Ex. 24

NEW YORK STATE CRIME VICTIMS BOARD
270 BROADWAY
NEW YORK, NEW YORK 10007

TRANSMITTAL SHEET
FAX NUMBER: (212) 417-4043

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.

93

CLAIMANT AFFIDAVIT
Must be completed and returned to the Crime Victims Board within 30 DAYS.

CRIME VICTIMS BOARD
845 Central Avenue, Albany, N.Y. 12206
Telephone (518) 457-8727

CLAIM NO. 202637 MF

FOR OFFICE USE, ONLY
DATE RECEIVED
INVESTIGATOR: McK
BOARD MEMBER: 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
- [X] 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): ~~FRANZO~~ FRANZA (First): MYRA (Middle): M

ADDRESS (No. and Street or P.O. Box): P.O. BOX 1149 (Apt.): (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

MARITAL STATUS (check the most recent status): [ ] SINGLE [ ] MARRIED [X] SEPARATED [ ] DIVORCED [ ] WIDOWED [ ] LIVING TOGETHER

WERE YOU DISABLED BEFORE THE CRIME? [ ] YES [X] 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 [X] NO

CHILD'S OR INCOMPETENT'S NAME AND RELATIONSHIP TO CLAIMANT AND VICTIM: NAME (Last): N/A (First) (Middle)
RELATIONSHIP TO CLAIMANT: N/A RELATIONSHIP TO VICTIM: N/A

b. Victim Information

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 [X] 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 A.M./P.M. 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 UF 61 NO.: 14921

ADDRESS WHERE CRIME OCCURRED (No. and Street): 485 W 187st APT #1D (Apt.) (City or Town): N.Y. (State): N.Y. (Zip Code): 10033

CRIME LOCATION (Check only one): [ ] OWNED RESIDENCE [X] APARTMENT [ ] STREET [ ] SUBWAY [ ] BAR/RESTAURANT [ ] WORK [ ] OTHER

DESCRIBE CRIME BRIEFLY: 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 point blank.

DID THE VICTIM HAVE PROPERTY LOST, DAMAGED OR DESTROYED WHILE ATTEMPTING TO (1) APPREHEND A PERSON WHO COMMITTED A CRIME (2) PREVENT A CRIME FROM OCCURRING (3) AID A LAW ENFORCEMENT OFFICER IN MAKING AN ARREST? [ ] YES [X] NO

DO YOU KNOW WHO (ALLEGED PERPETRATOR) COMMITTED THE CRIME? [ ] YES [X] NO

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

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

HAS AN ORDER OF PROTECTION BEEN ISSUED? [ ] YES [X] NO (If yes, please attach copy)

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

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

IF YES, DESCRIBE FACTORS WHICH DELAYED CLAIM FILING:

(continued on next page)

144

III. INJURY AND MEDICAL TREATMENT INFORMATION SECTION

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

DESCRIBE INJURIES BRIEFLY: GUN SHOT WOUND TO left SIDE OF FACE, SHAttered JAW, Nerve loss, teeth wired & JAW.

WAS MEDICAL TREATMENT RECEIVED FOR THESE INJURIES? [X] YES [ ] NO

HAS ALL MEDICAL TREATMENT BEEN COMPLETED? [ ] YES [X] NO [ ] DON'T KNOW

1. NAME OF FIRST TREATING HOSPITAL: Harlem Hospital (TRAUMA UNIT) / TRANSFERRED TO BETH ISRAEL 7/20/90 16st + 1st Ave N.Y. 100
   ADDRESS (No. and Street or P.O. Box) (Apt.) (City or Town) (State) (Zip Code): 138 st LENOX Ave N.Y. N.Y.
2. NAME OF FIRST TREATING DOCTOR (Not in hospital):
   ADDRESS (No. and Street or P.O. Box) (Apt.) (City or Town) (State) (Zip Code)
3. NAME OF FIRST TREATING DENTIST (Not in hospital): GARY J. Ruth, 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: SANDY MEDINA FROM Victim Services (212) 365-8500
   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 [X] NO (If yes, complete all questions in this Section that apply)

#	Insurance	YES	NO	Number
1	BLUE CROSS	[ ]	[X]	I.D. NUMBER
2	BLUE SHIELD	[ ]	[X]	I.D. NUMBER
3	MEDICARE	[ ]	[X]	I.D. NUMBER
4	MEDICAID	[ ]	[X]	I.D. NUMBER
5	CATASTROPHIC MEDICAID	[ ]	[X]	I.D. NUMBER
6	MAJOR MEDICAL	[ ]	[X]	POLICY NUMBER
	NAME OF AGENCY OR COMPANY			
7	WORKERS COMPENSATION	[ ]	[X]	POLICY NUMBER
	NAME OF AGENCY OR COMPANY			
8	AUTO INSURANCE	[ ]	[X]	POLICY NUMBER
	NAME OF AGENCY OR COMPANY			
9	OTHER INSURANCE	[X]	[ ]	POLICY NUMBER 056-58-6841
	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? [X] 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 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. NY. 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): 558 GRAND CONCOURSE N.Y. N.Y. 10451

(Continued on next page)

2212

384

45

Check claim #20263
#203104 Duplicate Pending #203104

CLAIM APPLICATION

(Read the instructions carefully before you complete the application. With the exception of optional information, all questions must be answered.)

CLAIMANT SECTION

1 Last Name: FRANZA-MENDEZ | First Name: MYLA | MI: | 2 Social Security #: 056586841

3 Address: Number, Street or P.O. Box: 2545 VALENTINE AVE | Apt.: 6E | 4 City or Town: New York City

6 County of Residence or Foreign Country: BRONX | 6 State: NY | 7 Zip Code: 10458- | 8 Date of Birth (Month Day Year): 2/2/1966

OPTIONAL INFORMATION (CHECK THE BOXES THAT APPLY)

9 Sex	10 Race	11 Ethnicity	12 Disabled	13 Veteran
☐ M ☒ F ☐ Unknown	☒ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Alaskan ☐ Other ☐ Unknown	☒ Hispanic ☐ Unknown ☐ Non-Hispanic	☐ Yes ☒ No ☐ Unknown	☐ Yes ☐ No ☐ 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: MENDEZ | First Name: JOSEPHINE | MI: | 16 Social Security #: 083240612

17 Address: Number, Street or P.O. Box: 485 W 187 St | Apt.: 1D | 18 City or Town: New York City

19 County of Residence or Foreign Country: MANHATTAN | 20 State: NY | 21 Zip Code: 10033- | 22 Date of Birth (Month Day Year): 9/1/1930

OPTIONAL INFORMATION (CHECK THE BOXES THAT APPLY)

23 Sex	24 Race	25 Ethnicity	26 Disabled	27 Veteran
☐ M ☒ F ☐ Unknown	☒ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Alaskan ☐ Other ☐ Unknown	☒ Hispanic ☐ Unknown ☐ Non-Hispanic	☒ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

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	32 Race	33 Ethnicity	34 Disabled	35 Veteran
☐ M ☐ F ☐ Unknown	☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Alaskan ☐ Other ☐ Unknown	☐ Hispanic ☐ Unknown ☐ Non-Hispanic	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

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 (Month Day Year): 7/7/1990 | 38 County Where Crime Occurred: MANHATTAN

39 Police Agency and Precinct Where Crime Was Reported: NYPDept 34th Precint | 40 Police Complaint or UF 61#: 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 CLAIMANT'S SIGNATURE: Myla Franza | DATE: 9/12/94 | DAYTIME TELEPHONE NUMBER (area code): 212 928-6804

2213

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

385

47

Please return completed Claim Form To:

CRIME VICTIMS BOARD
97 CENTRAL AVENUE
ALBANY, NEW YORK 12206

ATTN: New Claims Division

PLEASE PRINT

DO NOT WRITE IN THIS SPACE

CLAIM NO. 202637

BOARD MEMBER ______

INV. ______

COUNTY ______

Claimant's Name mayra mendez- franza

Claimant's Social Security Number 0 5 6 5 8 6 8 4 1

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

Bronx New York 10451
(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 ______ (Mo./Day/Yr.) Male ☐ Female ☑

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
Bronx N.Y. 10458

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 7/17/94 Location of Crime 485 W. 187 St
(Street Address)

County New York City New York

Name of alleged perpetrator (if known) unknown

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 Agency

Myra Mendez-Franza
(Claimant's Signature)

386

2216