CRIME VICTIM COMPENSATION PROGRAM
1000 JUDICIAL CENTER DRIVE, SUITE 100
BRIGHTON, CO 80601
Phone: 303-835-5690
Email: vcomp@da17.state.co.us

Claim Number_____

For Office Use Only

LOST WAGES FORM

THE CRIME VICTIM COMPENSATION PROGRAM MAY COMPENSATE CRIME VICTIMS FOR WAGES LOST DUE TO PHYSICAL OR EMOTIONAL INJURIES DIRECTLY CAUSED BY THE CRIME. LOST WAGES WILL NOT BE PAID FOR TIME LOST DUE TO COURT APPEARANCES, APPOINTMENTS WITH CRIMINAL JUSTICE PERSONNEL OR APPOINTMENTS WITH SERVICE PROVIDERS. IF YOU WERE NOT WORKING, YOU ARE NOT ELIGIBLE.

TAKE THIS FORM TO YOUR EMPLOYER AND HAVE IT COMPLETED, NOTING THAT THE MAXIMUM AMOUNT OF TIME THE BOARD CAN CONSIDER IS 2 WEEKS OF TIME FROM WORK DUE TO INJURY. IF YOU ARE SELF-EMPLOYED YOU MUST SUBMIT COPIES OF YOUR TAX RETURNS.

TO QUALIFY, YOU MUST SUPPLY ALL OF THE FOLLOWING DOCUMENTATION (Please X each box):

☐ **EMPLOYER COMPLETED LOST WAGES FORM (OR TAX RETURN IF SELF EMPLOYED)**

☐ **A LETTER FROM YOUR TREATING PHYSICIAN OR THERAPIST INDICATING YOUR INABILITY TO WORK DUE TO INJURIES SUSTAINED AS A RESULT OF THE CRIME AND INDICATING LENGTH OF TIME OF INABILITY TO WORK**

☐ **A COPY OF A RECENT PAY STUB INDICATING YOUR NORMAL HOURS AND RATE OF PAY**

EMPLOYEE'S NAME:	**JOB TITLE:**	**SOCIAL SECURITY NUMBER:**
WAS THIS PERSON EMPLOYED ON THE DATE OF INJURY? ☐ YES ☐ NO	**HAS THIS PERSON RETURNED TO WORK?** ☐ YES ☐ NO	**IF YES, DATE RETURNED?** / /
WAS THIS PERSON INJURED WHILE AT WORK? ☐ YES ☐ NO	**IF YES, WAS WORKERS COMP PAID?** ☐ YES ☐ NO	**IF YES, THROUGH WHAT PERIOD** FROM: TO:
WAS SICK LEAVE/ANNUAL LEAVE/ FUNERAL LEAVE OR DISABILITY PAID? ☐ YES ☐ NO	**IF YES, THROUGH WHAT PERIOD?** FROM: TO:	**HOURS WORKED PER DAY:**
REGUALR HOURS WORKED PER WEEK:	**REGULAR HOURS WORKED PER MONTH:**	**NUMBER OF DAYS MISSED:**
AVG OVER TIME HOURS WORKED PER DAY:	**OVER TIME HOURS WORKED PER WEEK:**	**OVERTIME HOURS WORKED PER MONTH:**
DID EMPLOYEE RECEIVE BONUS?(Circle One) WEEKLY MONTHLY QUARTERLY ANNUALLY	**ON AVERAGE WHAT WAS THE BONUS?**	**OTHER COMMENTS:**
RATE OF PAY: $ _____ PER ☐ HOUR ☐ DAY ☐ WEEK ☐ MONTH ☐ COMMISSION ☐ OTHER_____		

ESTIMATED TOTAL AMOUNT OF LOSS OF WAGES: $ _____

EMPLOYER'S NAME: _____

ADDRESS/CITY/STATE/ZIP: _____

EMPLOYER (SUPERVISOR/REPRESENTATIVE) NAME: _____ TITLE _____

ADDRESS/CITY/STATE/ZIP: _____

PHONE NUMBER(S): _____

EMPLOYER (SUPERVISOR/REPRESENTATIVE) SIGNATURE: _____

EMPLOYEE (VICTIM/CLAIMANT) SIGNATURE: _____

LOST WAGES WILL NOT BE PROCESSED UNTIL ALL REQUESTED DOCUMENATION IS RECEIVED AND VERIFIED