John S. Foote, District Attorney for Clackamas County

Victim Assistance Program, 708 Main Street, Oregon City, Oregon 97045
Office: 503-655-8616, Fax: 503-650-3598, www.co.clackamas.or.us/da/

FINANCIAL LOSS FORM

Victim Name: _____

Offender Name: _____ DA Case # _____

We ask that this information be returned to the above address **no later than 10 days** from the receipt of this form or the prosecution may not be able to consider your request for restitution. You must attach copies of any estimates/bills to support your claim for restitution.

PROPERTY LOSS

Please list any property items that **have not** been returned to you or that your insurance company **has not** reimbursed you for as a result of the crime (Please note any items that are being held as evidence in the event that they can not be returned to you at the end of the criminal case).

Property Description: Replacement cost:

_____

_____

_____

_____

Property Loss Insurance Information (Complete this section ONLY if you have made or expect to make a claim for your losses)

Name of your insurance company _____

Address of your insurance company _____

Contact person & phone number _____

Your insurance claim number _____

If your insurance covered your property losses, how much? $_____

If you had a deductible, how much did you pay? $_____

If the offender's insurance covered any of the cost of your losses, how much? $_____

PERSONAL LOSS

Crime Victim Compensation Program (CVCP) If you have been injured as a result of a "person" crime, you may be eligible for compensation from the state CVCP, however, this program does not compensate for property crime expenses.

Have you applied to the Crime Victims' Compensation Program? ____ Claim # _____

Personal Injuries If you suffered physical or emotional injuries that required medical, dental and/or mental health care as a result of this crime, please list YOUR expenses, including co-pays. Please note that Personal Loss does not include 'pain and suffering.'

Injury/treatment: Provider: Account#: Total Cost to Date:

_____

_____

_____

_____

Insurance Company Information (Complete this section ONLY if you have made or expect to make a claim for your injuries)

Name of your medical/dental insurance company _____

Address of your insurance company _____

Contact person & phone number _____

Your insurance claim number _____

If your insurance covered the cost of your care, how much? $_____

If the offender's insurance covered any of the cost of your care, how much? $_____

OTHER CRIME -RELATED EXPENSES

Please list any additional expenses you have incurred as a result of this crime that you have not previously listed.

Expense description: Total Cost to Date:

_____

_____

_____

Please contact the Victim Assistance Program of any additional expenses that incur following the submission of this Financial Loss Form or any long term anticipated personal care needs.

Victim Signature: _____ **Date:** _____