

**Victim Assistance Fund**

**Section 1. VICTIM INFORMATION** (All applicants MUST complete this section)

Name:	Victim ID # (internal number for confidentiality)
Best Method to Contact: Contact Information:	County:
<p><b>FEDERAL CIVIL RIGHTS INFORMATION:</b> The Department of Justice requires us to collect the following data and it is needed to comply with Federal regulations. This information is used for statistical purposes only and will remain confidential. (Self-reported)</p> <p>Ethnic Group: <b>(Information relates to victim only)</b></p> <p>_____ American Indian/Alaskan Native      _____ Asian</p> <p>_____ Black / African American      _____ Hispanic or Latino</p> <p>_____ Native Hawaiian or Other Pacific Islander      _____ White Non-Latino/Caucasian</p> <p>_____ Some Other Race      _____ Multiple Races</p>	
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Age: <input type="checkbox"/> 0-12 <input type="checkbox"/> 25-59 <input type="checkbox"/> 13-17 <input type="checkbox"/> 60 and Older <input type="checkbox"/> 18-24

**Section 2. CRIME INFORMATION** (All applicants must complete this section)

Type of Crime: (Please check)

_____ Sexual Assault	_____ Assault
_____ Child Sex Abuse	_____ Murder/Homicide
_____ Child Physical Abuse	_____ DUI/DWI
_____ Domestic Assault	_____ Other (please specify)

Was the crime committed by a family member or person living with the victim?  Yes  No

Was the crime related to any of the following:  
 Sexual Assault    Domestic Violence    Child Abuse    Underserved

**Brief description of crime & reasons for request. (Use additional sheet of paper if necessary)**

**Section 3. REQUESTS**

1. Relocation Costs (Rent/Deposits/Storage/Moving Expenses) \$ _____ Service Provider: _____
2. Emergency Funds (Food/Shelter/Clothing/Transportation) \$ _____ Service Provider: _____
3. Window/Door Lock Repair or Replacement \$ _____ Service Provider: _____
4. Transportation/Meals/Lodging to participate in Criminal Justice System Service Provider: _____ \$ _____
5. Other expenses (Explanation Please) Service Provider: _____ \$ _____
<b>TOTAL AMOUNT REQUESTED</b> \$ _____

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Approve    Deny

Reason:

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_  
Nebraska Victim Advocacy Coordinator

\_\_\_\_\_  
Date