MORRISON COUNTY
''HOME OF LINDBERGH''

County Attorney
BRIAN J. MIDDENDORF

ASSISTANTS
TODD E. CHANTRY
MICHEL P. CHISUM
KRISTYNA A. STAVISH
HEIDI A. SWISHER
LAURA E. WELLE

213 SE 1st Avenue
Little Falls, MN 56345
320-632-0190
Toll Free: 866-401-1111
Fax: 320-632-0193

RESTITUTION AFFIDAVIT

Name: _____

Address: _____

_____

Court File Number(s)	**Offender Name(s)**	**Date of Offense(s)**
_____	_____	_____

A request for restitution may include, but is not limited to, any out of pocket losses resulting from the crime, including medical and therapy costs, replacement of wages and services, property loss/damage, insurance deductibles and other expenses directly related to the crime.

The Judge will determine restitution based on this affidavit and any documents you submit. You should provide copies of medical bills, repair or replacement receipts, and/or estimates for repairs, as this is required for us to be able to adequately prove your restitution amount to the Court.

Please check one of the following:

☐ I AM NOT CLAIMING ANY MONETARY LOSS ON THIS OFFENSE OR DO NOT WISH TO RECEIVE RESTITUTION.

☐ I HAVE INCURRED OUT-OF-POCKET EXPENSES FROM THIS OFFENSE AND WISH TO REQUEST RESTITUTION. **(Complete the Financial Impact Worksheet on page 2) TOTAL AMOUNT: _____**

☐ I ANTICIPATE INCURRING ADDITIONAL OUT-OF–POCKET EXPENSES RESULTING FROM THIS OFFENSE. **(Please explain in the victim impact section below)**

Please use this portion of the form to provide any comments or other information that you wish the Court to be aware of. This statement does not replace your right to speak at the offender's sentencing hearing.

VICTIM IMPACT STATEMENT – PLEASE ATTACH ADDITIONAL PAGES AS NECESSARY.

Victim Names: Court File(s):

Financial Impact Worksheet

Please use this portion of the form to list any expenses that were a direct result of this crime. Some of the sections may not apply to you. Please attach copies of bills, receipts, and estimates of value, replacement costs, or other evidence of the costs listed below. Please attach additional pages if necessary.

A. **MEDICAL/COUNSELING/LOST WAGES/OTHER EXPENSES: (INCLUDE ONLY EXPENSES THAT ARE A DIRECT RESULT OF THIS OFFENSE)**	
Expenses	**Cost/Deductible**
1.	$
2.	$
3.	$
4.	$
5.	$

Have you submitted a claim to the Minnesota Crime Victims Reparations Board for these expenses?
☐Yes ☐No ☐Need claim form

If you have submitted a claim, what were the results? [check one] _
___Claim Denied ____Claim Still Pending ____Claim approved in the following amount: $_____

B. STOLEN OR DAMAGED PROPERTY: (ATTACH ADDITIONAL PAGE IF NECESSARY)

Item	**Was item recovered:** (Circle One)	**Repair/Replacement Cost:**
1.	Yes/No	$
2.	Yes/No	$
3.	Yes/No	$
4.	Yes/No	$
5.	Yes/No	$
	Subtotal:	$
TOTAL RESTITUITION (Sections A & B):		$

Insurance Information: You are not required to make an insurance claim, but you must disclose if you have done so, as you cannot collect from both the insurance company and the offender for the same loss.	
Have you submitted a claim? ☐Yes ☐No	Claim Number
Insurance Company:	Policy Number:
Contact Person:	Phone #:
Deductible Amount: $	**Amount covered by Insurance: $**

THIS FORM MUST BE SIGNED AND DATED

I declare under penalty of perjury that everything I have stated in this document is true and correct.

Date: _____ _____

Signature of victim/agent/representative or parent/guardian if victim is under age 18.

Please also fill in the following information:

This document was signed in _____County in the State of _____

[name of county] [name of State]