PLEASE FILL OUT THIS ENTIRE PACKAGE AND RETURN TO:

District Attorney's Office
Attn: Victim / Witness Department
300 Iberia Street Suite 200
New Iberia, LA, 70560

VICTIM'S NAME: _____ DOB: _____

CURRENT PHONE NO. (H) _____ (C) _____

SOCIAL SECURITY NUMBER: _____

PARENT (S) / GUARDIAN OF CHILD VICTIM: _____

REPRESENTATIVE OF DECEASED VICTIM: _____

CURRENT MAILING ADDRESS: _____

_____

FOR BUSINESS OWNERS, TIN NUMBER: _____

EMAIL ADDRESS: _____

CURRENT PHONE NO. (H) _____ (C) _____

EMPLOYER: _____

EMPLOYER PHONE NUMBER: _____

****** Please provide an additional contact person:**

CONTACT PERSON: _____ RELATIONSHIP: _____

CONTACT PHONE NUMBER: _____

NOTE: It is important that you notify this office of any changes to your address or phone number.

VICTIM QUESTIONNAIRE

Defendant Name	For Office Use Only
Docket #:	ADA Reviewed:
Charges: Charge:	Copy to Defense: Yes No

(If you need more space, please write on the back of this sheet)

SPECIFIC QUESTIONS

1. Do you believe incarceration (jail) is required in this case and if so, for how long?

_____

_____

2. Do you believe that mental health or substance abuse treatment is necessary for the defendant?

_____

_____

3. Would you agree to a sentence of probation instead of jail time?

_____

_____

4. If the defendant is placed on probation, are there any special conditions of probation you would like to see imposed?

_____

_____

5. Do you wish to be present when the defendant is sentenced and speak to the judge?

_____

_____

6. List any physical injuries suffered as a result of the above crime:

_____

_____

7. Describe any change in personal welfare or family relationships as a result of this crime.

_____

_____

_____

_____

8. List any request for psychological or counseling services initiated as a result of the crime.

_____
_____
_____
_____

9. List any other relevant information in regard to the above crime. Please feel free to discuss your feeling about what has happened and how it has affected your general well being in regard to the above crime. (If extra space is needed, please feel free to attach additional sheets.)

_____
_____
_____
_____

_____ _____
Signature of Victim Date

Printed Name: _____

VICTIM RESTITUTION SHEET

ATTACH DOCUMENTATION RECEIPTS

YOU MUST FILL OUT AND RETURN (EVEN IF NO RESTITUTION IS DUE)

Defendant Name:	For Office Use Only
Docket #:	ADA Reviewed:
	Copy to Defense: Yes No

1. **MEDICAL EXPENSES FOR INJURY**

Hospital _____ Amount $ _____

Doctor _____ Amount $ _____

Pharmacy _____ Amount $ _____

Ambulance _____ Amount $ _____

Other _____ Amount $ _____

2. **PROPERTY LOST/STOLEN AND NOT RECOVERED**

Item _____ Amount $ _____

Item _____ Amount $ _____

3. **PROPERTY DAMAGE TO BE REPLACED:**

Item _____ Amount $ _____

Item _____ Amount $ _____

4. **INSURANCE COMPANY**

Claim made: _____ Benefit received $_____

TOTAL AMOUNT OF LOSS, DAMAGE OR EXPENSES: $_____

Comments for Judge regarding the Defendant's sentencing:

_____

_____

_____

Date: _____ Victim/Complainant: _____

Printed Name: _____