DEPARTMENT OF JUSTICE
CRIME VICTIM & SURVIVOR SERVICES DIVISION

COUNSELING ONLY APPLICATION

This application is only for adult sexual assault or domestic violence victims seeking compensation for counseling expenses only. The crime must have occurred in Oregon. The Counseling Only Application should be used when the following three criteria are met:

(1) The claim involves sexual assault or domestic violence;

(2) The incidents occurred in Oregon; and

(3) There are no police reports, protective orders, or sexual assault forensic exams sought, obtained or pursued by the victim.

If these requirements are not met, victims and applicants may use the Crime Victims' Compensation application. If you are unsure which application to submit, please email cvssdportal@doj.state.or.us.

You may file this 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 email 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

If you need help completing the application please call your local Victim Assistance Office through the District Attorney's Office, contact information can be found at https://www.doj.state.or.us/crime-victims/victims-resources/other-resources/county-victim-assistance-programs/. You may also call Crime Victims Compensation at (503) 378-5348 or toll free 1-800-503-7983 for assistance. 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 us of changes to your mailing address, phone number, or email address.
*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:

www.doj.state.or.us/victims (http://www.doj.state.or.us/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 filling out this application or the Crime Victims' Compensation Program, please call us toll-free at 1-800-503-7983.

APPLICATION FORM – Sexual Assault & Domestic Violence Counseling Only

Please print clearly

Who referred you to our program?

☐ Police ☐ Medical Provider ☐ Other:
☐ Victim Services ☐ Tribal Advocate

Victim Information

(Person who was injured)

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

Insurance Information

(Required for all claims)

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 ☐ None

Insurance Company Name:	Insurance Company Name:

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 with the District Attorney's Office or non-profit agency)

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

Counselor Information

Counselor Name (First, Last):			Licensure:
Mailing Address:			
City:	State:	Zip:	Phone:

Crime Information

Type of Crime: ☐ Assault - Domestic Violence ☐ Sexual Assault – Domestic Violence ☐ Sexual Assault (Adult) ☐ Domestic Violence	Date of Crime:
Alleged Suspect (if known):	
Additional Suspect (if applicable):	
Did the crime occur in Oregon? ☐Yes ☐ no	In what **county** did the crime occur?
Have you reported this incident? (you are not required to report) ☐Yes ☐ No	If yes, provide the name of Police Department reported to:
Did you file a Protective Order or undergo a Sexual Assault Examination? ☐Yes ☐ No	If yes, in which **county** did you file the order or undergo the exam?
Please describe the incident(s):	

Information Release

Crime Victims' Compensation (CVC) must investigate all applications. This authorization will be used to gather information from your employer(s), insurance companies, 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, any employers, and any social services or governmental agencies including Worker's Compensation Division, or any other authorized person for purposes relating to my CVC application.

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

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 this authorization expires 180 days from the date of my signature below.** 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 the 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?**
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:** _____