



VIRGINIA R. DIAMOND, Chairman
WILLIAM L. DUDLEY, JR., Commissioner
LAWRENCE D. TARR, Commissioner
JAMES SZABLEWICZ, Chief Deputy
Commissioner

COMMONWEALTH of VIRGINIA
CRIMINAL INJURIES COMPENSATION FUND

Post Office Box 26927
Richmond, Virginia 23261

MARY VAIL WARE
DIRECTOR

Toll Free (800) 552-4007

RESTITUTION PAYMENT FORM

Person filling out this form: _____ Date: _____

This is **UNCLAIMED RESTITUTION**: ☐ YES ☐ NO **CICF Claim #:** _____

Please complete this section to the best of your ability with the information you have.

County: _____

Amount of Check enclosed: \$ _____ Unpaid Balance: \$ _____

Offender Name: _____

Victim Name: _____

Intended recipient of restitution (if other than victim) _____

Date of Crime: _____ Case Number: _____

I am: ☐ Victim Witness ☐ Probation ☐ An Individual **Court:** _____

***To receive a receipt, please print your name
and address:***

CICF use:

Amount Received: \$ _____

CICF Staff: _____

Date Received: _____

BALANCE: _____