CRIME VICTIM FINANCIAL STATEMENT

Name_____
Address_____
City/State/Zip_____
Home/Work Phones_____
_____
DA Case #_____**DA**_____
Defendant_____
Email _____

Benton County District Attorney
Victim Assistance Program
120 NW 4th Street
Corvallis, OR 97330-4785

Phone: 541-766-6688
Fax: 541-766-6701

Advocate_____

Restitution is money paid to a crime victim by a convicted defendant. The information on this form will assist us in submitting an itemized list of your losses to the court at the time of sentencing.

Please complete and return this form within two weeks.

1. **Personal Property** Have the police recovered any of your stolen property?___
If yes, has the property been returned to you?_____

Please list all personal property that was stolen, damaged or destroyed as a direct result of the crime, and the fair market value of that property. Fair Market Value is what the property could have been sold for in its condition prior to the crime. Replacement cost may not be used unless fair market value cannot be determined. Examples: damage to personal property; repair or replacement of locks/windows/doors; crime scene clean-up. Attach copies of receipts, invoices, estimates, repair bills or canceled checks.

PROPERTY DISCRIPTION	FAIR MARKET VALUE	REPLACEMENT COST
	$	$
	$	$
	$	$
	$	$

TOTAL $_____

2. Other Crime-Related Costs

Please list and attach documentation for all other crime-related expenses incurred, such as transportation costs for medical treatment, fees incurred in changing banking or credit card accounts and moving expenses.

EXPENSE	COST	EXPENSE	COST
	$		$
	$		$
	$		$
	$		$

TOTAL $_____

3. Mental Health Expenses

If you have received counseling because of this crime, please provide the following information.

NAME/ADDRESS OF COUNSELOR	SESSION COST	SESSONS TO DATE	# FUTURE SESSIONS
	$		

TOTAL $_____

4. Medical Expenses

Please list and attach documentation for all crime-related medical expenses, such as hospital, doctor, ambulance, laboratory costs, wheelchair rental, glasses, hearing aids and prescription drugs.

Doctor Name, Address and Phone	Brief description of treatment	Has Cost been paid?	By Whom?	Cost
				$
				$
				$
				$

TOTAL $_____

5. Lost Wages/Income

Please provide the following for any lost wages or income related to the crime.

Employer Name/Phone	Hours/Days Missed	Hourly Rate of Pay	Were any covered by Insurance or Vacation?

6. Insurance

☐ I have filed an insurance claim, but have not been paid
☐ I do not wish to file an insurance claim.

Please list insurance payments received/expected. Include property, auto, homeowner, and medical insurance, Medicare/Medicaid or Workman's Compensation.

NAME/ADDRESS OF INSURANCE COMP.	TELEPHONE	POLICY #	CLAIM #	$ PAID TO YOU	DEDUCTABLE

ORS 137.013 provides that at the time of sentencing a victim or victim's next of kin has the right to appear personally or by counsel and has the right to reasonably express any view concerning the crime, the person responsible, the impact of the crime on the victim, and the need for restitution or a compensatory fine. ***You are encouraged to exercise this right.***

Do you wish to be present at the sentencing hearing? Yes_____ No_____

If yes, do you wish to speak to the court at the hearing? Yes_____ No_____

Oregon law provides that a person commits the crime of unsworn falsification if the person knowingly makes any false written statement to a public servant in connection with a written application or benefit. By signing this document, you are certifying that the information contained herein is accurate to the best of your knowledge.

_____ _____
Signature Date

Authorization for Release of Information

I hereby authorize any hospital, physician, or medical facility to release:

_____ Medical Billing Information

_____ Medical Treatment Records

relating to the treatment of injuries of _____(patient name) on or about the date of _____ to the Benton County District Attorney.

_____ _____ _____

Signature of Patient (Guardian) Birth Date Date