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

OMB Number 1121-0309
Expiration: 3/31/2021

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:	Email:	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 Email/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:	Email:	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 Email/Fax:

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

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:	Email:	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 Email/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:	Email	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 Email/Fax:

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

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*

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

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

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(s) Who Paid	Contact Information for Person(s) Who Paid	Relationship Between Claimant and Who Paid	Amount Paid	For What Expense
Name:	Address, email, and telephone:			
Name:	Address, email, and telephone:			
Name:	Address, email, and telephone:			

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*

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, email and telephone			
Name	Address, email and telephone			