

## Hate Crime Checklist.pdf

# HATE CRIME CHECKLIST

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<b>VICTIM</b>	<p style="text-align: center;"><b><u>Victim Type:</u></b></p> <p><input type="checkbox"/> <b>Individual</b>                  Legal name (Last, First): _____                  Other Names used (AKA): _____</p> <p><input type="checkbox"/> <b>School, business or organization</b>                  Name: _____                  Type: _____  <i>(e.g., non-profit, private, public school)</i>                  Address: _____</p> <p><input type="checkbox"/> <b>Faith-based organization</b>                  Name: _____                  Faith: _____                  Address: _____</p>	<p style="text-align: center;"><b><u>Target of Crime (Check all that apply):</u></b></p> <p><input type="checkbox"/> Person    <input type="checkbox"/> Private property    <input type="checkbox"/> Public property</p> <p><input type="checkbox"/> Other _____</p> <p style="text-align: center;"><b><u>Nature of Crime (Check all that apply):</u></b></p> <p><input type="checkbox"/> Bodily injury                      <input type="checkbox"/> Threat of violence</p> <p><input type="checkbox"/> Property damage</p> <p><input type="checkbox"/> Other crime: _____</p> <p>Property damage - estimated value _____</p>
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<b>BIAS</b>	<p style="text-align: center;"><b><u>Type of Bias</u></b>  <b>(Check all characteristics that apply):</b></p> <p><input type="checkbox"/> Disability</p> <p><input type="checkbox"/> Gender</p> <p><input type="checkbox"/> Gender identity/expression</p> <p><input type="checkbox"/> Sexual orientation</p> <p><input type="checkbox"/> Race</p> <p><input type="checkbox"/> Ethnicity</p> <p><input type="checkbox"/> Nationality</p> <p><input type="checkbox"/> Religion</p> <p><input type="checkbox"/> Significant day of offense  <i>(e.g., 9/11, holy days)</i></p> <p><input type="checkbox"/> Other: _____</p> <p>Specify disability (be specific):                  _____                  _____</p>	<p style="text-align: center;"><b><u>Actual or Perceived Bias – Victim’s Statement:</u></b></p> <p><input type="checkbox"/> Actual bias [Victim actually has the indicated characteristic(s)].</p> <p><input type="checkbox"/> Perceived bias [Suspect believed victim had the indicated characteristic(s)].  <i>If perceived, explain the circumstances in narrative portion of Report.</i></p> <p style="text-align: center;"><b><u>Reason for Bias:</u></b></p> <p><b>Do you feel you were targeted based on one of these characteristics?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <i>Explain in narrative portion of Report.</i></p> <p><b>Do you know what motivated the suspect to commit this crime?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <i>Explain in narrative portion of Report.</i></p> <p><b>Do you feel you were targeted because you associated yourself with an individual or a group?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <i>Explain in narrative portion of Report.</i></p> <p><b>Are there indicators the suspect is affiliated with a Hate Group (i.e., literature/tattoos)?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <i>Describe in narrative portion of Report.</i></p> <p><b>Are there Indicators the suspect is affiliated with a criminal street gang?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <i>Describe in narrative portion of Report.</i></p>
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	<p style="text-align: center;"><b><u>Bias Indicators (Check all that apply):</u></b></p> <p><input type="checkbox"/> Hate speech                      <input type="checkbox"/> Acts/gestures                      <input type="checkbox"/> Property damage                      <input type="checkbox"/> Symbol used</p> <p><input type="checkbox"/> Written/electronic communication                      <input type="checkbox"/> Graffiti/spray paint                      <input type="checkbox"/> Other: _____</p> <p><i>Describe with exact detail in narrative portion of Report.</i></p>
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<b>HISTORY</b>	<p style="text-align: center;"><b><u>Relationship Between Suspect &amp; Victim:</u></b></p> <p>Suspect known to victim?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Nature of relationship: _____</p> <p>Length of relationship: _____</p> <p><i>If Yes, describe in narrative portion of Report</i></p>	<p><input type="checkbox"/> Prior reported incidents with suspect? Total # _____</p> <p><input type="checkbox"/> Prior unreported incidents with suspect? Total # _____</p> <p>Restraining orders?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><i>If Yes, describe in narrative portion of Report</i></p> <p>Type of order: _____    Order/Case# _____</p>
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<b>WEAPONS</b>	<p>Weapon(s) used during incident?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    Type: _____</p> <p>Weapon(s) booked as evidence?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Automated Firearms System (AFS) Inquiry attached to Report?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
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<b>EVIDENCE</b>	Witnesses present during incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Statements taken? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Evidence collected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Recordings: <input type="checkbox"/> Video <input type="checkbox"/> Audio <input type="checkbox"/> Booked
	Photos taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	Suspect identified: <input type="checkbox"/> Field ID <input type="checkbox"/> By photo
	Total # of photos: _____ D#: _____ Taken by: _____ Serial #: _____	<input type="checkbox"/> Known to victim

<b>OBSERVATIONS</b>	<b><u>VICTIM</u></b>	<b><u>SUSPECT</u></b>
	<input type="checkbox"/> Tattoos <input type="checkbox"/> Shaking <input type="checkbox"/> Unresponsive <input type="checkbox"/> Crying <input type="checkbox"/> Scared <input type="checkbox"/> Angry <input type="checkbox"/> Fearful <input type="checkbox"/> Calm <input type="checkbox"/> Agitated <input type="checkbox"/> Nervous <input type="checkbox"/> Threatening <input type="checkbox"/> Apologetic <input type="checkbox"/> Other observations: _____	<input type="checkbox"/> Tattoos <input type="checkbox"/> Shaking <input type="checkbox"/> Unresponsive <input type="checkbox"/> Crying <input type="checkbox"/> Scared <input type="checkbox"/> Angry <input type="checkbox"/> Fearful <input type="checkbox"/> Calm <input type="checkbox"/> Agitated <input type="checkbox"/> Nervous <input type="checkbox"/> Threatening <input type="checkbox"/> Apologetic <input type="checkbox"/> Other observations: _____

**ADDITIONAL QUESTIONS (Explain all boxes marked "Yes" in narrative portion of report):**

Has suspect ever threatened you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has suspect ever harmed you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does suspect possess or have access to a firearm?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you afraid for your safety?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other information that may be helpful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Resources offered at scene:**  Yes  No Type: \_\_\_\_\_

<b>MEDICAL</b>	<b><u>Victim</u></b>	<b><u>Suspect</u></b>	<b>Paramedics at scene?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Unit # _____
	<input type="checkbox"/>	<input type="checkbox"/>	Declined medical treatment
	<input type="checkbox"/>	<input type="checkbox"/>	Will seek own medical treatment
	<input type="checkbox"/>	<input type="checkbox"/>	Received medical treatment
Authorization to Release Medical Information, Form 05.03.00, signed? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name(s)/ID #: _____
			Hospital: _____
			Jail Dispensary: _____
			Physician/Doctor: _____
			Patient #: _____

Officer (Name/Rank)	Date
Officer (Name/Rank)	Date
Supervisor Approving (Name/Rank)	Date