Oregon Department of Justice
Crime Victim and Survivor Services Division
(503) 378-5348 or (800) 503-7983
1162 Court Street NE
Salem, Oregon 97301-4096
Fax (503) 378-5738
Email: cvssd@doj.state.or.us

Emergency Response Application for Crime Victim Compensation

Who is eligible for compensation benefits?

- This application is for any person present during a mass incident of violence who has suffered physical or psychological trauma.
- A family member of a deceased victim.
- Applicants who believe that they are eligible for and would like to receive compensation for unanticipated medical and counseling expenses that occurred as a direct result of the crime should apply.

What types of benefits may be available to eligible applicants?

- Counseling benefits
- Medical benefits
- Rehabilitation benefits
- Loss of Earnings benefits
- Transportation (60 miles roundtrip to and from crime related medical or counseling appointments only)
- Funeral benefits
- Survivor Counseling benefits
- Loss of Support benefits for survivors of homicide victims

Health insurance, including the Oregon Health Plan must be utilized prior to CVC. CVC can pay for co-pays and deductibles. If you do not have health insurance, CVC may pay for treatment related to the crime.

If you have questions regarding Crime Victims' Compensation, please call 503-378-5348 or 1-800-503-7983.

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Crime Date: _____

What was your experience in this incident?

Advocate/Volunteer assisting victim with application:

Name: _____ Ph#: _____

- ☐ My loved one was killed because of the incident.
- ☐ I was injured because of the incident OR was present and heard/saw the incident occur.
- ☐ My minor child was injured because of the incident OR was present and heard/saw the incident occur.

Victim Information *(Person who is injured or deceased or was present during the incident. If the victim is deceased date of death is required.)*

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

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

First Name:	Last Name:	Preferred Language:
Contact Person's Phone:	Contact Person's Email:	Contact person's relationship to the victim:

Loss of Earnings/Support (*Will the victim lose wages as a result of the incident? (☐ Yes ☐ No)*

Name of Employer	Address	Phone
Name of Victims Doctor	Address	Phone

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

Insurance Company Name:	Insurance Company Name:

For Homicide Claims Only

Provider for Funeral Services:	**Address:**	**Phone:**

Survivor Counseling **(please list names of family members seeking survivor counseling. If additional spaces needed, please attach another page)**

Name	**Date of Birth**	**Phone/Email**	**Insurance Provider**

Required Release to Process Your Application

Crime Victims' Compensation (CVC) must investigate all applications. When you sign this release, we use your permission 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 disclose information about your claim only when required by law to do so.

You must sign this form to allow CVC to investigate your application. Unsigned applications cannot be processed and will be returned.

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, and State Court Administrator; or any other authorized person or law enforcement agency for purposes relating to my CVC application.

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.

I voluntarily authorize disclosure of my records for the purposes of investigating my CVC application. I understand that I am not giving permission for any disclosure other than for verifying my application information. **I understand that I may revoke this authorization at any time**, but that revoking my authorization cannot apply retroactively to information disclosures that have already happened.

Signature of Victim/Applicant:	Date: