Crime Victim Compensation

Crime Victim Compensation Board
Seventeenth Judicial District
Adams and Broomfield Counties
1000 Judicial Center Drive Suite 100
Brighton, CO 80601
Email: vcomp@da17.state.co.us
Phone (303)835-5690 Fax (303)835-4165
www.crimevictimcompensation.org

The Crime Victim Compensation (CVC) Program operates pursuant to C.R.S §24-4.1-101, Part 1.

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 per *§24-4.1-101*.
2. The victim reasonably cooperated with law enforcement officials (law enforcement, district attorney, etc.).
3. The injury or death of the victim was not the result of the victim's own wrongdoing or substantial provocation.
4. The victimization occurred on, or after July 1, 1982.
5. Crimes causing property damage must have been reported within 72 hours after the crime occurred and the CVC application must be submitted within 6 months from the date of the crime.
6. The crime occurred in Adams or Broomfield County, or the victim is a resident of either county, but the crime occurred in a state or country without a reasonably accessible CVC program for which the victim would be eligible.
7. The crime must be reported to law enforcement, or in sexual assault cases, the victim must undergo a forensic examination by a licensed or registered nurse or medical provider.

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 any service in Section 7 of this application. Requests must be directly related to the crime reported to law enforcement.
3. Hearing or visually impaired persons may contact the CVC program by phone, mail, email, in person or through delegate to request assistance in submitting a CVC application.
4. To request an application in a language other than English or Spanish, please contact the CVC program by phone, mail, email, in person or through delegate.
5. All materials received, made or kept by the CVC program concerning a CVC application made under C.R.S. 24-4.1-100.1 are confidential. CVC documents are only releasable pursuant to C.R.S. 24-4.1-107.5. For crimes that fall under the Victims Right Amendment, victims will be notified by the District Attorney should a subpoena be issued for their CVC documents in the CVC claim file.
6. If your crime related bills have been turned over to collections, or for further information regarding CVC please call 303.835.5690.
7. By law, you must apply for all other sources of financial assistance or reimbursement, including private insurance, Medicaid and Medicare.
8. 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.
9. 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.
10. Compensation may not exceed the statutory limit of $30,000. Compensation for individual categories and total allowable compensation amount is limited by Board policy; please call 303-835-5690 for specific category limits.
11. Should your claim 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 of the denial. If the Board denies your reconsideration, you may have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure.

SECTION 1: APPLICANT INFORMATION

Enter information about the person applying for assistance. A separate application is required for each person requesting services. If you are filling out this application for someone under 18, incapacitated or deceased put their information in this section. For assistance with this application, contact 17th JD Victim Compensation at (303) 835-5690 or vcomp@da17.state.co.us

Full Legal Name: _____
First Middle Last

Date of Birth: ___/___/___ Social Security Number (Last 4 Digits): XXX – XX - _____

Gender Identity: ☐ Male ☐ Female ☐ Other not listed / prefer to not answer

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic or Latino ☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian
☐ Other race ☐ Multiple races ☐ Prefer to not answer

Mailing Address: _____
Street Address/PO Box

_____
City State Zip Code

Email Address: _____

Preferred Method of Contact: ☐ Mail ☐ Email

Primary Phone: _____ Secondary Phone: _____

Contact Instructions: _____

Are you disabled? ☐ Yes ☐ No Type of Disability: ☐ Mental ☐ Visually Impaired ☐ Hearing Impaired ☐ Other_____

Who referred you to the victim compensation program?
☐ Dept. of Human Services ☐ District Attorney's Office ☐ Hospital/Doctor ☐ Law Enforcement
☐ Victim Advocate ☐ Therapist ☐ Other: _____

SECTION 2: CLAIMANT INFORMATION (PARENT/GUARDIAN/LEGAL REPRESENTATIVE)

Leave this section blank if you are over 18 and are requesting services for yourself.
Enter information about the person who will be contacted regarding this claim. The person listed below should be the parent, guardian, conservator, or other individual authorized to apply on behalf of the person listed in Section 1.

Full Legal Name: _____
First Middle Last

Date of Birth: ___/___/___ Relationship to Applicant: _____

Mailing Address: _____
Street Address/PO Box

_____
City State Zip Code

Email Address: _____

Primary Phone: _____ Secondary Phone: _____

Contact Instructions: _____

SECTION 3: ADDITIONAL PARENT/GUARDIAN INFORMATION (OPTIONAL)

Leave this section blank if you are over 18 and are requesting services for yourself.
The person listed below should be a second parent, guardian, conservator, or other individual authorized to make decisions on behalf of the person listed in Section 1.

Full Legal Name: _____
First Middle Last

Mailing Address: _____
Street Address/PO Box

_____
City State Zip Code

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Relationship to victim: _____

SECTION 4: CRIME INFORMATION

Provide as much information as you are able about the criminal incident.

Type(s) of Crime:

- ☐ Arson
- ☐ Assault
- ☐ Child Abuse/Neglect
- ☐ Child Pornography
- ☐ Child Sexual Abuse
- ☐ DUI/DWI
- ☐ Homicide
- ☐ Human Trafficking
- ☐ Kidnapping
- ☐ Robbery
- ☐ Sexual Assault
- ☐ Stalking
- ☐ Terrorism
- ☐ Unknown
- ☐ Other - Vehicular Crime: _____
- ☐ Other – Domestic Violence: _____
- ☐ Other – Non-Domestic Violence: _____

Was the crime committed in the United States? ☐ Yes ☐ No

If 'No', in what country was the crime committed? _____

Did the crime occur in Colorado? ☐ Yes ☐ No

In what county did the crime occur? _____

Date of Crime: ____/____/____ **Date Reported:** ____/____/____

Agency Crime Reported To: _____ **Incident/Case Number:**

Law Enforcement Officer Handling Case: _____

Who committed the crime? _____

Applicants' relationship to offender, if any: _____

Court Case Number: _____

Did the crime occur at work? ☐ Yes ☐ No

Did the crime involve a motor vehicle? ☐ Yes ☐ No

Were there any active insurance policies on the vehicles? ☐ Yes ☐ No

** If "Yes", provide auto insurance information below in section 5. If there are multiple insurance polices and/or claims involved, submit the information on an additional piece of paper.*

SECTION 5: INSURANCE INFORMATION

Provide information on the applicant's health, dental, homeowner's/renter's, automobile, worker compensation, disability, or other insurance coverage. Crime Victim Compensation is the payor of last resort and information provided may be used to notify a provider of services that there is another source of payment before the Crime Victim Compensation program.

Health Insurance ☐ Yes ☐ No ☐ Medicaid ☐ Medicare ☐ Private

Carrier: _____ *Policy No.:* _____

Homeowner's/Renter's Insurance ☐ Yes ☐ No *Carrier:* _____

Deductible amount: _____ *Policy No.:* _____

Automobile Insurance ☐ Yes ☐ No *Carrier:* _____

Deductible amount: _____ *Policy No.:* _____

Disability Insurance ☐ Yes ☐ No *Carrier:* _____

Policy No.: _____

Worker Compensation Insurance ☐ Yes ☐ No *Carrier:* _____

Policy No.: _____

Other Insurance: ☐ Yes ☐ No *Carrier:* _____

Policy No.: _____

SECTION 6: CIVIL LAWSUIT AND ATTORNEY INFORMATION

Crime Victim Compensation MUST be notified of any civil action and be provided with written evidence of the amount and terms of settlement. Provide information about any attorney representation you have in a civil suit or insurance claim related to the crime.

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

If yes, please provide your attorney's contact information:

SECTION 7: CRIME RELATED SERVICES REQUESTED

Select which service(s) are being requested. Depending on the services selected, additional information may be required.

☐ **Medical Expenses** — *Medical expenses directly related to a crime related injury and not totally covered by insurance. Submit copies of itemized bills and any insurance statement if related.*

☐ **Dental Expenses** — *Dental expenses directly related to a crime related injury and not totally covered by insurance. Submit copies of itemized bills and any insurance statement if related.*

☐ **Medically Necessary Devices** — *Repair, replacement, or purchase of medical devices that were damaged, destroyed, or became necessary during the crime and are not totally covered by insurance.*

☐ *Dentures* ☐ *Eyeglasses/Contacts* ☐ *Hearing Aids* ☐ *Prosthetic Device* ☐ *Other:* _____

☐ **Mental Health Services** — *Expenses for mental health services related to the incident and not totally covered by insurance. If you have a provider selected, enter their information below.*

Provider Name: _____

Provider Phone: _____

Provider Address: _____

Provider Email Address: _____

☐ **Mental Health Services for Family Members** — *Expenses for mental health services for immediate family members under the age of 18 who are living in the same household.*
***Adults, 18 or older, must complete their own application.**

Name of Family Member	*Relationship to Victim*	*Date of Birth*	*Gender*	*Race*

** Additional family members may be listed on a separate page.*

☐ **Windows / Doors** — *Repair or replacement costs for residential windows and/or exterior doors that were damaged, destroyed, or otherwise compromised during the crime that are not totally covered by homeowner's or renter's insurance. Expenses may include emergency board-up services, garage doors, and doors connecting the residence to a garage. Window screens are not eligible for reimbursement.*

☐ **Residential Locks & Rekeying** — *Repair or replacement costs for residential locks necessary to ensure victim's safety that were damaged, destroyed, or otherwise compromised during the crime that are not totally covered by homeowner's or renter's insurance. Rekeying costs may be eligible when the offender likely had access to the victim's keys.*

☐ **Vehicle Locks & Rekeying** — *Rekeying costs for motor vehicles may be eligible when the offender likely had access to the victim's keys.*

☐ **Security Devices & Modifications** — *Security devices or safety modifications when the safety of the victim is a concern. Guard pets, mace, pepper spray, and weapons are not eligible for reimbursement.*

☐ **Post Office Box** — *Reimbursement for the rental of a PO Box to help ensure the safety of victims of Domestic Violence, Sexual Assault, and/or Stalking.*

☐ **Self-defense classes** — *Reimbursement or direct payment for a self-defense courses, such as Krav Maga, Jiu-Jitsu, Karate, Muay Thai, etc.*
**Courses involving weapons are not eligible.*

☐ **Relocation Expenses** — *Reimbursement or payment directly to landlords or property management companies for rental deposit, first month's rent, professional moving services, hotel during long distance move, packing materials, and one-way travel costs to secure safe, violence free housing.*
**Relocation must be requested within 60 days after the crime to be eligible.*

Please explain the reason(s) you are requesting relocation assistance due to the crime:

_____

_____

_____

_____

☐ **Lost Wages** — *Unpaid time missed at work due to physical or emotional injuries directly caused by the crime. Lost wages requests require documentation from a physician or mental health therapist outlining the inability to work due to physical or emotional injuries that are a direct result of the crime. Lost wages due to the investigation, medical/therapy appointments and court hearings is not eligible.*

SECTION 7: CRIME RELATED SERVICES REQUESTED - CONTINUED

☐ **Loss of Household Support from Offender**	*Financial assistance for when the offender was 1) living with and financially supporting their legal dependents/intimate partner in the household when the crime occurred, and 2) is no longer in the home due to the crime, and 3) is no longer providing financial support to the household. *Proof of the offender's income is required.*

Was the offender living in the home and providing financial support to the victim/legal dependent at the time of the crime? ☐ Yes ☐ No

Is the offender no longer in the home because of the crime? ☐ Yes ☐ No

Is the offender continuing the provide financial support for the household? ☐ Yes ☐ No

☐ **Funeral/Burial Expenses**	*Reasonable costs for funeral or memorial services, crematory and mortuary services, cemetery costs, permanent headstone or similar type item, and transportation of remains out of Adams or Broomfield County for burial.*
☐ **Funeral/Burial Travel Expenses**	*Reimbursement for transportation costs to attend funeral/burial services. Eligible expenses include air, train, bus, taxi or rideshare fare, mileage for personally owned vehicles, rental car expenses, gas/fuel costs for rental cars, and parking expense.*
☐ **Crime Scene Clean-up**	*Costs for the professional removal of bodily fluids/matter or other items that leave the residence uninhabitable and not fully covered by homeowner's or renter's insurance.*
☐ **Lost Support to Dependents because of victims' death**	*Financial assistance for dependents of a victim who died as the result of the crime. The deceased must have been lawfully employed. Payments will be divided among surviving dependents.*

Dependent Name: _____ *DOB:* __/__/____ *Relation:* _____

Dependent Name: _____ *DOB:* __/__/____ *Relation:* _____

Dependent Name: _____ *DOB:* __/__/____ *Relation:* _____

Dependent Name: _____ *DOB:* __/__/____ *Relation:* _____

If there are additional dependents provide their information on an additional sheet of paper.

☐ **Replacement services**	*Reasonable costs for hiring a third party to perform tasks the victim would perform for themselves, or their legal dependents had they not been injured or killed during the crime. Costs may include meal preparation (not the cost of food), cleaning, laundry, mowing, snow removal, grocery shopping, transportation of dependents.* **A note from a physician or therapist is required to verify the need.*
☐ **Dependent care**	*Reasonable costs of hiring a third party to care for the victim's legal dependents, who were previously cared for by the victim without pay but are no longer cared for due to the victim's injury or death resulting from the crime.* **Dependent care requests require documentation from a physician or mental health therapist outlining the inability to care for dependents due to physical or emotional injuries that are a direct result of the crime.*
☐ **Travel Expenses - Medical, Mental Health, and Critical Stages**	*Reimbursement for transportation costs for medical care, mental health care, and costs for victims to attend court for critical stages in which they are not under subpoena to testify. Critical stages are defined in Colorado Revised Statute §24-4.1-302(2). Eligible expenses include air, train, bus, taxi or rideshare fare, mileage for personally owned vehicles, rental car expenses, gas/fuel costs for rental cars, and parking expense.* **Verification of attendance is required.*
☐ **Vehicle Towing and Impound**	*Towing and storage costs not covered by law enforcement or insurance when the vehicle was determined by law enforcement to be the location of the crime and was towed to an impound lot because of the crime.* ** The victim must be the registered owner of the vehicle.*

*** The CVC Board can only assist with losses listed in section 7 ***
For other crime related losses, please contact your victim advocate for referrals to additional resources.

Signature required on back page →

SECTION 8: ACKNOWLEDGEMENTS AND RELEASES

Read and initial each statement. Any victim or secondary victim 18 years of age or older must sign and initial this page. All sections must be initialed in order to process the application.

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

_____	I understand that my failure to reasonably cooperate with law enforcement (police, sheriff, prosecutor, etc.) may result in the denial of my claim. Victims of strangulation who had a medical forensic examination may be considered cooperative.
_____	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. It is my responsibility to notify service providers and any collection agencies of my application to the Crime victim Compensation program.
_____	I hereby authorize the release of all information from my employer, physician, hospital, Department of Human Services, medical and/or mental health service provider(s) and/or creditor(s) for the purposes of verifying the claims I have submitted. 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 below authorizes release of all such information as specified above. A photocopy or exact reproduction of this signed release shall have the same force and effect as the original.
_____	I am advised that if I believe the Crime Victim Compensation Board is unable to impartially review my claim due to personal or professional relationship(s) with two or more Crime Victim Compensation Board members, it will be sent to another district for review. I understand this may delay the processing of the claim. A request for alternative review must be made in writing. If the claim is approved, bills will be paid from the judicial district where the crime occurred.
_____	I hereby authorize release of funds approved under the Colorado Crime Victim Compensation Act to be paid directly to the service provider(s) and/or out of pocket claimant(s) as applicable to my claim. I understand that any payments are subject to the availability of funds and the discretion of the Crime Victim Compensation Board.
_____	I am advised that should my claim for compensation be denied, I will 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 information that addresses the reason for the denial. 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 Crime Victim Compensation Board following the reconsideration, I understand that I may have the Crime Victim Compensation Board's decision reviewed in accordance with the Colorado Rules of Civil Procedures by a district court within 30 days.
_____	I agree to repay the Crime Victim Compensation Fund if payments are received from the offender, including restitution or civil action, insurance, or any other government or private agency as compensation for this injury or death after the receipt of payment from the Victim Compensation Fund. Furthermore, I understand that restitution may be sought from the offender(s) through the criminal or juvenile delinquency and may involve release of information necessary to establish the validity of a restitution claim for Crime Victim Compensation Funds paid.
_____	I agree to immediately inform the Crime Victim Compensation Board whenever any crime-related recovery is expected or received. Pursuant to C.R.S. §24-4.1-116, I agree to repay the Crime Victim Compensation Fund to cover the same losses for which payments were made by the Crime Victim Compensation Fund. I acknowledge and agree that the sources of recovery this subrogation agreement will pertain to include, but are not limited to, the following types of recovery sources: civil judgments against the offender or other liable/obligated third parties, insurance settlements, or settlements/benefits from any other governmental or private agency.
_____	I am advised that any materials received, made or kept by the Crime Victim Compensation Program or a District Attorney concerning an application for Crime Victim Compensation are confidential under C.R.S. §24-4.1-100.1 and I have the right to be notified by the District Attorney's Office if a subpoena for my Crime Victim Compensation file or materials in my claim file has been issued by the court under C.R.S. §24—4.1-302.5(VII). Furthermore, I understand that information provided to the Crime Victim Compensation Board may be discoverable in the criminal case.

SECTION 9: SIGNATURE

By signing and submitting this application I certify that the information contained in this application is true and correct to the best of my knowledge. I understand that untruthful statements provided or falsified information submitted may result in the denial of my claim and is punishable by law.

_____ _____

Signature of Applicant or Parent/Guardian *Date*

_____

Name of Applicant or Parent/Guardian (Please print)