

CRIME VICTIM FINANCIAL STATEMENT

Please complete and return this form with copies of receipts, estimates, invoices, and bills.

If you have questions please contact Carrie Paul our Restitution Advocate at 541-682-7445 or email her at carrie.paul@co.lane.or.us.

Name: _____	
Address: _____	
City/State/Zip: _____	
Hm Phone: _____	Wk Phone: _____
Case# _____	
Defendant : _____	

Please return to:

Lane County District Attorney
 Victim Services Program
 125 E. 8th Avenue, Room 400
 Eugene, Oregon 97401
 Phone: 541-682-4523
 Fax: 541-682-3693

Restitution is the money the court may order the defendant to pay a crime victim for certain losses including stolen or damaged property, medical bills, needed counseling or lost wages. **Restitution is only considered for losses directly related to the charge(s) against the defendant(s).** The judge in a criminal case cannot order a defendant to pay for a victim's pain and suffering.

Property Loss:

Please list only items that have **NOT** been recovered or that were damaged prior to their recovery.

Property Description	Property Value (Wholesale Value for Businesses)
1.	\$
2.	\$
3.	\$
4.	\$

Attach additional sheets if necessary.

TOTAL \$ _____

Please list items that have been returned or recovered.

Property Description		
1.	4.	7.
2.	5.	8.
3.	6.	9.

Attach additional sheets if necessary.

Insurance and Financial Institution Information:

Has a bank or other financial institution covered your loss? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please provide the information on the next page.	Did defendant's insurance cover your loss? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please provide the information on the next page.	Did your insurance cover your loss? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please provide the information on the next page.
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Company: _____ Phone: _____ Contact person: _____

Claim#: _____ Policy#: _____ Deductible: _____

Personal Loss:

(If you suffered injuries that required medical attention or mental health counseling as a result of this crime, please list your expenses.)

Provider	Account #	Has Cost Been Paid?	Total Cost to Date
1.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
2.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
3.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
4.		YES <input type="checkbox"/> NO <input type="checkbox"/>	

TOTAL \$ _____

Did defendant's insurance cover your loss? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please provide the information below:	Did your insurance cover your loss? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please provide the information below:
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Company: _____ Phone: _____ Contact person: _____

Claim#: _____ Policy#: _____ Deductible: _____

Loss of Earnings:

You may be able to recover wages if you had to take time off from work as a result of the crime. **(Please be prepared to provide documentation of earnings or recent pay stub.)**

What were your loss wages related to? Injury Property Repairs Other _____

Employer's Name: _____ Employer's Phone#: _____

Employer's Address: _____

Number of hours/days taken off: _____ Amount of lost wages: \$ _____

Did you use sick leave? YES NO Did you use vacation time? YES NO

Oregon law provides that a person commits the crime of unsworn falsification if the person knowingly makes a 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