VICTIM COMPENSATION FUND APPLICATION

EIGHTEENTH JUDICIAL DISTRICT
6450 S. REVERE PARKWAY
CENTENNIAL, COLORADO 80111
TELEPHONE: 720-874-8787 FAX: 720-733-4697
VictimComp@da18.state.co.us

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, within six months for residential property damage to exterior doors, locks, or windows.
7. The crime occurred in Arapahoe, Douglas, Elbert or Lincoln County, or, the victim is a resident of the 18th Judicial District 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, loss of support to dependents in the event of death and loss of household support (eligibility restrictions do apply). 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/windows that are damaged during the commission of a crime. Compensation may also be awarded for rekeying of vehicles.
4. By law, you must utilize all other sources of financial assistance or reimbursement, including private insurance, Medicaid and Medicare.
5. Please attach bills, receipts and estimates directly related to the crime. You may submit your application if you have not received an invoice or bill yet, 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 $30,000. Compensation for individual categories is limited by Board policy. Please call 720-874-8787 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 reconsideration, you may have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure.
9. Please note: Victim Compensation cannot compensate for property loss or damage, rent or other personal bills, loss of cash, pain and suffering, and repair to vehicles.

SECTION 1 – VICTIM INFORMATION (Please complete every section. Write N/A when a question is not applicable.)

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

Mailing Address | Gender: ☐ Male ☐ Female

City, State & Zip Code | Last 4 digits of Social Security #

Work Phone | Home Phone/Cell Phone | Email

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

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White Non-Latino or Caucasian
- ☐ Other Race
- ☐ Multiple Races

Referral Source:
- ☐ Police Agency Victim Advocate
- ☐ District Attorney Victim Advocate
- ☐ Social Services
- ☐ Hospital
- ☐ Therapist
- ☐ Service Provider
- ☐ Other ____________________

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

Disabled:
- ☐ No
- ☐ Yes

Disabled prior to the crime:
- ☐ No
- ☐ Yes

SECTION 2 – CLAIMANT INFORMATION (Please complete only if the victim is a minor, deceased or incapacitated.)

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

Mailing Address | City, State, Zip Code

Relationship to Victim | Phone Number | Email

SECTION 3 – CRIME INFORMATION (Please complete this section as completely as possible.)

Type of Crime (Check all that apply)

- ☐ Assault
- ☐ Burglary/Criminal Mischief
- ☐ Careless Driving Resulting in Death
- ☐ Child Physical Abuse
- ☐ Child Sexual Abuse – by a family member
- ☐ Child Sexual Abuse – by a non-family member
- ☐ Domestic Violence
- ☐ Drunk Driver
- ☐ Murder/Homicide
- ☐ Sexual Assault – Adult
- ☐ Vehicular Assault / Vehicular Homicide
- ☐ Other (please specify) ____________________

1. Date of Crime: ____________________
2. Reported Date: ____________________
3. Who committed the crime? ____________________
4. Date of birth of offender (if known) ____________________
5. Relationship to victim ____________________
6. Police Department/Agency reported to: ____________________
7. Police report number: ____________________
8. Police officer assigned: ____________________
9. Has the offender been charged in court? __________
10. District Attorney's case number: ____________________
11. County where crime occurred: ____________________

SECTION 4 – CIVIL LAWSUIT

☐ Yes ☐ No

Are you planning to sue the person(s) or business responsible for this injury? If Yes, please note that you must notify the CVC Board with written evidence of the amount and terms of settlement.

SECTION 5 – 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, check all that apply.)

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

Please list the company name, telephone, and policy number of any insurance listed above.

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SECTION 6 – 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 720-874-8787 or email VictimComp@da18.state.co.us. Or, if you would like help locating a counselor, please call 720-874-8787 or email VictimComp@da18.state.co.us.

☐ **MENTAL HEALTH COUNSELING – SECONDARY VICTIM(S)** (family members):

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

☐ **MEDICAL:** Submit copies of *crime related* itemized bills as you receive them.

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

☐ Other ________________________________

☐ **PERSONAL MEDICAL ITEMS (DAMAGED OR STOLEN):** Submit copies of *crime related* itemized bills or estimates.

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

☐ Other ________________________________

☐ **RESIDENTIAL PROPERTY (DAMAGED DURING COMMISSION OF THE CRIME):** Submit estimates/receipts for repair/replacement of exterior residential doors, locks or windows for reimbursement.

☐ Exterior Door(s) ☐ Exterior Window(s) ☐ Lock(s) ☐ Re-key Vehicle ☐ Crime Scene Clean-Up

☐ Other ________________________________

☐ **LOSS OF HOUSEHOLD SUPPORT – ELIGIBILITY RESTRICTIONS APPLY**

You MAY be eligible for Loss of Household Support if: 1) The victim was living with the offender at the time of the crime, 2) The offender has since vacated the home the victim shared with the offender, 3) The offender was lawfully employed, and 4) The offender was providing financial support to the victim. This is a one-time payment of $1000 and the Loss of Household Support form MUST be completed to determine eligibility. Please call 720-874-8787 or email VictimComp@da18.state.co.us to request a copy of the form.

☐ **LOST WAGES**

You MAY be eligible for Lost Wages if you missed work due to your physical or emotional injuries and you did not have paid vacation, sick, or bereavement leave time. A Lost Wages Form will be sent to you to give to your employer to verify your rate of pay and that the unpaid time from work is directly related to this criminal incident. If you request more than two weeks of lost wages, you will need to supply a note from a doctor or therapist, and pay stubs may be requested. If you are self-employed, you must furnish a copy of the past year's tax return and/or written copies of estimates, bids or contracts for at least a month period so that lost earnings can accurately be determined.

☐ **FUNERAL EXPENSES:** Submit copies of itemized bills, if available.

Have funeral expenses been paid? ☐ Yes ☐ No

Name of person who paid for funeral expenses? ______________________________

Funeral Service Provider and Telephone Number: ______________________________

Please check all boxes that apply:

☐ Travel for Funeral: (Airfare, Mileage, Rental Car, Hotel, etc.) Please submit receipts for reimbursement.

☐ Loss of Support to Dependents: Due to Victim's death only. You may be eligible for compensation if persons who were wholly or partially dependent upon the victim's income at the time of death or whose income has been severely lessened or lost because of this criminal incident. Documentation of the victim's verifiable income must be submitted.

PLEASE READ CAREFULLY, INITIAL EACH SECTION, SIGN AND DATE

All applicants 18 years of age or older must sign this form

____ **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 understand that the acceptance of a Victim Compensation award by an applicant shall subrogate the state to the extent of such award to any cause or right of action accruing to the applicant.

____ **ALTERNATIVE APPLICATION PROCESS:** If you believe the Victim Compensation Board in the Eighteenth 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 Eighteenth Judicial District must receive a request for alternative review in writing. If your claim is approved, bills will be paid from the Eighteenth Judicial District. I also understand that 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. Furthermore, I understand that restitution may be sought from the offender(s) through the criminal or juvenile delinquency case.

____ **RIGHT TO RECONSIDERATION:** 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 a letter which addresses the reason 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 Procedure 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 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 force and effect as the original.

______________________________ ______________

Signature of Victim or Claimant (if Victim is under 18 years of age) Date

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Printed name of Victim or Claimant (if Victim is under 18 years of age)

** *Please note that applications that are submitted without signatures may delay processing.*

Return application and
crime related bills to:
VICTIM COMPENSATION BOARD
6450 South Revere Parkway
Centennial, CO 80111