OREGON DEPARTMENT OF JUSTICE
CRIME VICTIM & SURVIVOR SERVICES DIVISION

APPLICATION FOR CRIME VICTIMS' COMPENSATION

You may qualify for help through Crime Victims' Compensation (CVC) if you have been the victim of a person crime in the state of Oregon. Claims will be verified by the program, through police and other reports.

An application must be filled out for each victim. If the victim is deceased, is a minor, or an adult that is unable to complete the application, the applicant (person filing for victim) must be an adult who is responsible for the victim. You are not required to be a US Citizen to apply for Crime Victims' Compensation. Please complete as thoroughly and accurately as possible. Type or print clearly. **Unsigned applications will be returned unprocessed**.

You can also file an application electronically through the Crime Victims' Compensation portal: https://justice.oregon.gov/victims/compensation/. Once your application is submitted you can register for the portal to view the status of your application. If you submit a paper application, please mail or e-mail it to:

Oregon Department of Justice
Crime Victims' Compensation Program
1162 Court Street NE
Salem, OR 97301-4096
Telephone: (503) 378-5348 or 1-800-503-7983
Email: cvssd@doj.state.or.us

Expenses CVC can assist with may include:

- Medical
- Dental
- Hospital
- Funeral
- Counseling
- Loss of Earnings or Support
- Physical Rehabilitation
- Transportation

*CVC cannot compensate for lost or damaged property, or for pain and suffering.
*Loss of earnings or support is only payable if the victim was employed and working at the time of the criminal incident.
*Expenses related to the crime must first be submitted to your insurance for payment, including health, dental, and auto insurance. Any expenses not fully covered by insurance will be considered for payment.

If you need help completing the application please call your local Victim Assistance Office through the District Attorney's Office, or call Crime Victims' Compensation at (503) 378-5348 or toll free 1-800-503-7983. You have one (1) year from the date of the crime to file an application.

Thank you for taking the time to complete this application. We will notify you by mail or email when we receive your application, and then again within 60 to 90 days with our claim decision.

What do you need to do?

*Please notify CVC if your mailing address, phone number, or email address changes.
*If we request information from you, please respond within the allowed time.

To learn more about the Crime Victims' Compensation Program, visit us online at:
https://www.doj.state.or.us/crime-victims/

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OREGON CRIME VICTIMS' COMPENSATION PROGRAM

We are here to help. Our mission is to reduce the impact of a crime on victims and their families. If you have any questions about completing this application or the Crime Victims' Compensation Program, please call us toll-free at 1-800-503-7983.

APPLICATION FORM

Please print clearly

Who referred you to our program?

☐ Police ☐ Child Advocacy Center ☐ Medical Provider
☐ Victim Assistance Program ☐ Tribal Advocate ☐ Other:

You are filing this application because you are (check one):

☐ The victim of a crime
☐ The parent/guardian of a crime victim under 18 years of age
☐ A family member of a victim who died as the result of a crime
☐ Other (explain):_____

Victim Information (Person who is injured or deceased)

First Name:	Middle Name:	Last Name:		
Mailing Address:	Apt #:	City:	State:	Zip:
Phone:	Social Security Number (only last 4 digits):	Preferred Language:		
Date of Birth:	If victim is deceased, date of death:	Gender:		
May we contact you by email? ☐ Yes ☐ No	If yes, please provide your email address:			

Applicant Information (Parent or Guardian of injured victim, or family member of deceased victim)

First Name:	Middle Name:	Last Name:		
Mailing Address:	Apt #:	City:	State:	Zip:
Phone:	Preferred Language:			
Date of Birth:	Gender:	Your relationship to the victim:		
May we contact you by email? ☐ Yes ☐ No	If yes, please provide your email address:			

Optional Contact Person (Person we can talk to about your claim)

First Name:	Last Name:	Preferred Language:
Contact person's phone:	Contact person's e-mail:	Contact person's relationship to the victim:

Advocate Information (Person at the DA's Office, non-profit, or Child Advocacy Center assisting with this application)

Advocate name:	Advocate e-mail:	Advocate phone #:	County:

Insurance Information (Please check ALL that apply to the victim at the time of the crime)

List insurance company and other resource information below. (use additional pages if necessary)
☐ Private Health Insurance ☐ Oregon Health Plan ☐ Medicare ☐ Workers' Compensation ☐ Dental ☐ None

Insurance Company Name:	Insurance Company Name:

Crime Information (Required for all claims)

Type of Crime:

☐ Assault	☐ Domestic Violence	☐ Harassment	☐ Stalking
☐ Sexual Assault (Adult)	☐ Sexual Assault (child)	☐ Physical Abuse (child)	☐ Human Trafficking
☐ DUII Assault	☐ Homicide	☐ Robbery	☐ Kidnapping
☐ Elder Abuse	☐ Hate/Bias	☐ Other:_____	

Did the crime involve a vehicle? ☐ Yes ☐ No	If yes, name of victim's auto insurance & claim #:
Alleged Suspect (if known):	Date of Birth:
Additional Suspect (if applicable):	Date of Birth:

Date of Crime:	Date Reported:	Report Number:
Name of Police Department reported to:		Name of Officer:
Was the crime reported within 72 hours? ☐ Yes ☐ No	If no, please explain why (required):	

Location of Crime: Address	City:	State:	Zip:	County:

Loss of Earnings (If you lost wages as a result of the criminal incident)

Was the victim employed on the date of the crime?			☐ Yes ☐ No	
Name of Victim's Employer:	Address:	City	State	Zip
Employer's Phone:	Employer's E-mail:			
Returned to work? ☐ Yes ☐ No	Date Returned to work:	Did you miss more than two weeks of work? ☐ Yes ☐ No		
Name of Victim's Doctor:	Address:	City	State	Zip
Doctor's Phone:	Doctor's E-mail:			

Additional Information (Add information you would like us to know)

Provider Information (Medical/counseling providers seen for crime related injuries)

Have you had any medical treatment or counseling as a result of the crime? Please list providers seen for crime-related injuries or trauma, paid or unpaid (attach additional pages if necessary):					☐ Yes ☐ No
Provider Name:	Address:	City:	State:	Zip:	Phone Number:

Additional Counseling (Homicide survivor counseling, child witness to domestic violence, family member of child victim of sexual or physical abuse)

Is there anyone besides the victim who is or will be receiving counseling as a result of the crime?			☐ Yes ☐ No
Name of Family Member:	Date of Birth:	Relationship to Victim:	Insurance Carrier:

Civil Attorney Information

Have you retained an attorney regarding a civil lawsuit due to this crime? ☐ Yes ☐ No ☐ Undecided			
Attorney Name:	Telephone:	Email:	
Address:	City:	State:	Zip:

For Homicide Claims Only (Please list all out-of-pocket and unpaid funeral expenses)

Provider of funeral services:	Address:	City:	State:	Zip:	Phone:

At the time of death, was the victim financially supporting any dependents? ☐ Yes ☐ No If yes, complete loss of support information below.

Name of Dependent:	Date of Birth:	Address:	Relationship to Victim:

Loss of Support Information (Income loss as a result of the homicide)

Was the victim employed on the date of the crime?			☐ Yes ☐ No	
Name of Victim's Employer:	Address:	City	State	Zip
Employer's Phone:	Employer's E-mail:			

Information Release

Crime Victims' Compensation (CVC) must investigate all applications. This authorization will be used to gather information from law enforcement, your employer(s), insurance companies, financial institutions, medical facilities, and other sources in order to determine and manage your claim. CVC 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 CVC and any hospitals, physicians, counselors, medical facilities and services, any insurer including social security and disability benefits, any employers, and any social services or governmental agencies including Employment Department, DHS, Worker's Compensation Division, State Court Administrator or any other authorized person or law enforcement agency for purposes relating to my CVC application.

I ALSO HEREBY CONSENT TO RELEASE TO CVC any document(s) related to disability information or income from other sources and/or my medical records even if it contains information about drugs, alcohol, mental health, or HIV testing.
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.

My Promise to the Program

BY SIGNING THIS APPLICATION I HEREBY AGREE to immediately inform CVC when any crime-related recovery is expected or received. I further agree to reimburse CVC from those recoveries a sum that is equal to the amount of the total CVC award. I acknowledge and agree that the sources of recovery this subrogation agreement will pertain to include, but are not limited to, the following: court-imposed restitution, civil judgments against the offender or other liable/obligated third parties, any insurance settlements, or settlements/benefits from any other governmental or private agency. I further agree to reimburse CVC all sums of money paid by CVC pursuant to this claim, if the claim is at any time determined to be in error, false or fraudulent.

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.

Signature of Victim/Applicant	Date:
Signature of 14-17 year old Victim:	Date:

OREGON DEPARTMENT OF JUSTICE
CRIME VICTIM & SURVIVOR SERVICES DIVISION
1162 Court St NE Salem, Oregon 97301-4096
(503) 378-5348 or 800 503-7983 Fax (503) 378-5738

Per ORS 147.105 (1)(i) the CVC has the authority to request information to process applications for compensation. If compensation is received by intentionally misrepresenting information which CVC relies upon to determine or pay compensation, compensation awards shall be forfeited.

Nondiscrimination

To be eligible to receive federal funds for distributing purposes of crime victims' compensation, the State of Oregon must comply with the nondiscrimination requirements of the Federal Victims of Crime Act of 1984. To ensure it meets those requirements regarding nondiscrimination, the State of Oregon must collect information about the victim's race, religion, sex, national origin, age, and any handicapping condition. The information you provide will not be used in any manner to determine acceptance or denial of your claim and will be kept confidential.

Recipients of funds under the Act are subject to Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000(d) (prohibiting discrimination in Federally-funded programs on the basis of race, color, or national origin), Section 504 of the Rehabilitation Act of 1974, as amended: Subtitle A, Title II of the Americans with Disabilities Act (ADA); and Department of Justice implementing regulations on disability discrimination, 28 CFR Part 35 and Part 39; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1974; and the Department of Justice Nondiscrimination Regulations, 28 CFR Part 42, Subparts C, D, E, and G.

The following voluntary information is used for statistical purposes only to comply with federal regulations	
Is the Victim disabled? ☐ **Yes** ☐ **No**	**Was the Victim disabled prior to the date of crime?** ☐ **Yes** ☐ **No**
Ethnicity of victim:	
☐ **Black or African American** ☐ **Asian** ☐ **American Indian or Alaska Native** ☐ **Native Hawaiian or Other Pacific Islander**	☐ **Hispanic or Latino** ☐ **White Non-Latino or Caucasian** ☐ **Other:** _____