepared to testify under oath that the information I have recorded on this form is true to the best of my knowledge._____ _____
Signature of victim or legal guardian Date