Crime Victim Compensation Application

Crime Victim Compensation Board
Seventeenth Judicial District
Adams and Broomfield Counties
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Brighton, CO 80601
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Phone (303)835-5615 Fax (303)835-5575

The Crime Victim Compensation (CVC) Program operates pursuant to C.R.S §24-4.1-101 et seq.

ELIGIBILITY REQUIREMENTS:

The Crime Victim Compensation Board may waive some of the requirements for good cause or in the interest of justice.

1. The victim sustained mental injury, physical injury, death or damage to *exterior residential* doors, locks or windows as the result of a compensable crime.
2. The victim fully cooperated with law enforcement officials (law enforcement, district attorney, etc.).
3. The crime was reported to a law enforcement agency within 72 hours.
4. The injury or death of the victim was not the result of the victim's own wrongdoing or substantial provocation.
5. The victimization occurred on, or after July 1, 1982.
6. The application was submitted within one year from the date of the crime, or, six months for residential property damage to exterior doors, locks, or windows.
7. The crime occurred in Adams or Broomfield County, or, the victim is a resident of Adams or Broomfield County but the crime occurred in a state or country that does not have a CVC program.

GENERAL INFORMATION:

1. There does not need to be an arrest or charges filed for a victim to be eligible for compensation.
2. Compensation may be requested for medical expenses, mental health therapy, medically necessary devices (dentures, eyeglasses, hearing aids, prostheses), loss of income due to injury, home health services, funeral expenses, exterior residential doors/locks/windows, and loss of support to dependants in the event of death. Requests must be directly related to the crime reported to law enforcement.
3. Compensation for property damage may be awarded for the cost of replacement or repair to *exterior residential* doors, locks, and windows that are damaged during the commission of a crime.
4. By law, you must apply for all other sources of financial assistance or reimbursement, including private insurance, Medicaid and Medicare.
5. Please attach all bills, receipts and estimates directly related to the crime. You may apply if you have not received an invoice or bill, but please forward bills as you receive them.
6. Your claim will be verified and presented to the CVC Board. This process can take 30-60 days after we have received and verified your losses.
7. Compensation may not exceed the statutory limit of $20,000. Compensation for individual categories is limited by Board policy; please call 303-835-5615 for specific category limits.
8. Should your request be denied, you have the right to request reconsideration of the Board's decision. You will be notified by mail of the reason for the denial and we will inform you of your right to submit new and/or additional information. This information must address the reason(s) for the Board's denial. You may request reconsideration by contacting the CVC program within 90 days from the date that you received the denial letter. If the Board denies the reconsideration, you may have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure.

FOR OFFICE USE ONLY

Primary Claim #: _____ Secondary Claim # 1: _____ Secondary Claim # 2: _____

Secondary Claim #3: _____ Secondary Claim #4: _____ Secondary Claim #5:_____

SECTION 1- VICTIM INFORMATION Please complete every question. Write N/A when a question is not applicable.

Victim Name (First, Middle, Last) | Birth Date | Age at time of crime

Gender: ☐ Male ☐ Female

Mailing Address

City, State & Zip Code | Social Security Number

Work Phone | Home Phone | Other Phone/E-mail

The following information is used for statistical purposes only. This information is needed to comply with Federal regulations.

Race:
- ☐ Caucasian
- ☐ African American
- ☐ Hispanic/Latin American
- ☐ Native American
- ☐ Asian/Pacific
- ☐ Unknown
- ☐ Other _____

Referral Source:
- ☐ Police Agency Victim Advocate
- ☐ District Attorney Victim Advocate
- ☐ District Attorney's Office
- ☐ Social Services
- ☐ Hospital
- ☐ Therapist
- ☐ Other _____

Marital Status:
- ☐ Married
- ☐ Single
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Disabled:
- ☐ No
- ☐ Mentally
- ☐ Physically

Disabled prior to crime?
- ☐ No
- ☐ Yes

SECTION 2- CLAIMANT INFORMATION Please complete if the victim is a minor, deceased or incapacitated.

Claimant's Name (Parent/Guardian/Relative) | Date of Birth | Social Security Number

Mailing Address | City/State/Zip

Relationship to Victim | Home Telephone | Other Phone/E-mail

SECTION 3- INSURANCE/COLLATERAL SOURCE INFORMATION Crime expenses must be submitted to all available financial assistance programs prior to CVC review. Please indicate if the victim is insured.

Medical Insurance:	☐ Yes ☐ No	Disability:	☐ Yes ☐ No	
Auto Insurance:	☐ Yes ☐ No	Worker's Compensation:	☐ Yes ☐ No	
Life Insurance:	☐ Yes ☐ No	Homeowner's/Renters:	☐ Yes ☐ No	Deductible: $_____
Medicare/Medicaid:	☐ Yes ☐ No	Other: _____		

Please list the company name, telephone and policy number of any insurance listed above (add additional sheets as needed):

SECTION 4-CIVIL LAWSUIT:

Are you planning to sue the person(s) or business responsible for this injury? ☐ Yes ☐ No

If yes, please note that you must notify the CVC Board with written evidence of the amount and terms of settlement.

SECTION 5-EMERGENCY REQUEST: In accordance with CVC statute and Board policies, CVC may be able to assist with some emergency requests. Please do not contact the CVC Program directly. You must contact the police/law enforcement agency where the crime was reported and inquire about emergency CVC assistance.

SECTION 6- CRIME INFORMATION Please complete this section as completely as possible.

Type of Crime: (check all that apply)

- ☐ Assault/ Kidnapping
- ☐ Burglary/Criminal Mischief
- ☐ Careless Driving Resulting in Death
- ☐ Child Physical Abuse
- ☐ Child Sexual Assault
- ☐ Domestic Violence
- ☐ Drunk Driver/Vehicular Assault/Vehicular Homicide
- ☐ Hit and Run Resulting in Death
- ☐ Murder/Homicide
- ☐ Sexual Assault-Adult

1. Date of Crime: _____ 2. Reported Date: _____

3. Who committed the crime? _____ 4. Relationship to victim: _____

5. Police department/agency crime reported to: _____ 6. Police report number: _____

7. Police officer assigned: _____ 8. Has the offender been charged in court? _____

9. District Attorney's case number: _____ 10. County where crime occurred: _____

11. Did the crime occur at work? _____

SECTION 7- REQUEST FOR SERVICES Please check the boxes for the service(s) you would like to request.

☐ **MENTAL HEALTH COUNSELING – PRIMARY VICTIM:**
Are you (victim) currently seeing a therapist related to this crime? ☐ Yes ☐ No
If yes, please have your counselor call. Or, if you would like help locating a counselor please call. 303-835-5615

☐ **MENTAL HEALTH COUNSELING – SECONDARY VICTIM(S) (family members):** add additional paper if necessary.

Name of Family Member(s)	Relationship to Victim	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ **MEDICAL:** You **must** submit copies of *crime related* itemized bills as you receive them. Please select the services that you have received and/or will need due to the crime.

☐ Hospital ☐ Physician ☐ Chiropractic/Physical Therapy ☐ Dental ☐ Home Nursing Care
☐ Other_____

☐ **PERSONAL MEDICAL ITEMS** Submit copies of *crime related* itemized bills or estimates. Please select the stolen or damaged item.

☐ Eyeglasses/Contact Lenses ☐ Dentures ☐ Hearing Aid ☐ Prosthetic Device ☐ Medication

☐ **LOSS OF INCOME**
You may request loss of income only if you missed work due to crime related injuries or bereavement, and you did not have paid vacation or sick time. A "Lost Wages" form will be mailed to you. Employment, rate of pay, unpaid time off of work and ability to work will be verified. Loss of income due to the law enforcement investigation, medical/ counseling appointments and court hearings is not eligible.

☐ **LOSS OF SUPPORT TO DEPENDANTS**
Persons who were wholly or partially dependant upon the victim's income at the time of death may be eligible for compensation. A "Loss of Support to Dependants" form will be mailed to you if this box is checked.

☐ **RESIDENTIAL PROPERTY**
Please submit an estimate/receipt for repair/replacement of exterior residential doors, locks or windows based on criminal damages.

☐ **FUNERAL EXPENSES:** Please submit copies of itemized bills, if available.
Name of Funeral Home: _____ Telephone Number: _____
Have services been paid? ☐ Yes ☐ No Who paid for the funeral services? _____

PLEASE READ CAREFULLY, INITIAL EACH SECTION, SIGN AND DATE

Any victim or secondary victim 18 years of age or older must sign and initial this page.

Initial Each Line Below

_____ **CERTIFICATE OF APPLICATION:** The information contained in this application for Crime Victim Compensation is true and correct to the best of my knowledge. I understand that untruthful statements provided or falsified documentation submitted may result in a denial of my claim and is punishable by law.

_____ **CLAIMANT RESPONSIBILITY:** I understand that I am responsible for my bills relating to this crime and have the burden of providing any documentation to the Crime Victim Compensation Board to assist with verification of my claim. I must also notify service providers of my application to the Crime Victim Compensation Program.

_____ **COOPERATION:** I understand that my failure to cooperate with law enforcement (police, sheriff, prosecutor, etc) may result in the denial of my claim.

_____ **SUBROGATION AGREEMENT:** I hereby agree to notify the CVC Program in the event that benefits become available to me, including but not limited to a civil lawsuit action, in payment of the same expenses for which I receive from the CVC Program. I further agree to retain so much of the recovered funds as necessary to reimburse the CVC Program to the extent of the compensation I received from the Program.

_____ **ALTERNATIVE APPLICATION PROCESS:** If you feel the CVC Board in the Seventeenth Judicial District is unable to impartially review your claim due to personal or professional relationship(s) with two or more Board members, it will be sent to another district for review. The Seventeenth Judicial District must receive a request for alternative review in writing. If your claim is approved, bills will be paid from the Seventeenth Judicial District. I understand this may delay the processing of my claim.

_____ **REPAYMENT OF CRIME VICTIM COMPENSATION:** I hereby agree to repay the Crime Victim Compensation Fund if payments are received from the offender (restitution or civil action), insurance, or any other government or private agency as compensation for this injury or death after receipt of payment from the Crime Victim Compensation fund.

_____ **RIGHT TO RECONSIDERATION:** Should my claim for compensation be denied, I would be notified of the reason in writing. I understand that I have the right to request reconsideration by the Crime Victim Compensation Board and may do this by submitting a letter which addresses the reason(s) for the denial as stated in the letter. The Crime Victim Compensation Board, in its discretion, may conduct a hearing to reconsider the denied claim. I understand that the burden of proof is upon me as the applicant to show the claim is reasonable and compensable under the Colorado Crime Victim Compensation Act. In the event the denial is upheld by the Board following the reconsideration, I understand that I may have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedures by a district court within 30 days.

_____ **RELEASE OF FUNDS:** 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)/out of pocket claimant as applicable to my claim. I understand that any claim request approval is subject to the availability of funds and the discretion of the Board.

_____ **RELEASE OF INFORMATION AUTHORIZATION:** I hereby authorize the release of all information from any employer, physician, hospital, Department of Social Services, civil attorney, medical and/or mental health service providers and/or any other creditor or agency for the purpose of verifying the claims that I have submitted to establish validity of a claim. I further understand that any information provided may be subject to disclosure under the law. This authorization may be revoked at any time in writing, except to the extent that action has already been taken in reliance upon it. My signature authorizes release of all such information as specified above. A photocopy or exact reproduction of this signed release shall have the same for and effect as the original.

_____ _____

Signature of Victim/Claimant Date

_____

Printed Name of Victim/Claimant

Applications submitted without signatures will be returned.

All persons, 18 years of age or older, requesting services must initial and sign this page.