CRIME VICTIMS' COMPENSATION PORTAL TUTORIAL – VICTIMS AND APPLICANTS

CRIME VICTIM & SURVIVOR SERVICES DIVISION

Victims and Applicant

If you are a victim of a person to person crime that occurred in Oregon and caused you physical or emotional injury, we encourage you to apply for the Crime Victims' Compensation (CVC) Program. CVC funds may be used to pay for certain crime-related expenses that you have incurred.

The purpose of this document is to provide you guidance on how to use the CVC Portal to apply for compensation and manage your claim.

DM#9594297 | Updated 02/10/2020

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Crime Victims' Compensation Portal Tutorial – Victims and Applicants

PORTAL USE

The portal was designed to give victims, survivors, and applicants access to view their Crime Victims' Compensation (CVC) claim securely. Additional functions of the portal are shown below.

Portal Features

- Apply for CVC- You may apply directly or work with an advocate for assistance. If you do not already have an advocate you are working with, consider contacting your local District Attorney's Office.
- View claim status and payment information
- View insurance information
- Upload bills, Explanation of Benefits (EOB's), and receipts
- Update contact information
- E-mail claim specialist

PORTAL ACCESS

1. Begin by registering for an account at: https://justice.oregon.gov/victims/compensation/Account/Login.
2. Click on "Register".
3. Select "Victim" as your role, or "Applicant" if you are a family member applying on behalf of a victim.
4. Enter your information and create a password.
5. Click "Register"
6. Once CVC has approved your registration, you will receive an email with a link to confirm your email address.

If you have any questions during this process please contact us at (503) 378-5384 or at cvssdportal@doj.state.or.us.

Submitting an Application

The preferred method for applying for CVC is through the Portal. While you are not able to initiate the application using your smartphone, you may use this device to finish an application, check the status of your claim and payments, and upload documents.

Application Options

1. The Crime Victims' Compensation Application should be used when the crime has been reported to law enforcement, the victim is a child, and/or the victim is deceased.
2. The Counseling Only Application should be used by victims and survivors of sexual assault, domestic violence, stalking and/or human trafficking who did not report the incident to law enforcement, obtain a protection order, or have Sexual Assault Forensic Exam . If you've obtained a protective order or had a Sexual Assault Forensic Exam, please use the Crime Victims' Compensation application.

APPLICATION ACCESS

1. Login to the portal - https://justice.oregon.gov/victims/compensation/Account/Login.
2. Select "File an Application"

3. Select the "Crime Victims' Compensation" or "Counseling Only" application.

CRIME VICTIMS' COMPENSATION APPLICATION: REQUIRED INFORMATION

The Crime Victims' Compensation application should be used when the crime has been reported to law enforcement, the victim is a child, and/or the victim is deceased.

All required fields are highlighted in yellow.

Who referred you to our program?

APPLICATION FORM

Please complete the highlighted fields

Who referred you to our program?

- [ ] Police
- [ ] Tribal Advocate
- [x] Victim Assistance Program
- [ ] Child Abuse Assessment Center
- [ ] Medical Provider
- [ ] Other:

You are filing this application because you are (check one):

- [ ] The victim of a crime
- [ ] The parent or guardian of a crime victim under 18 years of age
- [ ] A family member of a victim who died as the result of the crime
- [ ] The parent or guardian of adult victim who can't apply on their own
- [ ] Other (explain):

- If you were referred by an agency, please note which one.

Victim Information

Victim Information

(Person who is injured or deceased)

First Name:		Middle Name:	Last Name:	
Mailing Address:	Apt #:	City:	State: Oregon	Zip:
Phone:	Social Security Number:		Language Spoken: English	
Date of Birth:	If victim is deceased, date of death:			Gender: Please Select
May we contact you by email? No		If yes, please provide your email address:		

- The victims' information is always required.

Victim's Address

If you are homeless: Add "homeless" to the mailing address or list the address of a friend or family members whose address is ok to use.

Social Security Number: You are not required to list your social security number on the application and CVSSD does not look at legal status at any time during the life of a claim.

E-Mail: Provide an e-mail address that CVC can use to contact you if you want to receive information through e-mail.

Applicant Information (Legal Guardian)

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: Oregon	Zip:
Phone:	Social Security Number (see page 8):		Language Spoken: Select a Language	
Date of Birth:	Gender: Select a Gender	Your relationship to the victim		
May we contact you by email? No		If yes, please provide your email address:		

- If the victim is under the age of 14 or if the victim is deceased, an Applicant must be listed.

Crime Information

Crime Information
(Required for all claims)

Type of Crime: Select Type of Crime
Did the crime involve a vehicle?: Please select
Alleged Suspect (if known): First Name / Last Name — Date of Birth:
Additional Suspect (if applicable): First Name / Last Name — Date of Birth:
Date of Crime: — Date Reported: — Report Number:
Name of Police Department reported to: Select Police Department — Name of Officer:
Was the crime reported within 72 hours? No
If No, please explain why (required):
Location of Crime: — City: — State: Oregon — Zip: — County: Select County
Reports to be provided by Child Assessment Center (Please check ALL that apply): Forensic Interview; Medical Assessment

- While it is helpful to have as much information as possible about the crime, only the highlighted fields are required to submit the application.

Crime Information

1. **Type of Crime:** Select the type of crime that describes the incident.
2. **Did the crime involve a vehicle?** Mark "yes" if a vehicle was involved or if you were in a vehicle when the crime occurred.
3. **Alleged Suspect:** If the suspect is unknown, type "unknown" in the first and last name fields.
4. **Crime Date:** While this field is not required, this information is important to include if available.
5. **Name of Police Department:** Please choose the law enforcement agency that received a report about this incident.
   - If you did not report, select "unreported".
   - If reported to the Department of Human Services, select "DHS".
6. **Location of Crime:** Be as specific as possible. This can be an address, intersection, or the name of a business.

How can we help you?

How can we help you?
Check all that apply

Medical; Dental; (For homicide claims only): Counseling; Physical Rehabilitation; Funeral; Survivor Counseling; Loss of Earnings; Transportation; Loss of Support

Was the victim employed at the time of the crime and applying for loss of earnings or loss of support? Please Select
Name of Victim's Employer: — Address: — Phone: — Returned to work? Please select
Did you miss more than two weeks of work? Please Select
Name of Victim's Doctor: — Address: — Phone: — Date returned to work:
Do you have any of the following to help with Loss of Earnings or Support?:
Sick Pay or Disability through employer; Workers' Compensation; Social Security

- Select the crime-related benefits you are requesting.
- Loss of Earnings pertains to victims who were employed at the time of the crime and lost earnings as a result of the incident.
- Loss of Support pertains to only to homicide claims when the victim was employed and was financially supporting dependents at the time of the crime.
- If requesting Loss of Support or Loss of Earnings, be sure to complete the hi-lighted fields.
- If the crime happened at your place of employment, a Workers' Compensation claim also needs to be filed.

Injuries and Expenses

Injuries and Expenses

Please describe your injuries (including mental trauma) resulting from the crime:

Have you had any medical treatment or counseling as a result of the crime? Please list providers seen for crime-related injuries or trauma, paid or unpaid: No

Provider Name:	Address:	City:	State:	Zip:	Phone Number:
			Select a State		
			Select a State		
			Select a State		

- This section is not required. The "describe your injuries" fields provides you with space to share additional information with CVSSD that might not fit elsewhere.
- Add information about providers if you were seen at a hospital or medical facility after the incident.

Insurance Information

Insurance Information

(required for all claims)

Please check ALL that apply to the victim at the time of the crime, or as the result of the crime. List insurance company and other resource information below. (use additional pages if necessary)

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

Insurance Company Name:

Do you have auto insurance? No

If yes, Auto insurance name

Claim #

- Check the boxes for any of the insurance coverage that you have, including the Oregon Health Plan, private health insurance (e.g. Blue Cross, MODA, Cigna, Keizer, etc.), or dental.
  * If you have private health insurance, the name of the insurance company is required.
  *If a vehicle was involved in the incident, the auto insurance section is required.

Optional Contact

Optional Contact Person

(Person we can talk to about your claim)

First Name:	Middle Name:	Last Name:
Contact person's phone:	Contact person's relationship to the victim:	Language Spoken:

- The optional contact person is someone you give CVCP permission to discuss your claim. CVCP will not be able to talk to any person who is not listed in this section. If you prefer, the optional contact person may act as the primary point of contact for CVCP.

Optional Contact

Examples for optional contacts include a family member (e.g. other parent) or close friend.

Additional Counseling

Additional Counseling

Did anyone besides the victim receive or will be requesting counseling because of the crime? (Homicide Survivor Counseling, Child witness to domestic violence, family member of child victim of sex abuse).			No
Name of Family Member:	**Date of Birth:**	**Relationship to Victim:**	**Insurance Carrier:**
First Name Last Name			
First Name Last Name			
First Name Last Name			

- For each family member listed, include their name, date of birth, relationship to the victim, and insurance carrier.

Additional Counseling

This benefit is for immediate family members of:

- Victims of child physical or sexual abuse
- Victims of homicide

Children who have witnessed domestic violence and individuals who were the first to discover the corpse of a friend or acquaintance may also be eligible for this benefit.

For more details on how many counseling sessions are authorized please contact the claim specialist.

Civil Attorney Information

Civil Attorney Information

Have you hired an attorney regarding a civil suit involving this crime?			No
Attorney Name: First Name Last Name			**Telephone:**
Address:	**City:**	**State:** Select a State	**Zip:**

- If you have hired a civil attorney in relation to this incident, add their contact information here. If you're unsure if you will hire a civil attorney to represent, select "undecided" from the menu.
- If you select yes to "have you hired an attorney", the the remainder of the fields become requied.

For Homicide Claims Only

For Homicide Claims Only

Please list all out-of-pocket and unpaid Funeral Expenses:					
Provider of Funeral Services:	**Address:**	**City:**	**State:**	**Zip:**	**Phone:**
			Select a State		
			Select a State		
At the time of death, was the victim financially supporting any dependents?					No
Name of Dependent:		**Date of Birth:**	**Address:**		**Relationship to Victim:**
First Name Last Name					
First Name Last Name					

This section is only to be used if the victim is deceased.

Homicide Claims

- **Provider of Funeral Services:** Add any funeral providers information you may have.
- **Dependents:** If the victim was financially supporting any dependents, enter their information here.

Advocate Contact Information

Advocate Contact Information (Person who is assisting victim with application)			County: Marion
Advocate name: Cecilia	Lucero	Advocate e-mail: cecilia.v.lucero@doj.state.or.us	Advocate phone#: 503-378-6269

- If you have an advocate with the District Attorney's Office or a community-based program, please add their name and contact information here.

Submit

Submit

- Once all the required fields (highlighted in yellow) are complete, click "Submit". If required information was not listed or if the signature does not match the name on the application, you will need to correct these items before submitting the application.

Correcting Errors

- **Missing Information:** If you did not complete a required field, the portal will automatically redirect you to the incomplete section and provide additional instructions in red font.

You must check at least one who referred you checkbox.
Who referred you to our program?
- Police
- DA Office
- Medical Provider
- Other:

You are filing this application because you are (check

- **Signature Error:** If you receive the signature error, check that the name in the Victim Information section (or Applicant Section if used) matches exactly.
  - Check for and remove any extra spaces in the name fields. This is the most common cause of a signature error.
  - If a middle name is entered, make sure to include it in the signature as well.

By checking this box and typing my name below I am electronically signing my application. I understand that my electronic signature has the same legal effect and can be enforced in the same way as my handwritten signature.

Signature of Victim/Applicant	Date
Test Signature The signiture must match either the victim or the applicant.	10/14/2019
Signature of 14-17 year old	Date

Application Submitted

Your Online Web Claim Submission has been submitted. Your Online Submission Id is **52269**.

To check the status of your claim, go to your My Claims section.

If you have any questions email: cvssdportal@doj.state.or.us

Go Back to My Claims

- Immediately after submitting the application you will receive confirmation and the submission ID.

COUNSELING ONLY APPLICATION

The Counseling Only Application should be used if you are a victim of sexual assault, domestic violence, stalking and/or human trafficking and did not report the incident to law enforcement, obtain a protection order, or have Sexual Assault Forensic Exam. If you've obtained a protective order or had a Sexual Assault Forensic Exam, please use the Crime Victims' Compensation application.

Just like the Crime Victims' Compensation application the highlighted fields are required.

Who referred you to our program?

Who referred you to our program?

- Police
- DA Office
- Victim Assistance Program
- Medical Provider
- Other:

➢ If the victim was referred by an agency please check the appropriate box.

Victim Information

Victim Information
(Person who is injured or deceased)

First Name:		Middle Name:	Last Name:	
Mailing Address:	Apt #:	City:	State: Oregon	Zip:
Phone:	Social Security Number:		Language Spoken: English	
Date of Birth:	If victim is deceased, date of death:			Gender: Please Select
May we contact you by email? No		If yes, please provide your email address:		

➢ The victim's information is always required.

Victim Information

- **If the victim is homeless:** Add "homeless" to the mailing address or list the address of a friend or family members that is safe or appropriate to use.
- **E-Mail:** If the victim/applicant prefers to be contacted by e-mail, make sure to provide the e-mail address.

Insurance Information

Insurance Information
(required for all claims)
Please check ALL that apply to the victim at the time of the crime, or as the result of the crime. List insurance company and other resource information below. (use additional pages if necessary)
Private Health Insurance Medicare Oregon Health Plan None

Insurance Company Name:	Insurance Policy Owner Name:

➢ Check the boxes for any of the insurance coverage the victim has including Oregon Health Plan, private health insurance (e.g. Blue Cross, MODA, Cigna, Keizer,etc.), and/or dental insurance. If the victim has private health insurance include the name of the insurance company.

Optional Contact

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

First Name:	Middle Name:	Last Name:
Contact person's phone:	Contact person's relationship to the victim:	Language Spoken:

- The optional contact person is someone the victim or applicant gives CVCP permission to discuss their claim. CVCP is unable to talk to any person who is not listed in this section. If preferred, the optional contact person may act as the primary point of contact for CVCP.

Optional Contact

Examples for optional contacts include a family member (e.g. other parent) or close friend.

Counselor Information

Counselor Information

Counselor Name (First, Last):			Licensure:
Mailing Address:			
City:	State: Select a State	Zip:	Phone:

- If the victim is seeing a counselor for crime-related treatment, provide the counselor's information here.

Crime Information

Crime Information

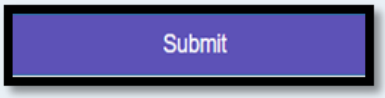
Type of Crime: Select Type of Crime	Date of Crime: 01/01/0001
Offender's Name (if known): First Name	Last Name
Additional Offender's Name (if applicable): First Name	Last Name
Did the crime occur in Oregon? No	What county did the crime occur? Select County
Have you reported this incident?(you are not required to report) No	Name of Police Department reported to: Select Police Department
Did you file a Protective Order or undergo a Sexual Assault Examination?:	No
If yes, in which county did you file the order or undergo the exam?: Select County	
Please describe the incident(s):	

- Most of the crime information fields are required. Please complete the highlighted fields. Depending on the information that is added, other fields might become required.

Crime Information

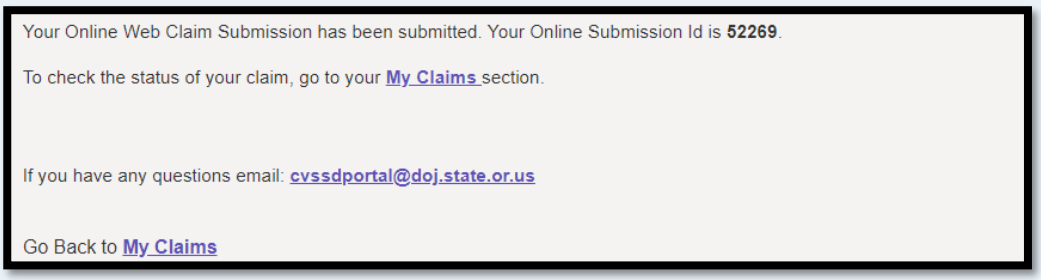
1. **Type of Crime:** Select a type of crime that best fits the incident.
2. **Crime Date:** If you don't know the exact date, please enter your best estimate.
3. **Alleged Suspect:** If the suspect is unknown, type "unknown" for first and last name.
4. **Describe the Incident:** Describe the incident with as much information as possible to help the CVC program make a determination on the claim.

Submit



- Once all the required fields (highlighted in yellow) are complete, click "submit".
- If a required field was missed, the portal will redirect you to the incomplete section.
- **Signature Error:** If you receive the signature error, check that the name shown in the victim section (or applicant section if an applicant is entered) matches the signature exactly.
    - Check for and remove any extra spaces in the name fields. This is the most common cause of a signature error.
    - If a middle name is entered, make sure to include it in the signature as well.

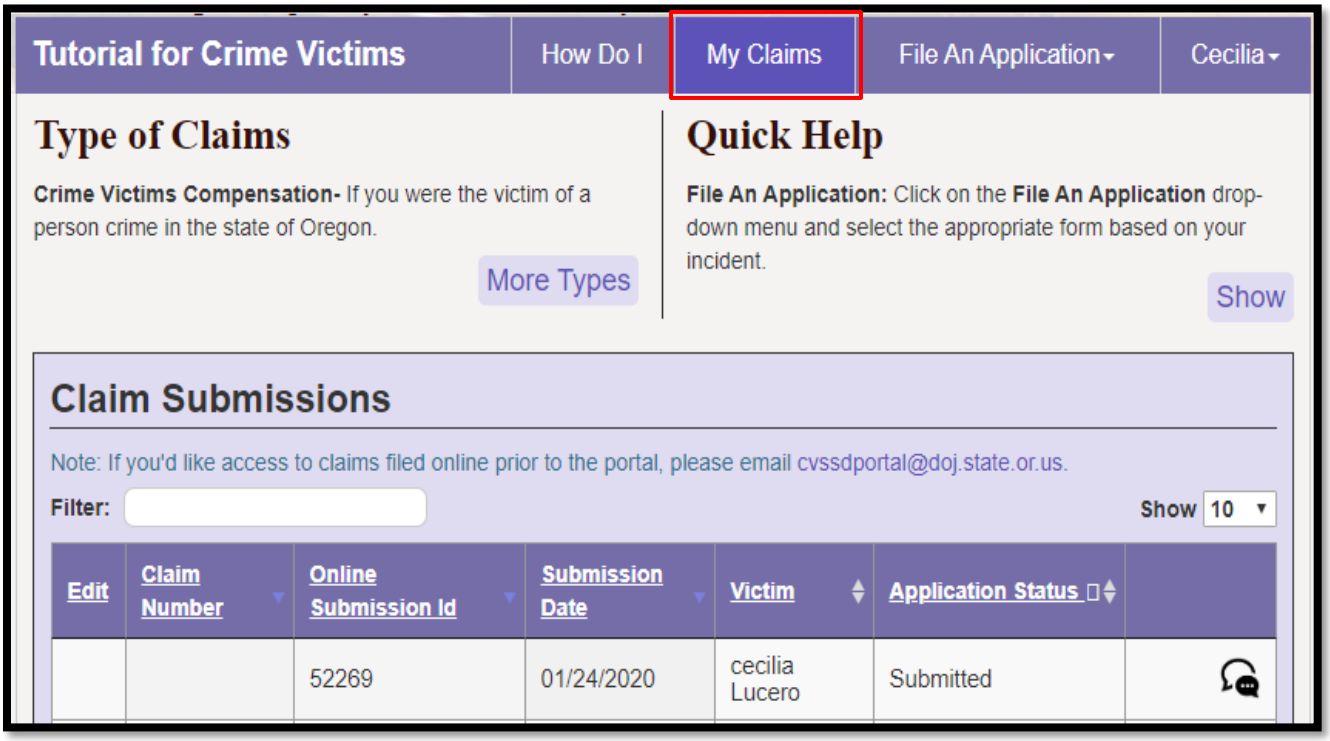
Application Submitted

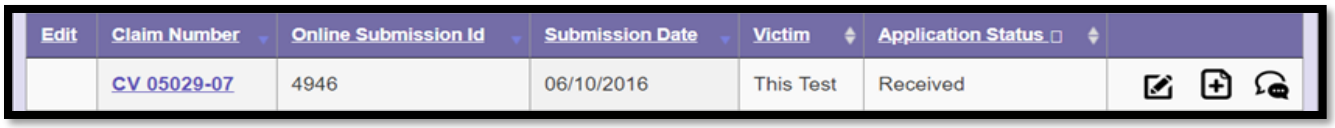


- Immediately after submitting the application you will receive confirmation and the submission ID.
- As the advocate who submitted the application you will have access to it under the Claims Submissions section.

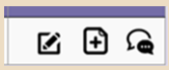
VIEWING YOUR CLAIM

Once you've submitted your application, you can locate it under the "My Claims" tab.





Field Explanation

1. **Online Submission ID:** The number generated by the portal before a claim number is assigned. If you have questions before a claim number is noted please use the online submission ID number.
2. **Claim Number:** The number CVC assigns an application once it is uploaded into our system. Please use this number as a reference when contacting our office.
3. **Submission Date:** The date the application was received.
4. **Victim:** The name of victim.
5. **Application Status:** Status of the application. (received, duplicate, rejected.)
   - **Duplicate:** this means that an application was previously received by CVC for the same victim and incident. Please contact CVC for the claim number.
6.  These icons mean Edit, Upload, and Message the CVC staff, respectively.

Requesting access to your claim:

If an advocate or Children's Assessment Center (CAC) representative applied on your behalf, or if you applied by mail, you may request that your claim to be linked to your portal profile. Please answer the questions shown below when you email your request to cvssdportal@doj.state.or.us.

Questions:

1. What is the name and date of birth of the victim?
2. What insurance provider was noted on the application?
3. What is the city in the mailing address you provided in the application?

If for some reason you are unable to answer one of these questions, please contact our office and speak to a claim's specialist.

CLAIM INFORMATION

Claim Detail

To see claim information, click on the "Claim Number".

This section shows information about the determination status, determination date, and victim's insurance information.

From this page you can click on the "Payments Detail" and "Forms" sections or close the page to return to the home page.

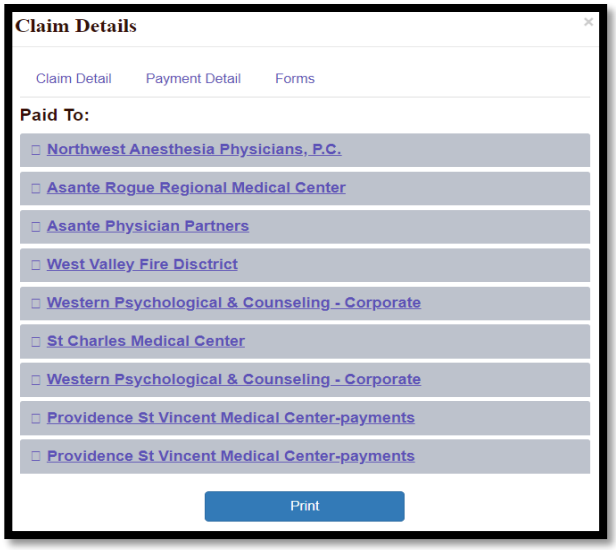
Claim Field Explanation

- If your insurance has changed, please notify our office.
- Determination Status shows the status of your claim.
  - "Pre-determined" means the claim is in the examiners queue to review and determine.
  - "Claim accepted" means the claim was reviewed and accepted.

Payment

By selecting the "Payment" tab, you will see the payments that have been made under the claim.

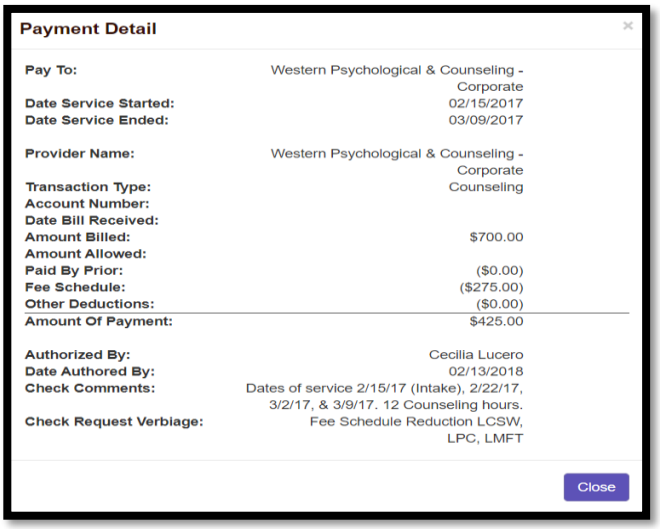
- Click on the name of the provider whose payment you would like more information.



Printing Payment Detail

- Click on "Print" to print the claim details.

Payment Details



Payment Detail

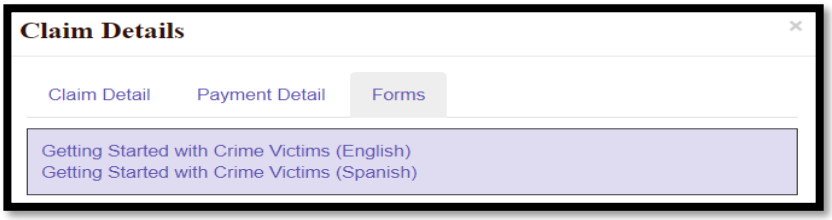
Pay To:	Western Psychological & Counseling - Corporate
Date Service Started:	02/15/2017
Date Service Ended:	03/09/2017
Provider Name:	Western Psychological & Counseling - Corporate
Transaction Type:	Counseling
Account Number:	
Date Bill Received:	
Amount Billed:	$700.00
Amount Allowed:	
Paid By Prior:	($0.00)
Fee Schedule:	($275.00)
Other Deductions:	($0.00)
Amount Of Payment:	$425.00
Authorized By:	Cecilia Lucero
Date Authored By:	02/13/2018
Check Comments:	Dates of service 2/15/17 (Intake), 2/22/17, 3/2/17, & 3/9/17. 12 Counseling hours.
Check Request Verbiage:	Fee Schedule Reduction LCSW, LPC, LMFT

Close

1. **Amount Billed:** May include one or more dates of services.
2. **Paid by Prior:** The amount shows your insurance payment and deductible.
3. **Fee Schedule:** The amount is a provider write-off that must be taken if the provider accepts payment from CVC.
4. **Other Deductions:** If you made any out-of-pocket payments or if restitution was paid to you or to the provider, the amount would be noted here.
5. **Date Authorized:** The date the payment was authorized and sent to fiscal for payment processing.
6. **Check Comments:** May include specific dates of services, counseling hours remaining, etc.
7. **Amount Paid:** This is the amount CVSSD paid.

Forms

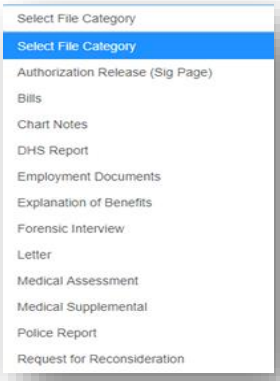
CVC will be adding more forms in the future. The "Getting Started with Crime Victims" is the initial letter we send to you after we import your application into our system.



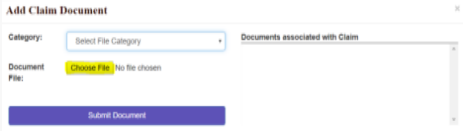
DOCUMENT UPLOAD

You can upload bills, receipts, chart notes, Explanation of Benefits, and any other documentation you would like CVC to review once your application is imported into our system.

You will find the upload icon throughout the portal.



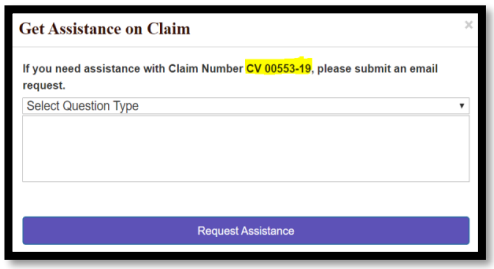
1. Choose the icon pertaining to the claim to which you are uploading a document.
2. Select a Category to identify the type of document you are uploading.
3. Click on "Choose File" to browse your computer for the document to upload.
4. Click on "Submit" once you have chosen the document.



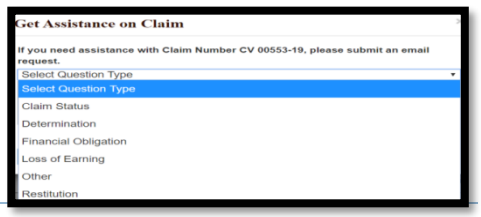
CONTACTING OUR STAFF

If you have questions regarding a specific claim, contact our staff through the portal.

This is the message icon that can be found throughout the portal.



1. Select the message icon for the appropriate claim.
2. Select the type of question from the dropdown menu. This helps our system identify the best way to route your message.
3. Enter your message and then click "Request Assistance".
4. Please allow one to two business days for a staff member to respond.



BILLING CRIME VICTIMS' COMPENSATION

Crime Victims' Compensation (CVC) assists victims with an accepted claim in paying for crime-related medical and counseling treatment. We've included this information to assist with questions you may have. If you and/or the victim/applicant, have questions after reviewing the information below, please feel free to contact us at 503-378-5348 or cvssd@doj.state.or.us .

Insurance

You will need to provide all necessary medical and auto (if appropriate) information to each provider. If you have insurance (including OHP), the insurance must be billed as primary. The provider must submit the explanation of benefits (EOB) to CVC. Insurance must be billed in a timely fashion as CVC can only pay patient responsibility. If the primary insurance denies for untimely billing and there is no patient responsibility, CVC may deny payment as well.

Fee Schedule/Write-off

If you do not have insurance, a Workers' Compensation Fee Schedule will be applied. By law, the provider cannot bill the patient for the fee schedule (write-off).

Sending Victims to Collections

You will need to contact your providers to let them know that you have a CVC claim. If you have been sent to collections for any crime related medical bills, please notify CVC.

Counseling

- Chart notes are not required for counseling sessions unless requested by CVC.
- A treatment plan is required after 15 sessions.
- Therapist must be licensed.
- Therapy is reimbursed using the CVC fee schedule.
- Contact CVC with the name and address of your therapist so that CVC can send the provider a packet authorizing sessions.

Vision

- CVC will reimburse the provider for the exam and office visit using the workers comp fee schedule.
- You will need to pay for glasses and then be reimbursed by CVC for your out of pocket expense. CVC cannot pre-pay for services.

Dental

- Dental work must be pre-authorized. The provider will need to submit a treatment plan and chart notes.
- CVC will reimburse the provider using the dental fee schedule when there is not dental insurance coverage.

Prescription Reimbursement

When submitting receipts for out of pocket expenses for prescriptions, CVC will need the following:

- A receipt from the pharmacy that includes the name of the prescription, doctor who prescribed the medication and date of the prescription.

QUESTIONS

We hope that this portal tutorial provides the information you need to submit your application; however, we encourage you to call or email us if you have questions.

For **Portal Questions:** Contact cvssdportal@doj.state.or.us

For **Claim Questions:** Click the message icon or email cvssd@doj.state.or.us

For all questions, **call**: 503-378-5348