Claim Number:

For Office Use

CRIME VICTIM COMPENSATION PROGRAM

1000 Judicial Center Drive Ste 100
Brighton, CO 80601
Tel: 303-835-5615 Fax: 303-835-5575

LOST WAGES FORM

If you have been unable to work due to crime related physical or mental injuries, the Crime Victim Compensation (CVC) Board could reimburse your lost wages. Due to fiscal limitations, victims could be reimbursed one month salary. Family members of deceased victims could receive 5 days of bereavement leave.

All previously earned sick, vacation or bereavement time must be used before CVC can compensate your loss. CVC will not approve lost wages for court appearances, appointments with criminal justice personnel or medical service providers.

To qualify you must supply all of the following documentation (Please X each box):

- ☐ Employer completed lost wage form (or submitted tax return if self-employed)
- ☐ A letter from your treating physician or therapist indicating your inability to work due to crime related injuries and the amount of time you are unable to work.
- ☐ A copy of a recent pay stub indicating your salary or hourly rate and the number of hours worked.

Please take this form to your employer and have it completed.

Name and Title of Employee: _____ Job/Title: _____

Was this person employed at time of crime/injury? _____ Was this person injured at work? _____

Number of *hours and days* missed due to crime/injury? _____

Has this person returned to work? _____ If yes, date of return? _____

Was paid sick/ vacation or funeral time available for this person? _____

How many hours of paid sick/vacation or funeral hours has this person used due to crime/injury? _____

How many hours of paid sick/vacation or funeral hour does this person still have available? _____

Prior to crime/injury:

Average number of regular hours worked per day/week/month? _____

Average number of overtime hours worked per day/week/month? _____

Rate of Pay: *$* _____ *per* _____ *Hour* _____ *Day* _____ *Week* _____ *Month* _____ *Commission* _____ *Other* _____

Estimated total loss of wages (up to one month) $ _____

Employer's Name: _____ Phone Number: _____

Address/City/State/Zip: _____

Supervisor/Representative Name: _____ Title: _____

EMPLOYER (SUPERVISOR/REPRESENTATIVE) SIGNATURE: _____

EMPLOYEE (VICTIM/CLAIMANT) SIGNATURE: _____

Lost Wages will not be processed until all requested documentation is received and verified.