Oregon Department of Justice
Crime Victim and Survivor Services Division
Every victim, every crime, every right, every time.

Crime Victims' Compensation Application

You may qualify for Crime Victims' Compensation (CVC) if you have been the victim of a violent crime in Oregon. Crimes that may qualify for CVC include domestic violence, sexual assault, child abuse, robbery, assault, bias or hate, human trafficking (sex or labor), and additional crimes that cause physical or psychological injury.

You can apply for CVC to help with crime-related expenses like:

- Medical / Dental
- Counseling / Mental Health Support
- Loss of Earnings
- Crime Scene Cleanup
- Physical Therapy and Additional Alternative Treatment
- Mileage Reimbursement

Answers to Commonly Asked Questions

- If the crime was reported to law enforcement or a medical provider, a SANE or SKIT exam was done (for sexual assault or strangulation), or a protective order was obtained, you may qualify for full CVC benefits. There is a Counseling Only benefit available, if none of these apply.
- You cannot receive CVC compensation for lost or damaged property.
- You can only receive CVC compensation for loss of earnings if you were employed at the time of the crime and missed work because of the crime. CVC is unable to assist with lost wages due to court appearances, doctor appointments, or intermittent leave. A work release from a doctor is required beyond 2 weeks of missed work.
- CVC is a payor of last resort and can only pay for expenses that are not covered by health or dental insurance, homeowners' insurance, short term disability, Paid Leave Oregon, Worker's Compensation, or auto insurance (if applicable).

Please note: CVC does not request or consider immigration status when determining eligibility for compensation.

How do I apply?

You can apply electronically through the Crime Victims' Compensation Portal at doj.state.or.us/cvcportal.

You can also submit your application by email: cvssd@doj.state.or.us

You can mail a paper application 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

You must sign the form, giving us permission to verify the information provided in your application. CVC cannot process unsigned applications. We will not process an application until we receive a signed release from you.

Accessible Materials

To request this application in another language, in an electronic format for screen readers, or to request an accommodation, please contact us at:

Email: cvssd@doj.state.or.us
Telephone: 503-378-5348 or 1-800-503-7983

How can I get help with this application?

- You can find victim service programs to assist with your application in each county: doj.state.or.us/davap
- When using the CVC Portal, consult the tutorial at doj.state.or.us/cvcportal-tutorial.

What happens next?

- We will notify you by mail or email when we receive your application. You will receive a claim number within 2 business days.
- When you register for the CVC Portal at doj.state.or.us/cvcportal, you can use the claim number to check your application's status online.
- We will contact you again in 60 to 90 days to tell you if we have accepted your application.

What do I do while I wait for CVC's decision?

- Notify us if your mailing address, phone number, or email address changes. Call us at 503-378-5348 or toll free at 1-800-503-7983 or email us at cvssd@doj.state.or.us.
- Once you have a claim number, please let any medical or dental providers you have seen for crime-related treatment know that you have applied with CVC. CVC works directly with providers to pay crime-related bills.

For more information, visit our website: doj.state.or.us/crime-victims

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Oregon Crime Victims' Compensation Program

The Crime Victims' Compensation (CVC) program is here to help you. Our mission is to reduce the impact of crime on victims and their families. If you have any questions about the CVC program, please call us toll free at 1-800-503-7983 or email us in any language at cvssd@doj.state.or.us .

Application Form – Information marked with * is required. Information marked with ♦ is required based on a previous answer. Read the instructions in that section to see if the information is required for your situation.

Who referred you to our program? *

☐ Police ☐ Child Advocacy Center ☐ Medical Provider
☐ Victim Services/Advocate ☐ Tribal Advocate ☐ Other: _____

I am filling out this application because I am (check one):

☐ The victim of a crime ☐ Another reason (explain): _____
☐ The parent/guardian of a crime victim under age 18

Victim Information (Person who is injured.)

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

Applicant Information (Parent or guardian of injured victim. If you are applying for someone else, information marked ♦ is required.)

First Name: ♦	Middle Name:	Last Name: ♦		
Mailing Address: ♦	Apt #:	City: ♦	State: ♦	Zip: ♦
Phone: ♦	Preferred Language:			
Date of Birth: ♦	Pronouns:	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's Phone:	Contact's Email:	Contact person's relationship to the victim:

Advocate Information (The victim services person or advocate assisting you with this application, if applicable.)

Advocate Name:	Advocate Email:	Advocate Phone:	County:

Insurance Information

What insurance did the victim have at the time of the crime? Please check ALL that apply. *

☐ Private Health Insurance ☐ Oregon Health Plan ☐ Medicare ☐ Workers' Compensation ☐ Dental ☐ None

If the victim had private health insurance, insurance company information marked with ♦ is required. List all insurance information below and use additional pages if necessary.

Insurance Company Name: ♦	Insurance Company Name: ♦

Provider Information (If victim saw a provider for crime-related injuries, CVC will request medical records. If CVC approves your application, you will have the opportunity to submit bills/statements for crime-related expenses.)

Did the victim receive any medical treatment because of the crime? ☐ Yes ☐ No

If yes, information for the initial crime-related visit (hospital, urgent care, or medical office) marked with ♦ is required.

Provider Name(s): ♦	Facility Name: ♦	Date of Service: ♦
Address: ♦	City, State, ZIP: ♦	Phone Number: ♦

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	☐ Hate/Bias	☐ Kidnapping	☐ Hit and Run Resulting in Injury or Death
☐ Elder Abuse	☐ Robbery	☐ Other crime:	

Did the crime involve a vehicle? * ☐ Yes ☐ No	If yes, name of victim's auto insurance & claim #:

Please indicate which of the following apply: ☐ Reported to law enforcement
☐ Reported to a medical provider ☐ SANE or SKIT exam ☐ Obtained protective order ☐ None

Alleged Offender (if known): *	Date of Birth:
Additional Offender (if applicable):	Date of Birth:

Date of Crime:	Date Reported:	Report Number:	Name of Police Department reported to: *

Location of Crime – Address: *	City: *	State: *	ZIP:	County: *

Loss of Earnings (If the victim lost wages because of the crime.)

Did the victim lose earnings due to the crime? * ☐ Yes ☐ No

If yes, information marked ♦ below is required.

Name of Victim's Employer: ♦	Phone: ♦	Address and/or Email:

Has the victim returned to work? ♦ ☐ Yes ☐ No ♦ If yes, date returned to work:	Did the victim miss more than 2 weeks of work? ♦ ☐ Yes ☐ No

Name of Victim's Doctor/Mental Health Provider & Facility: ♦	Phone: ♦	Address and/or Email: ♦

Additional Information (If you wish to add additional information, please remember this application may be subject to disclosure under public record law.) Provide the information below.

Additional Counseling (Such as counseling for a child witness to domestic violence, or a family member of a child victim of sexual or physical abuse.) Provide the information below.

Name:	Date of Birth:	Relationship to Victim:	Insurance Carrier:

Civil Attorney Information

Have you retained an attorney for a civil lawsuit related to this crime? ☐ Yes ☐ No
If yes, attorney information marked with ♦ in this section is required.

Attorney Name: ♦	Phone: ♦	Email: ♦	
Address:	City:	State:	ZIP:

Required Release to Process Your Application

Crime Victims' Compensation (CVC) must verify the information in an application. By signing this release, you are giving permission to CVC to gather information related to your application, including information from law enforcement, employer(s), insurance companies, financial institutions, medical facilities, and other sources to determine and manage your claim. We will never contact the perpetrator or civilian witnesses in the process of reviewing your claim.

You must sign this form to allow CVC to verify the information in your application. We will return any unsigned applications.

Medical and Other Information Release

By signing this application, I consent to release records between CVC and any hospitals, physicians, counselors, and medical facilities and services; any insurer, including Social Security and Disability benefits; any employers; any social services or governmental agencies, including the Employment Department, Department of Human Services, Worker's Compensation Division, county District Attorney's Office, and State Court Administrator; or any other authorized person or law enforcement agency for purposes relating to my CVC application, management of my claim, and restitution.

I also consent to release to CVC any document(s) related to disability status or benefits, income from other sources, and/or my medical records, even if they contain information about drugs, alcohol, mental health, or HIV testing.

The claim is valid for 3 years from the date of acceptance. This release is valid until the claim expires or the claimant revokes consent.

I understand that I may revoke my consent at any time, but my revocation cannot be applied retroactively to disclosures that have already occurred.

Other Compensation or Fraudulent Information

By signing this application, I agree to immediately inform CVC when I expect or receive any crime-related recovery (any payments or compensation related to this crime, like insurance payments).

If I receive crime-related recovery from other sources, I agree to reimburse CVC from those recovery payments up to the total amount of my CVC award. I agree that the sources of recovery that this agreement applies to include, but are not limited to, 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 agree to reimburse CVC all money paid by CVC related to this claim if the claim is determined to be fraudulent.**

Signature – By signing this application, I declare under penalties of unsworn falsification that the information in this application is true and accurate. I authorize the Crime Victims' Compensation program of the Oregon Department of Justice to verify any information on this application.

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

Legal Background

According to ORS 147.105 (1)(i), CVC has the authority to request information to process applications for compensation. If you receive compensation because you intentionally misrepresented information that CVC used to determine or pay compensation, your compensation awards will be forfeited.

Nondiscrimination

CVC is committed to providing services free from discrimination based on race, color, national origin, ethnicity, religion, sex, disability, age, gender identity, sexual orientation, and caste. All federally funded programs, including CVC, are prohibited from this discrimination based on Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000(d); Section 504 of the Rehabilitation Act of 1974, as amended: Subtitle A, Title II of the Americans with Disabilities Act (ADA); Department of Justice regulations on disability discrimination, 28 CFR Part 35 and 39; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1974; the Omnibus Crime Control and Safe Street Act; the Victims of Crime Act; the Violence Against Women Act; 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	**Gender:**

Race/Ethnicity of victim:

☐ Black or African American	☐ Asian	☐ Multiple Races
☐ American Indian or Alaskan Native	☐ Hispanic or Latino	☐ Another ethnicity:
☐ Native Hawaiian or Other Pacific Islander	☐ White Non-Latino or Caucasian	