APPELLATE ADVOCACY PROGRAM

Compensation Application

Claim Process according to ORS Chapter 147 & OAR 137-076-0000 - 0070

If you have applied for Crime Victims Compensation for this crime please notify your AAP Advocate

APPLICATION MUST BE RECEIVED WITHIN 6 MONTHS OF HEARING

AAP Use Only

CV#: ____________

Are you the Victim of the Crime ☐ Yes ☐ No If No, List Minor Victim's or Deceased Victim's name:

Name: Date of Birth:

APPLICANT NAME (Full Legal Name) **PRINT CLEARLY** **DATE OF BIRTH** (mm/dd/yyyy)

APPLICANT'S MAILING ADDRESS: ____________

SOCIAL SECURITY #: ____________ EMAIL: ____________
(only used as identifier for payments) **(Only if you use it regularly)**

BEST CONTACT PHONE NUMBER: ____________ **IS ANYONE AUTHORIZED TO DISCUSS YOUR CLAIM?** (List Name) ____________

Are you currently receiving restitution payments? ☐ Yes ☐ No

CLAIM FOR TRAVEL EXPENSES REIMBURSEMENT :(RECEIPTS MUST BE PROVIDED)

Maximum available per hearing per family unit $3000

DATE / TIME OF TRAVEL ____________

TYPE OF TRAVEL: Round trip mileage from home address to hearing address will be calculated. Other tickets are reimbursed at coach rate. ☐ Car Mileage ☐ Airfare ☐ Bus ☐ Train

OTHER TRAVEL EXPENSES ☐ Taxi/Shuttle/Parking ☐ Hotel Room ☐ Meals ☐ Other

CLAIM FOR COUNSELING OUT OF POCKET EXPENSES:

Maximum per hearing per family $5000

Only licensed providers will be approved for payment

PROVIDER NAME: ____________ **PROVIDER PHONE #** ____________

PROVIDER ADDRESS: ____________

DO YOU HAVE INSURANCE?
(Attach Copy of Card) **INSURANCE NAME:** ____________ **POLICY # :** ____________

DID YOU HAVE SESSIONS BEFORE THE HEARING DATE? ☐ NO ☐ YES (Attach Receipts for Payments already made)

TO BE COMPLETED BY AGENCY PERSONNEL/VICTIM ADVOCATE

OFFENDER'S NAME : ____________ **SID #:** ____________ DOB: ____________

JUDGEMENT COUNTY: ____________ **DATE OF CRIME:** ____________

COUNTY CASE #: ____________

LIST ALL CRIMES WITH GUILTY CONVICTIONS: ☐ Police Report Attached

TYPE OF HEARING: ☐ BOPPPS ☐ COA ☐ PCR ☐ FEDHAB ☐ PSRB ☐ SHRP

DATE OF HEARING: ____________ ☐ By Phone ☐ In Person ☐ Other Participation Per advocate

☐ **SUPPLEMENTAL INFORMATION ATTACHED FOR CONSIDERATION**

PREPARED & VERIFIED PARTICIPATION BY:

PHONE #: **EMAIL:**

Rev. Date 05/2010

The Crime Victims' Compensation Program (CVCP) must investigate all applications. This authorization will be used to gather information from law enforcement, your employer(s), insurance companies,medical facilities, and other sources in order to determine and manage your claim. CVCP will disclose information about your claim only when required by law to do so.

MEDICAL AND OTHER RELEASE:

BY SIGNING THIS APPLICATION I HEREBY CONSENT TO RELEASE RECORDS between CVCP and any hospitals, physicians, counselors, medical facilities and services, any insurer including social security and disability benefits,or any other authorized person or law enforcement agency for purposes relating to my CVCP application.

I EXPRESSLY AND VOLUNTARILY AUTHORIZE DISCLOSURE of my records for the purpose stated above. I further understand that I am not giving permission for any disclosure other than that described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

BY SIGNING THIS APPLICATION I UNDERSTAND THAT UNDER PENALTIES OF UNSWORN FALSIFICATION, I declare that the information in this application is true and accurate. I, or we, authorize the Crime Victims' Compensation Program of the Department of Justice to verify any information on this application.

Applicant / Victim's Signature	**Date**

Department of Justice / Appellate Advocacy Program / 1162 Court St NE Salem, OR 97301 / 503-378-4284