VERMONT
CENTER FOR CRIME VICTIM SERVICES

I. Victim Information

Victim's Name: FRED SARGEANT

[redacted]

[redacted]

If you do not want us to contact you at the above address, please provide another mailing address and phone number:

_____

_____

If the victim is a minor:

☐ Parent or ☐ Legal Guardian's name:

_____

Parent/Guardian date of birth:_____

Home phone:_____ Work phone: _____

Cell phone:_____ Email address: _____

If address is different from victim's address:

_____

_____

If in DCF (Dept. of Children & Families) custody, case worker's name:

_____

If the victim is deceased:

Survivor's name:_____

Mailing Address: _____

City or town: _____

State:_____ Zip:_____

Home phone:_____ Work phone: _____

Cell phone:_____ Email Address:_____

Survivor's Date of birth:_____

Relationship to victim:_____

II. Information about the Crime

Please complete as much of the following information as you can. If you do not have this information, leave the space blank, and we will try to obtain the documentation from the police or your Victim Advocate.

Date of Crime: 9/18/22 Date reported: SAME

Name(s) of suspect(s): LESLIE E. FULLER & OTHERS UNKNOWN

Date of birth of suspect(s): UNK

Town where crime occurred: BURLINGTON VT

Police department reported to: BPD

Name of police officer: KIRAN

Incident number: UNK

Type of crime: (check all that apply)

- ☐ Arson
- ☒ Assault
- ☐ Burglary
- ☐ Child physical abuse/neglect
- ☐ Child pornography
- ☐ Child sexual abuse
- ☐ Domestic violence
- ☐ DUI (Driving under influence of intoxicating liquor or other substance)
- ☐ Fraud/financial crimes
- ☐ Homicide
- ☐ Human trafficking
- ☐ Kidnapping
- ☐ Other vehicular crimes
- ☐ Robbery
- ☐ Sexual assault
- ☐ Stalking
- ☐ Terrorism
- ☒ Other ELDERLY [redacted] / ATTEMPTED THEFT OF SIGNS & THEFT

Are you represented by a private attorney in a civil lawsuit or insurance action regarding this crime? ☐ Yes ☒ No

Attorney's name:

Email: Phone:

III. Requests for Compensation

Please complete as much of the following information as you can. If you do not have this information, leave the space blank.

I am requesting compensation for the following crime-related losses:

- ☐ Child care
- ☐ Counseling
- ☐ Crime scene clean-up
- ☐ Dental
- ☐ Eyeglasses, hearing aids, dentures, or any prosthetic device taken, lost, destroyed during the crime

- ☐ Funeral costs
- ☐ Loss of support
- ☐ Lost wages (time missed from work)
- ☐ Medical
- ☐ Mileage/gas
- ☐ Payment of bills for pets that are injured or killed during the crime
- ☐ Boarding of pets
- ☐ Rent/relocation
- ☐ Safety/security
- ☐ Temporary living expenses
- ☐ Travel expenses/transportation costs
- ☐ Other: _

➔ **Please send any crime-related bills that you receive to the Victims Compensation Program. Please indicate the name and phone number of the provider(s) that you are seeing for crime related treatment below:**

Dentist:_____ Phone:_____

Doctor:_____ Phone:_____

Hospital:_____ Phone:_____

Counselor:_____ Phone:_____

Funeral Home:_____ Phone: _____

[redacted]

Employer N _____

Address: _____

City/Town:_____ State:_____ Zip:_____

Phone:_____ Employer Email:_____

Name of contact person at work:_____

Due to the crime, I have missed work for the following:

Date(s) Missed:	Reason:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

PLEASE BE ADVISED: IF YOU ARE ASKING FOR COMPENSATION FOR LOST WAGES (TIME MISSED FROM WORK), WE WILL CONTACT YOUR EMPLOYER.

Were you paid for time missed from work? ☐Yes ☐No

➔ **If you miss work in the future due to crime-related reasons, please contact us with the additional dates.**

IV. Optional Information

Where did you hear about the Victims Compensation Program?

- ☐ Counselor
- ☐ Department of Children and Families
- ☐ Victim Advocate
- ☐ Hospital
- ☐ Police
- ☐ TV
- ☐ Internet
- ☐ Radio
- ☐ Organization serving person with a disability
- ☒ Other (please specify) MAIL

The following information is optional and requested to comply with federal regulations, and is for statistical purposes only.

Race/Ethnicity: (self-reported)

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White-Non-Latino or Caucasian
- ❑ Another Race
- ❑ Multiple Races

Gender: (self-reported) ❑Male ❑Female ❑Self Identify:_____

In order to better assist you, do you need accommodations for any of the following:
(Optional)

- ❑ Visual Disability
- ❑ Deaf or Hard of Hearing
- [redacted]
- ❑ Mental Health Diagnosis
- ❑ Intellectual Disability

Please identify disability if not listed above:_____

Please let us know what accommodation(s) you would like us to provide:

- ❑ American Sign Language Interpretation ❑ Language Interpretation
- ❑ Large Printed Materials

- ❑ Communication Assistance (Please specify):_____

Other Please specify:_____

Each county has a Victim Advocate located in the State's Attorney's Office. We encourage you to call your Advocate with any questions you may have about the court process. For information on how to contact your Advocate, call the Victims Compensation Program at

1-800-750-1213 (Voice–VT only)

or 1-802-241-1250 (Voice)

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You must sign and date in the three (3) places that follow to be eligible for Victims Compensation.

AUTHORIZATION TO OBTAIN INFORMATION

I hereby voluntarily authorize, in accordance with the privacy regulations under HIPAA (the Health Insurance Portability and Accountability Act, 42USC § 132d et seq.) any hospital, clinic, physician, health care provider or other person who attended or examined the victim named below; any funeral director, insurance company, counselor, attorney or other person who rendered related services; any employer of the victim or claimant; any police or governmental agency, including state or federal revenue services; or any organization having relevant knowledge, to furnish the Vermont Victims Compensation Program with any and all information in their possession with respect to the incident that is the basis for this claim. A photocopy of this authorization is as effective and valid as the original unless otherwise required by law. Further release of this information is prohibited. I understand that this authorization will expire one year from the date of this authorization unless I otherwise specify.

I further understand that I may revoke this authorization at any time by notifying the Victims Compensation Program in writing, except to the extent it has already been relied upon.

Alternative expiration date if desired: _____

Victim's name: FRED SARGEANT Date of birth: 7/29/48

Signature of victim or survivor: F. Sargeant Date: 2/5/23

Signature of parent or guardian, if victim is under 18: _____

Date: _____

REPAYMENT, RESTITUTION, AND SUBROGATION AGREEMENT

I understand, on behalf of myself, assignee, heir, or dependent, that Vermont law requires me to contact and repay the Victims Compensation Program if I receive payments from the offender, a civil action, or an insurance company, and that the Victims Compensation Program has a lien against any monies I may recover as a result of this crime. I also understand that I must notify the Program if I hire a lawyer to represent me in any action related to this crime. I understand that my signature indicates that I agree with all statements specified in this agreement.

Victim's name: F. Sargeant FRED SARGEANT Date of birth: [redacted]

Signature of victim or survivor: F. Sargeant Date: 2/5/23

Signature of parent or guardian, if victim is under 18: _____

Date: _____

CERTIFICATION

I certify that the information in this application is true and correct to the best of my knowledge.

Signature of victim or survivor: F. Sargeant Date: 2/5/23

Signature of parent or guardian, if victim is under 18: _____

Date: _____