

REQUEST FOR RESTITUTION

VICTIM: _____

DEFENDANT(S): _____ DA#: _____ COURT#: _____

_____ DDA: _____

_____ UNIT: _____

Please Check at least ONE box:

I am not requesting restitution.

My insurance company has covered the entire loss, except that I had to pay my insurance deductible which is \$_____. **Please complete section 1 below**

I have losses that were not or only partially covered by insurance. The total amount of my out of pocket expenses (including any insurance deductible that I've paid) is \$_____ as described below. **Please complete sections 1, 2 and 3 below as appropriate**

Do you expect any future additional costs? NO YES **Please attach explanation / estimate of future costs**

1. INSURANCE

Please list each insurance company that you are aware is involved in this case. Under the "cost to you" please list any insurance related out of pocket expenses that you have actually had to pay (a deductible or co-pay). You will be able to itemize uncovered losses below.

Insurance Company Information

Company Name: _____ Claim #: _____

Adjustor Name: _____ Phone #: _____

This is: My insurance Defendant's insurance

| <i>Amount Paid by Insurance</i> | <i>Cost to You</i> |
|---------------------------------|--------------------|
| | |

2. PROPERTY DAMAGE / LOSS

If you need more space, attach additional pages. Please also attach copies of supporting documentation.

| <i>Item / Brief Description of Damage</i> | <i>Type of Expense</i> | <i>Cost to You</i> |
|---|--|--------------------|
| | <input type="checkbox"/> Estimated cost <input type="checkbox"/> Actual repair cost | |
| | <input type="checkbox"/> Estimated cost <input type="checkbox"/> Actual repair cost | |
| | <input type="checkbox"/> Estimated cost <input type="checkbox"/> Actual repair cost | |

3. MEDICAL BILLS

If you need more space, attach additional pages. Please also attach copies of supporting documentation.

| <i>Treatment Date(s)</i> | <i>Hospital/Provider & Brief Description of Expense</i> | <i>Cost to You</i> |
|--------------------------|---|--------------------|
| | | |
| | | |
| | | |

Due to the injuries I sustained in this incident I could not work and lost wages that were not covered by sick time or workers compensation. *Please enter amount at right and attach documentation.*

To the best of my knowledge, the above facts are true and accurate.

Date Signature Print Name



Rod Underhill, District Attorney

Victim's Assistance Program

1021 SW Fourth Avenue, Room 804

Portland, OR 97204-1193

Phone: 503-988-3222

www.mcda.us

Date: _____

RESTITUTION INFORMATION

State of Oregon v. _____ DA#: _____ C#: _____

Our records indicate that you are a victim on this case. In order to seek restitution (economic damages caused by a crime) on your behalf, **we must have** documentation of your losses. Please fill this form out completely and return it with any bills, receipts or estimates. Remember to keep copies of all documents submitted for your records.

Failing to file a claim for restitution does not impair your right to sue and recover damages from the defendant(s) in a civil action or to apply for Crime Victim's Compensation.

PLEASE RETURN THIS COMPLETED FORM WITHIN 14 DAYS FROM THE DATE PRINTED AT THE TOP SO THAT WE ARE ABLE TO SUBMIT THIS INFORMATION IN A TIMELY MANNER TO ASSIST IN RESOLUTION OF THIS CASE.

****PLEASE SEE OTHER SIDE FOR MORE INFORMATION****

To insure correct contact information, please provide your phone number(s):

Home _____

Work _____

Cell _____

Regards,

ROD UNDERHILL
District Attorney
Multnomah County, Oregon