

DATE: 2/19/82

PLEASE DELIVER THE FOLLOWING TO:

NAME: MR. BRANCATO

FROM: L. Levinson
NEW YORK STATE CRIME VICTIMS BOARD

RE: Myra Franza-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 417-5143.

CLAIMANT AFFIDAVIT
Must be completed and returned to the
Crime Victims Board within 90 DAYS.

CRIME VICTIMS BOARD
845 Central Avenue, Albany, N.Y. 12208
Telephone (518) 467-8727

CLAIM NO.

FOR OFFICE USE ONLY
DATE RECEIVED
INVESTIGATOR
BOARD MEMBER

mck
Bernard

INSTRUCTIONS

1. Type or print 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 preprinted answer is not correct for a given question, make all necessary changes.

TYPE OF AFFIDAVIT

- PERSONAL INJURY (claimant is the victim)
 PERSONAL INJURY (claimant is not the victim)
 DEATH
 PROPERTY LOSS ONLY

I. CLAIM IDENTIFICATION SECTION

a. Claimant Information

CLAIMANT NAME (Last) **FRANZA** (First) **MYRA** (Middle) **M**
 ADDRESS (No. and Street or P.O. Box) (Apt.) (City or Town) (State) (Zip Code)
P.O. BOX 1149 BRONX NY 10451
 DATE OF BIRTH (Mo., Day, Yr.) **2/12/1964** SOCIAL SECURITY NO. **056-58-6841** DAYTIME TELEPHONE NO. (include area code) **(212) 960-6888**
 MARITAL STATUS (Check the most recent status)
 SINGLE MARRIED SEPARATED DIVORCED WIDOWED LIVING TOGETHER
 WERE YOU DISABLED 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 INCOMPETENT'S NAME AND RELATIONSHIP TO CLAIMANT AND VICTIM
 NAME (Last) (First) (Middle)
N/A **N/A** **N/A**
 RELATIONSHIP TO CLAIMANT RELATIONSHIP TO VICTIM
N/A **N/A**
 VICTIM NAME (Last) (First) (Middle)
 ADDRESS (No. and Street or P.O. Box) (Apt.) (City or Town) (State) (Zip Code)
 DATE OF BIRTH (Mo., Day, Yr.) SOCIAL SECURITY NO. DAYTIME TELEPHONE NO. (include area code)
 MARITAL STATUS (Check the most recent status)
 SINGLE MARRIED SEPARATED DIVORCED WIDOWED LIVING TOGETHER
 WAS VICTIM DISABLED BEFORE THE CRIME? YES NO

c. Attorney Information

IS AN ATTORNEY REPRESENTING YOU ON THIS CLAIM? YES NO
 ATTORNEY NAME (Last) (First) (Middle)
 ADDRESS (No. and Street or P.O. Box) (Apt.) (City or Town) (State) (Zip Code)

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 AGENCY WHERE THE CRIME WAS REPORTED **NYC PD 034TH PRECINCT** POLICE COMPLAINT OR UP # (No.) **14921**
 ADDRESS WHERE CRIME OCCURRED (No. and Street) (Apt.) (City or Town) (State) (Zip Code)
485 W 187ST APT #1D N.Y. N.Y. 10033
 CRIME LOCATION (Check only one)
 OWNED RESIDENCE APARTMENT STREET SUBWAY BAR/RESTAURANT WORK OTHER
 DESCRIPTION OF CRIME
SOMEONE 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. COUNT BLANK.
 DID THE VICTIM HAVE PROPERTY (E.G. DAMAGED OR DISTURBED WHILE AT SCENE) TO BE APPROPRIATELY A PERSON WHO COMMITTED A CRIME (2) PREVENT A CRIME FROM OCCURRING (3) AID A LAW ENFORCEMENT OFFICER IN MAKING 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 RELATIVE IN SAME HOUSEHOLD? YES NO
 HAS AN ORDER OF PROTECTION BEEN ISSUED? YES NO (If yes, please attach copy)
 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)

2217

III. INJURY AND MEDICAL TREATMENT INFORMATION SECTION

DID VICTIM SUFFER ANY PHYSICAL INJURIES AS A RESULT OF THE CRIME? YES NO (If yes, complete all questions in Sections II and III that apply)

DESCRIBE INJURIES BRIEFLY: GUN SHOT WOUNDS TO LEFT SIDE OF FACE, SHATTERED JAW, NERVE LOSS, TEETH WIRED, JAW.

WAS MEDICAL TREATMENT RECEIVED FOR THESE INJURIES? YES NO HAS ALL MEDICAL TREATMENT BEEN COMPLETED? YES NO DON'T KNOW

1. NAME OF FIRST TREATING HOSPITAL: HARLEM HOSPITAL (TRAUMA UNIT) TRANSFERRED TO BETH ISRAEL 7/24/90 16 ST. + 1st Ave N.Y. 10011

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

2. NAME OF FIRST TREATING DOCTOR (Not in hospital)

3. NAME OF FIRST TREATING DENTIST (Not in hospital): GARY D. ROTH, D.D.S. (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

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 BX N.Y. 10458

IV. MEDICAL INSURANCE INFORMATION SECTION

IS THERE INSURANCE THAT WILL PAY FOR ANY MEDICAL TREATMENT RECEIVED? YES NO (If yes, complete all questions in this Section that apply)

1. BLUE CROSS YES NO I.D. NUMBER

2. BLUE SHIELD YES NO I.D. NUMBER

3. MEDICARE YES NO I.D. NUMBER

4. MEDICAID YES NO I.D. NUMBER

5. CATASTROPHIC MEDICAID YES NO I.D. NUMBER

6. NA/OP 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 GHI

V. EMPLOYMENT INFORMATION SECTION

DID VICTIM LOSE TIME FROM WORK AS A RESULT OF THE INJURIES DESCRIBED IN SECTION III? YES NO (If yes, complete all questions in Sections V and VI that apply)

1. NAME OF DOCTOR WHO DETERMINED YOUR DISABILITY PERIOD FROM WORK: GARY ROTH, D.D.S. (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

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)
558 GRAND CONCOURSE N.Y. N.Y. 10451

Continued on next page

2212

CLAIMANT SECTION

1 Last Name: FRANZ-MENDOZA First Name: MYRA MI: NY 2 Social Security #: 056586847
 3 Address Number, Street or P.O. Box: DISC. VALENTINO AVE Apt: DE 4 City or Town: NEW YORK EVAN
 5 Country of Residence or Foreign Country: BRANK 6 State: NY 7 Zip Code: 10018 8 Date of Birth: 2/12/1966
 Month Day Year

OPTIONAL INFORMATION (CHECK THE BOXES THAT APPLY)

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

15 Last Name: MEDEZ First Name: JOSEPHINE MI: NY 16 Social Security #: 083240612
 17 Address Number, Street or P.O. Box: 185 W 187 ST Apt: 1D 18 City or Town: NEW YORK EVAN
 19 Country of Residence or Foreign Country: HAWAIIAN 20 State: NY 21 Zip Code: 10013 22 Date of Birth: 9/1/1976
 Month Day Year

OPTIONAL INFORMATION (CHECK THE BOXES THAT APPLY)

23 Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> Unknown	24 Race <input checked="" type="checkbox"/> Spanish <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Other <input type="checkbox"/> Unknown	25 Ethnicity <input checked="" type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Hispanic	26 Disabled <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	27 Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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IN-BEHALF-OF CLAIMANT SECTION (SEE INSTRUCTIONS FOR WHEN TO COMPLETE)

28 Last Name: _____ First Name: _____ MI: _____ 29 Social Security #: _____ 30 Date of Birth: _____
 Month Day Year

Optional Information (Check the boxes that apply)

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

36 How Did You First Hear About the Crime Victims Compensation Program?
 Police Hospital Family/Friends Employer Church Victim Assistance Program Other

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

39 Police Agency and Precinct Where Crime Was Reported: WVPR Dept 34th Precinct 40 Police Complaint or UP # #: 14920

41 Brief Description of Crime: MULTIPLE GUN SHOT WOUNDS (5X) 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 Maura Tranga 9/12/94 812 928-6904
 CLAIMANT'S SIGNATURE DATE DAYTIME TELEPHONE NUMBER

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

2213

845 CRIME VICTIMS BOARD
99 CENTRAL AVENUE
ALBANY, NEW YORK 12206

*ref
202637 mch
renewed*

CLAIM NO. 203104
BOARD MEMBER _____
INV. _____
COUNTY _____

ATTN: New Claims Division

PLEASE PRINT

Claimant's Name Josephine Mendez

Claimant's Social Security Number 0 8 3 2 4 0 6 1 2

Claimant's Address 485 West 187th St. #10
(No.) (Street)

New York New York 10033
(City) (State) (Zip)

Telephone No. 212 928-6804 Office Telephone No. 9-1-30

Claimant's Relationship to Victim _____ Claimant's Date of Birth 9-1-30
(If other than victim)

Victim's Date of Birth 9-1-30 Male Female
(Mo./Day/Yr.)

Victim's Social Security Number _____

Victim's Name _____
(To be completed if different than claimant)

Type of Claim: Personal Injury Death Other

Victim's Address 485 West 187th #10 N.Y.N.Y. 10033

Brief description of crime WAS ASSAULTED IN APARTMENT.

Brief description of injuries MULTIPLE GUN SHOTS TO FACE,
CHEST, WRIST, BROKEN WRIST.

Date of Crime 7-17-90 Location of Crime 485 W 187th #10 N.Y.C. 10033
(Street Address)

County MANHATTAN City New York

Name of alleged perpetrator (if known) UNKNOWN

Police precinct where crime was reported 34th Prec. 392

Police Complaint No. (U.P. 61 Number) # 14920
(May be obtained at Police Pct.)

Source from which you heard of this agency Victim Service Agency

Josephine Mendez
(Claimant's Signature)

2214

CRIME VICTIMS BOARD
97 CENTRAL AVENUE
ALBANY, NEW YORK 12206

ATTN: New Claims Division

PLEASE PRINT

CLAIM NO. 202637
BOARD MEMBER _____
INV. _____
COUNTY _____

Claimant's Name Myra Mander-Franza

Claimant's Social Security Number 026886841

Claimant's Address P.O. Box 1149
(No.) (Street)

Brooklyn New York 10431
(City) (State) (Zip)

Telephone No. 212 295-0080 Office Telephone No. _____

Claimant's Relationship to Victim SELF Claimant's Date of Birth 2/12/64
(If other than victim)

Victim's Date of Birth _____ Male Female
(Mo./Day/Yr.)

Victim's Social Security Number _____

Victim's Name _____
(To be completed if different than claimant)

Type of Claim: Personal Injury Death Other

Victim's Address 2545 Valentine Ave

Brief description of crime was assaulted in
mother apartment

Brief description of injuries one gun shot
to the left side of the face

Date of Crime 7/17/70 Location of Crime 485 W. 187 St
(Street Address)

County New York City New York

Name of alleged perpetrator (if known) unk (woman)

Police precinct where crime was reported 34th (392)

Police Complaint No. (U.F. 61 Number) 14921
(May be obtained at Police Pct.)

Source from which you heard of this agency Victim Service

Myra Mander-Franza
(Claimant's Signature)