



State of Nevada Victims of Crime Program

Payment Request Voucher

Submit with original bill, EOB, or receipt for any crime related expense

Victim/Applicant Name:

VOCP Claim #

Claim Information:

Invoice #

Invoice Date:

Date of Service:

Amount Requested:

Description of attached document:

Was this service or product provided to the victim or applicant listed above?

- Yes
 No If *No* please explain:

Was this service or claim necessitated by the crime?

- Yes
 No If *No* please explain:

Did the victim or applicant pay any portion of this claim?

- Yes If *Yes* please explain:
 No

Is there any additional information or instructions about the claim the VOCP should consider?

- Yes If *Yes* please explain:
 No

Where should payment be sent?

The information provided herein is true and accurate to the best of my information and belief

Authorized Signature:

Print Signers Name:

Date:

Telephone #

Email address:

Mail to: VOCP
P O Box 94525
Las Vegas, NV 89193-4525

Fax to:
(888) 941-7890

Scan and email to:
applications@voc-net.com