



Crime Victim Compensation Board
 First Judicial District of Colorado
 500 Jefferson County Parkway
 Golden, CO 80401-6020
 Phone 303-271-6846 Fax 303-271-6785

Office Use Only
Claim No. _____
Date Received _____

VICTIM COMPENSATION FUND APPLICATION

(Please read the enclosed brochure regarding eligibility requirements and compensation information)

General Information:

1. There does not have to be an arrest made for a victim to be eligible for compensation.
2. By law, you must apply for all other available sources of financial assistance or reimbursement, including Medicaid and Medicare. This application will not be processed if you do not indicate whether or not you had insurance at the time of the crime.
3. Please attach all available bills, receipts and/or employment information. You may apply even if you have not received any bills as of this date. You may submit bills to this office as you receive them.
4. Total recovery may not exceed the statutory limit. Compensation for some categories (i.e. chiropractic, eyeglasses, etc.) is limited by Board policy. You will be notified in writing of any such limitations.
5. Normal processing time is 45 – 60 days.

SECTION 1- VICTIM INFORMATION (All applicants must complete this section)

Victim's Name _____	
Street Address _____	City/State/Zip _____
Home Telephone () _____	Work Telephone () _____
Date of Birth _____	Age When Crime Occurred _____
Social Security No. _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

The following information is used for statistical purposes only to comply with federal regulations.

Handicapped: <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic/ Spanish <input type="checkbox"/> Native American <input type="checkbox"/> Asian/ Pacific <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	Who referred you to the compensation program? <input type="checkbox"/> Victim Advocate <input type="checkbox"/> Hospital <input type="checkbox"/> Police Officer <input type="checkbox"/> Therapist <input type="checkbox"/> District Attorney's Office <input type="checkbox"/> Social Services <input type="checkbox"/> Child Advocacy Center <input type="checkbox"/> Other: _____
If yes, circle one: Mental or Physical		

SECTION 2- CLAIMANT INFORMATION (Complete only if person submitting application is not the victim, i.e. victim's parent or guardian)

Claimant's Name _____	
Street Address _____	City/State/Zip _____
Home Telephone () _____	Work Telephone () _____
Relationship to victim _____	Social Security No. _____

SECTION 3- CRIME INFORMATION (All applicants must complete this section)

Type of Crime:

- | | |
|--|--|
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Drunk Driver/ Vehicular Assault/ Homicide |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Child Physical Abuse |
| <input type="checkbox"/> Burglary/ Criminal Mischief | <input type="checkbox"/> Child Sexual Assault by Family Member |
| <input type="checkbox"/> Sexual Assault- Adult | <input type="checkbox"/> Child Sexual Assault – Non Family Member |
| <input type="checkbox"/> Murder/ Homicide | <input type="checkbox"/> Other _____ |

Date of Crime	Police Dept./ Agency Crime Was Reported To
Crime Report Number	Law Enforcement Officer Handling Case
Who Committed the Crime?	Suspect's Relationship to Victim
Did the Crime Occur at Work?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 4- REQUEST FOR SERVICES (Please check either "Yes" or "No" to request compensation for the following services. If any are left blank, it will be assumed that payment for that service is not needed.)

Yes No **MEDICAL** (Including dental services and medically necessary devices, i.e. eyeglasses, which are damaged or destroyed during the crime.)

Yes No **MENTAL HEALTH** (Including grief therapy for family members of deceased victims.)

If you are already in therapy, please give the therapist's name _____ and phone number _____

Yes No **LOST WAGES** (Lost wages compensation is available only to actual victims whose physical or mental state prevents them from working as a result of the crime. Compensation is not applicable for lost wages due to reporting the crime, testifying in court, interviews with police and/or D.A., or any other time for court/ interview sessions. If you were paid for your time away from work through your employer's sick or vacation benefits, you cannot apply to this program for additional pay. You can only apply to this program for unpaid time from your job.)

Yes No **LOST SUPPORT** (May be requested for dependents of deceased victims; by minimally employed or unemployed victim's of domestic violence being supported by the suspect at the time the crime occurred; or for a child incest victim whose guardian is unemployed.)

Please list the victim's dependents below if you are requesting lost support compensation (add a page if necessary):

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Yes No **FUNERAL EXPENSES**

Yes No **REKEYING OF EXTERIOR RESIDENTIAL LOCKS** (Applicable in domestic violence situations only.)

Yes No **RESIDENTIAL PROPERTY** (Only damaged exterior doors, locks and windows are applicable.)
 Exterior Door(s) Exterior Lock(s) Exterior Window(s)

Please note that compensation for personal property i.e., automobiles, money, clothing, etc. cannot be awarded per statute.

SECTION 5- INSURANCE INFORMATION (This section must be completed before this claim may be processed.)

Please indicate if the following applies to you:

- Yes No Medical Insurance
 Yes No Medicaid
 Yes No Auto Insurance
 Yes No Disability

- Yes No Medicare
 Yes No Worker's Compensation
 Yes No Homeowner's/ Renter's Insurance
Deductible for Homeowner's/Renter's Insurance \$ _____

SECTION 6- RELEASE OF INFORMATION AND VICTIM'S RIGHTS AND RESPONSIBILITIES

I, the applicant of the Crime Victim Compensation Program of the First Judicial District of Colorado, do hereby attest that all information given on this application is truthful and accurate to the best of my knowledge.

I hereby authorize the release of all information from my employer, physician, hospital, medical and/or mental health service provider(s) and/or creditor(s) for the purposes of verifying the claims I have submitted, or to establish the validity of a restitution claim. I understand that untruthful statements will disallow payment of my claims. I further understand that any award is subject to the availability of funds and the discretion of the Board.

I hereby authorize release of funds awarded to me under the Colorado Crime Victim Compensation Act to be paid directly to the service provider(s) applicable to my claim.

I further agree that if, at a future date, I receive monies relative to this same matter from any collateral source such as the offender, anyone on behalf of the offender or a government program, I will immediately notify the Crime Victim Compensation office and provide documentation to the office of such receipt. A determination will then be made as to whether reimbursement to the Crime Victim Compensation Fund is required by Section 24-4.1-110, C.R.S. I agree to promptly make any reimbursement required by said section.

I am further aware that if I fail to cooperate in the investigation and prosecution of the criminal case from which my losses were sustained, I will be ineligible for any further compensation monies and will be fully liable to reimburse the Crime Victim Compensation Fund for any and all compensation awards received.

As an applicant, you are advised that if your Crime Victim Compensation claim is denied you have the right to request a hearing before the Crime Victim Compensation Board. You will be entitled to present evidence and witnesses. At said hearing, the burden of proof is upon you as the applicant to show that the claim is reasonable and compensable under the terms of the Colorado Crime Victim Compensation Act. In the event the denial is upheld by the Board at the appeal hearing, the applicant has the ability to have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure within 30 days.

Signature of Victim, Parent/Guardian or Estate Executor

Date

RETURN APPLICATION AND ALL INFORMATION TO:

Crime Victim Compensation Board
500 Jefferson County Parkway
Golden, CO 80401-6020