STATE OF CONNECTICUT, DEPARTMENT OF PUBLIC SAFETY-
INVESTIGATION REPORT (DPS-302-E) (REVISED 2/3/06)

Report #: 1200704559 - 00257147

Report Type: Initial Report: ☐ Prosecutors Report: ☐ Supplement: ☒ Re-open: ☐ Assist: ☐ Closing: ☐

Attachments: Statements: ☐ Teletype: ☐ Photos: ☐ Sketchmap: ☐ Evidence: ☐ Other: ☒

CFS NO	INCIDENT DATE	TIME	INCIDENT DATE	TIME	PRIMARY OFFICER	BADGE NO	INVESTIGATING OFFICER	BADGE NO
1200704559	12/14/2012	09:41	12/14/2012		JEWISS, DANIEL E.	0034	VAN NESS, RACHAEL	1431

INCIDENT ADDRESS	APARTMENT NO	TOWN CD	TYPE OF EXCEPTIONAL CLEARANCE	CASE STATUS
00012 Dickenson Dr Newtown 06482			Not Applicable	Active

Action Taken: Throughout the course of the investigation, in conjunction with the FBI's Victim Services Unit, Detectives maintained contact with the parties most intimately impacted by the incident. Those persons were, in part, students, staff and faculty from the Sandy Hook Elementary School, as well as the families of the decedents.

The aforementioned parties were given various documents including, but not limited to documentation and applications from the Office of Victim Services, 225 Spring Street, 4th Floor, Wethersfield, CT, pertaining to personal injury compensation, which includes reimbursement of up to $2,000 in mental health expenses for any child that was within the Sandy Hook Elementary School at the time of the shooting. Additionally, the family members of the decedents were advised of the availability of reimbursement funds for funeral services.

A copy of the applications given to the involved parties has been attached for reference purposes (see attached.)

The status of the case remains actively under investigation.

THE UNDERSIGNED, AN INVESTIGATOR HAVING BEEN DULY SWORN DEPOSES AND SAYS THAT: I AM THE WRITER OF THE ATTACHED POLICE REPORT PERTAININGTO THIS INCIDENT NUMBER. THAT THE INFORMATION CONTAINED THEREIN WAS SECURED AS A RESULT OF (1)MY PERSONAL OBSERVATION AND KNOWLEDGE: OR (2)INFORMATION RELAYED TO ME BY OTHER MEMBERS OF MY POLICE DEPARTMENT OR OF ANOTHER POLICE DEPARTMENT:OR (3)INFORMATION SECURED BY MYSELF OR ANOTHER MEMBER OF A POLICE DEPARTMENT FROM THE PERSON OR PERSONS NAMED OR IDENTIFIED THEREIN, AS INDICATED IN THE ATTACHED REPORT. THAT THE REPORT IS AN ACCURATE STATEMENT OF THE INFORMATION SO RECEIVED BY ME.

INVESTIGATOR SIGNATURE:	INVESTIGATOR I.D.#:	REPORT DATE:	SUPERVISOR SIGNATURE:	SUPERVISOR I.D.#:
/TFC RACHAEL VAN NESS/	1431	12/28/2012 11:25 am	Sgt. [signature]	130

SECTION 6 - CRIME INFORMATION

If the crime was a sexual assault, please do not fill out this section but answer the questions in Section 6a. This section must be filled out for all other crimes.

Type of crime: O assault O robbery with injury O dui O hit and run O other ______

Briefly describe the crime and physical injuries: ______

______

______

Date of crime ______ Address and city or town where crime happened ______

Date crime was reported to police ______ Police department crime was reported to ______

Police department incident number ______ Name of police officer investigating the crime ______

Was the crime reported to the police within 5 days? O yes O no (If no, please explain)

______

______

Was someone arrested for the crime? O yes O no O unknown ______ Name of person(s) arrested, if known

Did the person(s) arrested go to court? O yes O no O unknown ______ If yes, court location ______ Docket number, if known

SECTION 6a - SEXUAL ASSAULT CRIMES

Date of crime ______ Address and city or town where crime happened ______

Did you go to a hospital for a sexual assault medical examination and evidence collection? O yes O no

If yes, name of hospital or healthcare facility ______ Date of examination ______

Please check which professional you told about the sexual assault:

O alcohol and drug counselor
O clinical social worker
O counselor
O emergency medical services provider
O employee of Department of Children and Families
O marriage and family therapist
O mental health professional
O nurse (advanced practice, practical, or registered)
O physician or physician assistant
O police officer
O psychologist
O resident physician or intern at a Connecticut hospital
O sexual assault or battered women's counselor
O surgeon

Name of the person you told about the assault ______ Title ______ Date of disclosure ______

Address ______ City ______ State ______ Zip ______

Telephone number ______

01366

SECTION 7 - CRIME EXPENSES

Please list all of the hospitals, doctors, dentists, counselors, ambulance services, radiology services, and others who provided treatment or services because of the crime and list the prescriptions (drugs and eyeglasses) you were given because of it (attach additional pages, if needed) and include copies of any crime related bills.

Provider	*Telephone*	*Address*	*City*	*State*	*Zip*

SECTION 8 - EMPLOYMENT INFORMATION

Please fill out this section if you were employed or self-employed at the time of the crime and are applying for lost wages. If self-employed, attach a copy of your tax return and W2 or 1099 form for the year of the crime. If you have not filed your taxes before completing this application, forward the information for the year before the crime. Please note that we can only consider taxable income. We will contact your employer for dates absent, salary, and benefit information. If you have a concern about this, please call us. If you missed more than 1 week of work, please provide a doctor's note.

Name of employer ____ Contact name ____ Telephone number ____

Address ____ City ____ State ____ Zip ____

Hours worked per week ____ Wage per hour ____ Tips, bonuses per week ____

Dates absent because of crime related injuries or care to victim ____

Name of treating doctor or hospital ____ Telephone number ____

Address ____ City ____ State ____ Zip ____

SECTION 9 - INSURANCE & OTHER FINANCIAL RESOURCES

This section must be filled out. Please check yes or no for each type of victim compensation benefit listed below that you are applying for. If you are applying for that benefit, you must check yes or no for each of the financial resources below that benefit that you have or may be able to get paid by. If the financial resource is not one that you can get paid by, please check no. You must contact us if any of the financial resources checked as No become available in the future.

1. Are you applying for Medical or Mental Health Benefits? ○ yes ○ no

Financial Resources	*Yes*	*No*	*Provider Name*	*Address*	*Telephone*	*Account No.*
Dental Insurance	○	○				
Department of Social Services	○	○				
Health Insurance (PRIMARY)	○	○				
Health Insurance (SECONDARY)	○	○				
Health Savings/Spending Accounts						
Flexible Spending Account	○	○				
Health Reimbursement Account	○	○				
Health Savings Account	○	○				
Medicare	○	○				
Veterans Administration	○	○				
Workers Compensation (CRIMES WHILE AT WORK)	○	○				

2. Are you applying for Crime Scene Cleanup Benefits? ○ yes ○ no

Financial Resources	*Yes*	*No*	*Provider Name*	*Address*	*Telephone*	*Account No.*
Homeowners Insurance	○	○				
Renters Insurance	○	○				

3. Are you applying for Lost Wages Benefits? ○ yes ○ no

Financial Resources	*Yes*	*No*	*Provider Name*	*Address*	*Telephone*	*Account No.*
Department of Social Services	○	○				
Disability Insurance	○	○				
Life Insurance with Disability Rider	○	○				
Police/Firemen's Insurance	○	○				
Police Association of Connecticut	○	○				
Sick Leave	○	○				
Social Security Disability	○	○				
Workers Compensation (CRIMES WHILE AT WORK)	○	○				
Unemployment Compensation	○	○				

4. Did the incident involve a Motor Vehicle? ○ yes ○ no

Financial Resources	*Yes*	*No*	*Provider Name*	*Address*	*Telephone*	*Account No.*
Auto Insurance	○	○				
Claims against Other Parties' Auto Insurance	○	○				
Did you receive an auto insurance settlement?	○	○				
Did you file a Dram Shop Liability claim?	○	○				

5. You must check yes or no for each of the sources listed below.

Other Sources of Income	*Yes*	*No*	*Court Location and Docket Number*
Was restitution ordered by the court?	○	○	
Did you or will you file a lawsuit?	○	○	
Other	○	○	
Other	○	○	
Other	○	○	

SECTION 10 - STATEMENT OF FACTS AND AUTHORIZATION

I certify that the information in this application for compensation is true to the best of my knowledge, information, and belief and I give permission to any hospital, physician(s) or other person(s) who attended, examined, or gave services to ______________________ (*victim/claimant name*), any employer(s) of the victim or claimant, any police or other municipal authority or agency, or public authorities including state and federal revenue services, any insurance company or organization having knowledge of the incident to give to OVS or its representative any and all information regarding the incident leading to the victim's personal injuries and the victim's or family member's application for compensation. A copy of this authorization will be considered as effective and valid as the original.

I, ______________________ (*victim/claimant name*) give permission to OVS to disclose any information in its records, including confidential information, to the offices of the Court Support Services Division, the State's Attorney, the Attorney General and to private attorneys retained by OVS or the victim, and to communicate freely with them when necessary (Sections 54-208(e), 54-212, and 54-215 of the Connecticut General Statutes).

I understand that I must notify OVS if I file a lawsuit against whoever is responsible for the injury or death for which OVS paid the award within 30 days of the filing of the action in court. If I recover money from the lawsuit, either by a judgment or by settlement, I understand that OVS is entitled by law to 2/3 of the amount OVS paid. (Section 54-212 of the Connecticut General Statutes). If I have filed a lawsuit, I agree to provide a copy of the writ, summons, and complaint to OVS immediately.

I understand that OVS will have the right to bring a lawsuit in my name against whoever is responsible for the injury or death for which the money was paid. I also understand that if OVS recovers money from the lawsuit, it is entitled by law to keep 2/3 of the amount paid, plus costs and interest. OVS will pay me any balance over that amount (Section 54-212 of the Connecticut General Statutes).

I understand that if I receive money from any other sources, including payments from state or municipal agencies, insurance benefits, or workers' compensation as a result of the criminal incident, OVS is entitled by law to 2/3 of the amount OVS paid (Section 54-212 of the Connecticut General Statutes).

I understand that if the court orders restitution to the victim for expenses paid by OVS, OVS is entitled to receive full reimbursement, unless the court orders differently (Section 54-215 of the Connecticut General Statutes).

I also understand that my providers may be reimbursed directly for debts that I owe.

____ ______________________

Applicant signature **Date**

An adult victim/claimant, the parent/legal guardian of a minor child (under 18 years old), or the legal guardian of an incapacitated adult ***must sign*** *this application. Applications that are not signed will be returned.*

Please return completed application to:
Office of Victim Services
225 Spring Street, 4th Floor
Wethersfield, CT 06109

Contact OVS at:
1-888-286-7347 (Toll-free)
860-263-2761
www.jud.ct.gov/crimevictim

FOR OFFICE USE ONLY | Claim Number | Claims Examiner

SECTION 3 - PARENT/LEGAL GUARDIAN INFORMATION

This section is for parents and legal guardians of children under 18 years old and legal guardians of an incapacitated adult. If you have your own expenses because of the crime, please fill out another application and list yourself as the claimant. (Legal guardians or conservators must provide a copy of the court order.)

Name of parent or legal guardian (last, first, middle) _______ How are you related to the victim/claimant? _______

Address _______ City _______ State _______ Zip _______

Home telephone _______ Work telephone _______ Cell phone _______ Email _______

Primary language spoken _______ Gender: ○ Female ○ Male ○ Other _______

SECTION 4 - ATTORNEY REPRESENTATION

Please check if an attorney is representing you on this application, a civil lawsuit, or both and provide the attorney's contact information. ○ Representing me on this application ○ Representing me in a civil lawsuit

Name of attorney (last, first, middle) _______ Name of firm _______

Address _______ City _______ State _______ Zip _______

Work telephone _______ Fax number _______ Juris number _______

SECTION 5 - STATISTICAL INFORMATION

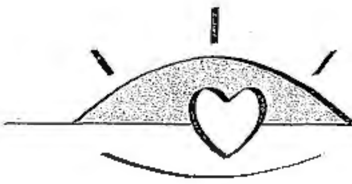
How did you find out about the Victim Compensation Program?

○ community advocate
○ family member
○ friend/acquaintance
○ hospital
○ Infoline 211
○ medical provider
○ mental health provider
○ Office of Adult Probation
○ OVS victim advocate
○ OVS web page
○ police
○ poster/brochure
○ private attorney
○ prosecutor/state's attorney
○ public service announcement
○ telephone book
○ other _______

Statistics are voluntary and needed for federal reporting requirements.

○ white
○ hispanic
○ asian
○ other
○ black/african american
○ native hawaiian/pacific islander
○ american indian/alaskan native
○ unknown

Was the victim disabled before the crime? ○ yes ○ no



PERSONAL INJURY COMPENSATION

APPLICATION

ID-VS-8PI 10/12

9 $2000 mental health expenses
- any child in School

OFFICE OF VICTIM SERVICES

Focusing on a brighter future

We are here to help. If you have any questions about filling out this application or the Compensation Program, please call us toll-free at 1-888-286-7347. Please know that it is important that you tell us if your contact information changes. If we cannot reach you, your claim may be closed or you may miss important deadlines set by state law.

SECTION 1 - VICTIM INFORMATION

The victim is the person who was physically injured because of the crime. Parents and legal guardians of a minor child (under 18 years old) and legal guardians of an incapacitated adult must also fill out Section 3. A separate application must be filled out for each victim who was physically injured.

Name of victim (last, first, middle) ________ Birth date ________ Age ________

Address ________ City ________ State ________ Zip ________

Home telephone ________ Work telephone ________ Cell phone ________ Email ________

Primary language spoken ________ Gender: ○ Female ○ Male ○ Other ________

SECTION 2 - CLAIMANT INFORMATION

The claimant is the person who has expenses because of the crime. If the victim and the claimant are the same person, you do not have to fill out this section. Parents and legal guardians of a minor child (under 18 years old) and legal guardians of an incapacitated adult must also fill out Section 3.

Name of claimant (last, first, middle) ________ Birth date ________ Age ________

Address ________ City ________ State ________ Zip ________

Home telephone ________ Work telephone ________ Cell phone ________ Email ________

Primary language spoken ________ Gender: ○ Female ○ Male ○ Other ________

Relationship to victim:

○ child ○ spouse ○ parent ○ grandchild ○ grandparent ○ spouse's parent ○ stepparent ○ brother ○ sister ○ half-brother ○ half-sister ○ stepchild ○ adopted child ○ party to a civil union ○ other ________

An adult victim/claimant, the parent/legal guardian of a minor child (under 18 years old), or the legal guardian of an incapacitated adult ***must sign*** *Section 10 of this application. Applications that are not signed will be returned.*