

Ex. 13

DATE: 2/19/92

PLEASE DELIVER THE FOLLOWING TO:

NAME: MR. BRANCATO

FROM: L. Levinson
NEW YORK STATE CRIME VICTIMS BOARD

RE: Myra Franze-Mendez
Josephine Mendez

TOTAL NUMBER OF PAGES SENT INCLUDING TRANSMITTAL SHEET 6

IF YOUR EXPERIENCE ANY PROBLEMS WITH TRANSMISSION OR DO NOT RECEIVE THE
PROPER NUMBER OF PAGES, PLEASE CALL 817-5143.

U-65

9

120

2215

INSTRUCTIONS

1. Type of crime clearly.
2. Last page of the claimant affidavit must be signed by a NOTARY PUBLIC.
3. Complete all questions. If a question is not applicable answer with N/A.
4. If the prescribed answer is not correct to a given question, make all necessary corrections.

NAME: *McK Bernard*

- TYPE OF AFFIDAVIT
- PERSONAL INJURY (BATTERY, SEXUAL ABUSE, STALKING, ETC.)
 - PERSONAL INJURY (OTHER THAN THE ABOVE)
 - DEATH
 - PROPERTY LOSS ONLY

I. CLAIM IDENTIFICATION SECTION

CLAIMANT NAME: **FRANZO FRANZA** AKA: **KYRA** SEX: **M**

ADDRESS (No. and Street or P.O. Box): **P.O. BOX 1149** CITY or TOWN: **BRONX** STATE: **NY** ZIP CODE: **10451**

DATE OF BIRTH (Mo., Day, Yr.): **2/12/1964** SOCIAL SECURITY NO.: **056-58-6841** DAYTIME TELEPHONE NO. (Include Area Code): **(212) 960-6828**

a. Claimant Information

MARRIAGE STATUS (Check the box that most nearly applies):

SINGLE MARRIED SEPARATED DIVORCED WIDOWED LIVING TOGETHER

WAS YOUR STATUS BEFORE THE CRIME? YES NO

ARE YOU FILING THIS CLAIM ON BEHALF OF EITHER A CHILD UNDER THE AGE OF 18 YEARS OLD? OR INCOMPETENT ADULT WHO IS NOT THE VICTIM? YES NO

b. Victim Information

CHILD'S OR ACCIDENT VICTIM'S NAME AND RELATIONSHIP TO CLAIMANT AND VICTIM:

NAME (Last, First, Middle): **N/A** RELATIONSHIP TO CLAIMANT: **N/A** RELATIONSHIP TO VICTIM: **N/A**

c. Attorney Information

VICTIM NAME (Last, First, Middle):

ADDRESS (No. and Street or P.O. Box):

DATE OF BIRTH (Mo., Day, Yr.):

MARRIAGE STATUS (Check the box that most nearly applies):

SINGLE MARRIED SEPARATED DIVORCED WIDOWED LIVING TOGETHER

WAS YOUR STATUS BEFORE THE CRIME? YES NO

IS AN ATTORNEY REPRESENTING YOU ON THIS CLAIM? YES NO

ATTORNEY NAME (Last, First, Middle):

ADDRESS (No. and Street or P.O. Box):

II. CRIME IDENTIFICATION SECTION

DATE OF CRIME (Mo., Day, Yr.): **7/17/1990** TIME OF CRIME: **7:30 AM** COUNTY OF CRIME: **MANHATTAN** DATE CRIME REPORTED TO POLICE (Mo., Day, Yr.): **7/17/90**

POLICE PRECINCT: **NYC PD 034TH PRECINCT** NO. OF COMPLAINT OR OF FILES: **14923**

ADDRESS WHERE CRIME OCCURRED (No. and Street): **485 W 187ST Apt #1D** CITY or TOWN: **N.Y.** STATE: **NY** ZIP CODE: **10033**

CRIME LOCATION (Check only one):

TRAIN RESIDENCE APARTMENT STREET BUSWAY BAR/RESTAURANT WORK OTHER

DESCRIPTION OF CRIME: **"Bourgeois said flowers when mother opened door they pushed her in and shot her 5 times (2 in the face) and when I came to rescue I got shot in my face while alone."**

DID THE VICTIM HAVE PROPERTY LOST, DAMAGED OR DESTROYED WHILE ATTEMPTING TO IDENTIFY A PERSON WHO COMMITTED A CRIME, TO PREVENT A CRIME FROM OCCURRING, OR AS A LAW ENFORCEMENT OFFICER IN WARDING AN ARREST? YES NO

DO YOU KNOW WHO ALLEGED PERPETRATOR COMMITTED THE CRIME? YES NO

ALLEGED PERPETRATOR NAME (Last, First, Middle): **N/A**

IS ALLEGED PERPETRATOR A MEMBER OF VICTIM'S FAMILY OR RESIDE IN SAME HOUSEHOLD? YES NO

IS AN ORDER OF PROTECT ON BEEN ISSUED? YES NO (If yes, please specify date)

IS (OR WILL) ALLEGED PERPETRATOR BEING PROSECUTED FOR CRIME? YES NO

IS CLAIM BEING FILED MORE THAN ONE YEAR AFTER DATE OF CRIME? YES NO

IF YES, DESCRIBE FACTORS WHICH DELAYED CLAIM FILING:

(continued on next page)

9)

121

U-66
2217

III. INJURY AND MEDICAL TREATMENT INFORMATION SECTION

DESCRIBE INJURIES GUN SHOT WOUNDS TO LEFT SIDE OF FACE, SHATTERED EARPLUG
JAW, NOSE LOSS, TEETH WIPED & TRIM

WAS MEDICAL TREATMENT RECEIVED FOR THIS INJURY? YES NO

HAS A MEDICAL TREATMENT BEEN COMPLETED? YES NO

1. NAME OF FIRST TREATING HOSPITAL HARLEM HOSPITAL (TRAUMA UNIT) TRANSFERRED TO BETH ISRAEL 7th Ave. 16th St. N.Y. 10011

ADDRESS (No. and Street or P.O. Box) 138 E LENOX Ave (APT) N.Y. (City or Town) N.Y. (State) (Zip Code)

2. NAME OF FIRST TREATING DOCTOR (No. if known)

ADDRESS (No. and Street or P.O. Box) (APT) (City or Town) (State) (Zip Code)

3. NAME OF FIRST TREATING DENTIST (No. if known)

ADDRESS (No. and Street or P.O. Box) (APT) (City or Town) (State) (Zip Code)

4. NAME OF FIRST TREATING COUNSELOR BANDY MEDINA FROM Victim Services (212) 865-9500

ADDRESS (No. and Street or P.O. Box) (APT) (City or Town) (State) (Zip Code)

2530 GRAND CONCOURSE 7th Floor BY N.Y. 10458

IV. MEDICAL INSURANCE INFORMATION SECTION

IS THERE INSURANCE THAT WILL PAY FOR ANY MEDICAL TREATMENT RECEIVED? YES NO (If you complete all questions in this Section, this entry is not needed.)

1. BLUE CROSS YES NO ID NUMBER

2. BLUE SHIELD YES NO ID NUMBER

3. MEDICARE YES NO ID NUMBER

4. MEDICAID YES NO ID NUMBER

5. DOMESTIC MEDICAID YES NO ID NUMBER

6. MAJOR MEDICAL YES NO POLICY NUMBER

NAME OF AGENCY OR COMPANY

7. WORKERS COMPENSATION YES NO POLICY NUMBER

NAME OF AGENCY OR COMPANY

8. AUTO INSURANCE YES NO POLICY NUMBER

NAME OF AGENCY OR COMPANY

9. OTHER INSURANCE YES NO POLICY NUMBER 036-58-6841

NAME OF AGENCY OR COMPANY GNT

V. EMPLOYMENT INFORMATION SECTION

DID VICTIM LOSE TIME FROM WORK AS A RESULT OF THE INJURIES DESCRIBED IN SECTION III? YES NO (If you complete all questions in Sections I and IV, this entry is not needed.)

1. NAME OF DOCTOR WHO DETERMINED YOUR DISABILITY PERIOD FROM WORK GARY RUTH, D.D.S. TELEPHONE NO. (Include area code) (212) 983-7516

ADDRESS (No. and Street or P.O. Box) (APT) (City or Town) (State) (Zip Code)

236 E 46 St. N.Y. N.Y. 10017

2. EMPLOYER NAME U.S. Postal Service TELEPHONE NO. (Include area code) (212) 960-7021

ADDRESS (No. and Street or P.O. Box) (APT) (City or Town) (State) (Zip Code)

559 GRAND CONCOURSE N.Y. N.Y. 10451

Continued on next page

9)

22

2212

U-67

1. Last Name: FERRER-HERNANDEZ First Name: MYLIA Social Security #: 026 58768 47
 2. Address Number, Street or PO Box: DISC. VALENTINE AVE Apt.: 2E City or Town: NEW YORK CITY
 3. County of Residence or Foreign Country: BREXID State: NY Zip Code: 10045B Date of Birth: 2/12/1964
 Month Day Year

OPTIONAL INFORMATION (CHECK THE BOXES THAT APPLY)

8 Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	10 Race <input checked="" type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander	11 Ethnicity <input checked="" type="checkbox"/> Hispanic <input type="checkbox"/> Unknown	12 Disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13 Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No
9 Other <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

14 What is your relationship to the victim? (Check one box)
 Self Parent Spouse Child Other Relative Attorney Guardian Other: _____

VICTIM SECTION (COMPLETE ONLY IF DIFFERENT THAN CLAIMANT)

16 Last Name: HERNANDEZ First Name: JOSEFINA Social Security #: 093 24061 2
 17 Address Number, Street or PO Box: 185 W 187 ST Apt.: 1D City or Town: NEW YORK CITY
 18 County of Residence or Foreign Country: HAWAIIAN ISLANDS State: NY Zip Code: 10053 Date of Birth: 9/1/1930
 Month Day Year

OPTIONAL INFORMATION (CHECK THE BOXES THAT APPLY)

23 Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	24 Race <input checked="" type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander	25 Ethnicity <input checked="" type="checkbox"/> Hispanic <input type="checkbox"/> Unknown	26 Disabled <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	27 Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Unknown	<input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

IN-BEHALF-OF CLAIMANT SECTION (SEE INSTRUCTIONS FOR WHEN TO COMPLETE)

28 Last Name: _____ First Name: _____ Social Security #: _____ Date of Birth: _____
 Month Day Year

Optional Information (Check the boxes that apply)

31 Sex <input type="checkbox"/> M <input type="checkbox"/> F	32 Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander	33 Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown	34 Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	35 Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Unknown	<input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

CRIME DATA SECTION (COMPLETE ALL QUESTIONS)

36 How did you first hear about the Crime Victims Compensation Program?
 Police Hospital Family/Friend Employer Church Victim Assistance Program Other

37 Date of Crime: 17/7/1990 38 County Where Crime Occurred: HAWAIIAN ISLANDS
 Month Day Year

39 Police Agency and Precinct Where Crime Was Reported: WVPRIDEPT 344A AVENUE 40 Police Complaint or UF #:
64920

41 Brief Description of Crime: MULTIPLE GUN SHOT WOUNDS (5) to FACE, CHEST, WRIST, & BROKEN WRIST.

42 Which of the following was the result of the crime described above? (Check all that apply)
 Loss of Property Physical Injury Death

43 Signature: Maria Ferrer Date: 9/12/64 Daytime Telephone Number: 212 928-6804

ANY INCOMPLETE OR INACCURATE INFORMATION WILL DELAY THE PROCESSING OF YOUR APPLICATION FOR COMPENSATION BENEFITS.

9) 123 2213 U-68