APPELLATE ADVOCACY PROGRAM

Reverse and Remand 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 Advocate

AAP Use Only

PC#:

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

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

CLAIM FOR COUNSELING

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 #:

PREPARED & VERIFIED PARTICIPATION BY:

PHONE #: **EMAIL:**

The Crime Victims' Compensation Program (CVCP) must review 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**