

**MARION COUNTY DISTRICT ATTORNEY'S OFFICE
VICTIM IMPACT STATEMENT FOR CHILDREN**

DA # _____ STATE VS. _____

VICTIM: _____

PART A: GENERAL INFORMATION

This packet is designed to obtain information about the impact of this crime on your child. Before you begin, we suggest that you read through this packet once to make sure you understand the questions. As the parent or guardian, please complete these questions on behalf of your child with her or his input, if appropriate. Part C is for your child to complete on her or his own or with your help. There are two sheets for you or your child to pick from. Please choose whichever is appropriate for your child. If more room is needed to write the responses, please feel free to attach additional pages.

The defendant's attorney will receive a copy of this form. It is likely that the defendant will see these responses. Should the defendant be convicted, information from this form will also be provided to the judge and the corrections department.

We realize that answering these questions may be difficult or painful. If you need assistance, please contact the Victim Assistance Division at 503-588-5253 or 1-866-780-0960.

Please sign, date and return this form within 10 days. If you need an extension of that time, please notify this the Victim Assistance Office.

1. Please briefly describe the impact that this crime has had on your child:

2. If your child was physically injured as a result of this crime, please describe:

3. If this crime has affected your child emotionally, please describe: _____

INSTRUCTIONS:

- 1) *List only those items that have not been recovered (or were recovered damaged) by you, the police, or an insurance company.*
- 2) *List cost of repair and clean-up to personal property.*
- 3) *Attach proof of loss wherever possible (such as copies of receipts, invoices, estimates, repair bills, or canceled checks. Please do not send originals.)*
- 4) *Provide insurance information if you have filed or intend to file a claim.*

1. LIST OF MEDICAL BILLS FOR INJURIES: (cost of medication, ambulance, hospital, etc.)

| PROVIDER/ADDRESS/PHONE | ACCT. # | AMOUNT |
|------------------------|---------|--------|
| _____ | | |
| _____ | | |
| _____ | | |

2. PROPERTY LOSS/DAMAGE: (cost to replace or repair items that are **NOT** being held as evidence.)

| ITEM | MARKET VALUE | REPLACEMENT COST |
|-------|--------------|------------------|
| _____ | | |
| _____ | | |
| _____ | | |

3. COUNSELING: If your child has received counseling as a result of this crime, please provide the following information:

Therapist: _____ Phone: _____

Address: _____

Your cost per session: \$ _____ Number of sessions to date: _____

Anticipated number of sessions in the future: _____

4. IF YOUR CHILD HAS NOT RECEIVED COUNSELING, is it because of:

- a) inability to pay for the sessions: _____
- b) uncertainty about who to see: _____
- c) other: _____

5. **LOST WAGES FOR YOU OR YOUR CHILD WHO WORKS:**

Parent Occupation: _____ Employed Since: _____

Employer: _____ Phone: _____

Number of work days missed: _____ From _____ To _____

Rate of daily net pay: \$ _____ Total net loss: \$ _____

I was _____ was not _____ covered by sick leave or vacation time during my absence.

Child's Occupation: _____ Amount of Lost Wages: _____

6. **ANTICIPATED FUTURE EXPENSES:** (specify) _____

7. **INSURANCE INFORMATION:**

Have you or will you be filing an insurance claim? Yes _____ No _____

If yes, Please provide the following:

Insurance Company: _____

Address: _____

Adjustor: _____ Phone: _____

Claim Number: _____ Deductible: \$ _____

Has the claim been settled: Yes _____ No _____

Amount insurance has/will pay for your losses: \$ _____

8. **CRIME VICTIMS' COMPENSATION:** Have you filed a claim with the Crime Victims' Compensation Program, State of Oregon? (Does not cover property loss or damage.)

Yes _____ No _____ Status of Claim: _____

If not, have you received an application for Crime Victims' Compensation?

Yes _____ No _____

9. **TOTAL FINANCIAL LOSSES:** \$ _____

Filing a claim for restitution does not guarantee that a restitution order will be sought, or that if sought, it will be ordered in full or in part. It also does not guarantee that, if ordered, it will be paid in full or in part. Filing a claim for restitution does not impair your right to sue and seek damages in a civil action, or to apply for Crime Victims' Compensation through the State of Oregon.

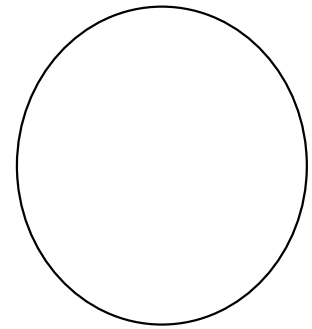
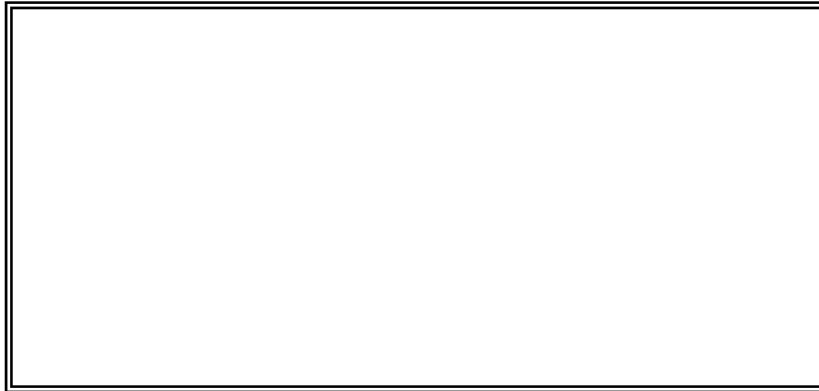
PART C: VICTIM IMPACT STATEMENT FOR CHILDREN

To Parents: Please do not tell your child what to write or draw. This is your child's chance to tell the judge how he or she is feeling about what has happened. If your child becomes uncomfortable in any way while completing her or his victim impact statement, reassure your child that he or she does not have to fill out this form unless he or she wants to.

My name is: _____ . I am _____ years old.

Because of what happened, I have trouble with: _____

This is how I feel about what happened:



DRAW A PICTURE OR WRITE A POEM OR A STORY

DRAW A FACE

I want the judge to know: _____

This is what I want the judge to do: _____

I hope that: _____

To Parents: If your child is too young or is just learning to read, you may want to help your child fill out this Victim Impact Statement. When helping your child, it is okay to talk about what feelings are. For example, those identified here are happy, sad, mad and scared. Please do not tell your child what to write or draw. This is your child's chance to tell the judge how she or he is feeling about what has happened. If at any time your child becomes uncomfortable while completing their Victim Impact Statement, reassure your child that she or he does not have to fill out this form unless he or she wants to.

My name is: _____ . I am _____ years old.

Check one: _____ I go to school and I am in the _____ grade.

_____ I do not go to school yet.

This is how I feel about what happened to me: (Color as many as you like.)



Happy



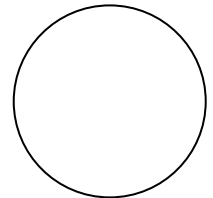
Sad



Mad



Scared



Other

I want the judge to tell _____ to:
(Defendant's Name)

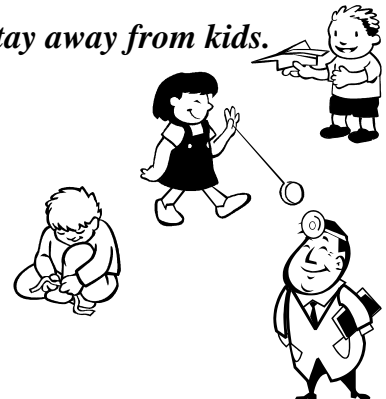
Go to jail.



Pay some money



Stay away from kids.



Do nothing



Go to a doctor to get help.

Anything else? Put your own idea or picture here. If you don't want to write or draw anything here, that's okay, too!

Thank you for listening to me.

PART D: APPEARANCE NOTIFICATION

As victims, your child and you have the right to attend court hearings and, if there is a conviction, the sentencing of the defendant. Your schedules will be considered when scheduling or rescheduling the trial or sentencing. Please indicate what dates within the next several months that you and your child would not be able to attend a hearing. The judge may ask why you are not available.

If you receive a subpoena or notice of sentencing that conflicts with your schedule, immediately advise the deputy district attorney.

My Name: _____

My child's Name: _____

We would like to attend the trial: Yes ____ No ____ Uncertain ____

We would like to attend the sentencing: Yes ____ No ____ Uncertain ____

We would like to make a statement at the sentencing: Yes ____ No ____ Uncertain ____

We are unavailable for court on the following dates:

We are unavailable on those dates for the following reasons:

Signature of Parent/Guardian

Date

PART E: CONFIDENTIAL INFORMATION

This information will not be provided to the defense attorney or the defendant. It is important that you keep our office advised of any change of address. A current address will enable us to keep you informed of case status and, if restitution is ordered and paid, will enable the court clerk to forward any monies to you.

Sometimes hearing dates are changed. Please make sure you confirm dates with the deputy district attorney or advocate before coming to court.

1. PERSONAL INFORMATION:

Parent/Guardian: _____

Mailing Address: _____

Physical Address: _____

Email Address: _____

Home # _____ Cell # _____ Work # _____

Date of Birth: _____ Soc. Sec. # _____

Drivers License # _____ State _____

2. CONTACT PERSON: Closest relative or friend not living with you who will always know how to reach you.

Name: _____ Relationship: _____

Mailing Address: _____

Physical Address: _____

Email Address: _____

Home # _____ Cell # _____ Work # _____

3. EMPLOYER: If you lost wages due to this crime, please provide the following information about the employer for whom you were working at the time.

Business Name: _____ Phone: _____

Mailing Address: _____

PLEASE RETURN THIS FORM WITHIN 10 DAYS. *If you need additional time, please call 503 588-5253 or 866 780-0960. Send to: Victim Assistance Division, Marion County District Attorney's Office, PO Box 14500, Salem, OR 97309*