



VICTIM COMPENSATION APPLICATION STATE OF COLORADO

The Victim Compensation program operates pursuant to C.R.S. §24-4.1-101 et seq.

Eligibility Requirements:

1. The crime must be one in which the victim sustains mental or bodily injury, dies, or suffers property damage to locks, windows or doors to residential property as a result of a compensable crime.
2. The victim must cooperate with law enforcement officials (e.g. district attorney, police, sheriff).
3. The law enforcement agency was notified within 72 hours after the crime occurred.
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 for compensation must be submitted within one year from the date of the crime; six months for residential property damage claims.

NOTE: The Victim Compensation Board MAY waive some of these requirements for good cause or in the interest of justice.

General Information:

1. There does not have to be an arrest made for a victim to be eligible for compensation.
2. Compensation may be made for medical expenses, mental health counseling, dentures, eyeglasses, hearing aids, or other prosthetic or medical devices, loss of earnings, outpatient care, homemaker or home health services, funeral expenses, and loss of support to dependents.
3. Compensation for property damage may be awarded for the cost of replacement or repair to exterior doors, locks or windows that are damaged during the commission of a crime.
4. By law, you must apply for all other available sources of financial assistance or reimbursement, including private insurance, Medicaid and Medicare.
5. Please attach all bills and receipts. You may apply even if you have not received any bills as of this date.
6. Your claim will be investigated and presented to the Victim Compensation Board. This process may take up to 60 days.
7. Total recovery may not exceed the statutory limit of \$20,000. Compensation for some categories is limited by Board policy. Some jurisdictions do not pay up to the statutory limit of \$20,000.
8. Should your claim be denied, you have a right to request reconsideration of the Board's decision and have the right to submit new or additional information related to the reason(s) for the Board's denial or reduction of your claim. You may arrange for reconsideration by contacting the Victim Compensation program within 30 days from the date on which you receive notice of the denial or reduction of your claim. If you request reconsideration of the Board's decision, further information concerning the reconsideration process will be mailed to you. In the event the denial is upheld by the Board, you have a right to have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure within 30 days.

Please complete every question. Write N/A if the question is not applicable.

SECTION 1 - VICTIM INFORMATION (PLEASE TYPE OR PRINT)

_____		_____	
Victim's Name (First, Middle, Last)		Social Security Number	
_____		_____	
Mailing Address		City/State/Zip	
_____		_____	
Home Telephone		Work Telephone	
_____		_____	
Date of Birth		Age when crime occurred	
_____		_____	
		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

State of Residency			

The following information is used for statistical purposes only. It is needed to comply with federal regulations.			
Handicapped:		Race:	
<input type="checkbox"/> Yes <input type="checkbox"/> Physical		<input type="checkbox"/> White	
<input type="checkbox"/> No <input type="checkbox"/> Mental		<input type="checkbox"/> African American	
		<input type="checkbox"/> Hispanic/Spanish	
		<input type="checkbox"/> Native American	
		<input type="checkbox"/> Asian Pacific	
		<input type="checkbox"/> Unknown	
		<input type="checkbox"/> Other: _____	
		Who Referred You to the Victim Compensation Program?	
		<input type="checkbox"/> Victim Advocate	
		<input type="checkbox"/> Police Officer	
		<input type="checkbox"/> District Attorney's Office	
		<input type="checkbox"/> Social Services	
		<input type="checkbox"/> Hospital	
		<input type="checkbox"/> Therapist	
		<input type="checkbox"/> Other: _____	

SECTION 2 - CLAIMANT INFORMATION (Complete only if person submitting application is not the victim, i.e.: victim's parent or guardian, or relative of victim).

_____		_____	
Claimant's Name		Social Security Number	
_____		_____	
Mailing Address		City/State/Zip	
_____		_____	
Home Telephone		Work Telephone	
_____		_____	
Relationship to Victim _____			

SECTION 3 - CRIME INFORMATION (All applicants *must* complete this section)

Type of Crime:	
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Drunk Driver/Vehicular Assault/Homicide
<input type="checkbox"/> Assault	<input type="checkbox"/> Child Physical Abuse
<input type="checkbox"/> Burglary/Criminal Mischief	<input type="checkbox"/> Child Sexual Assault by Family Member
<input type="checkbox"/> Sexual Assault – Adult	<input type="checkbox"/> Child Sexual Assault - Non Family Member
<input type="checkbox"/> Murder/Homicide	<input type="checkbox"/> Other _____
Date of Crime:	Police Dept./Agency Crime Was Reported To:
Crime Report Number:	Law Enforcement Officer Handling Case:
Who Committed the Crime?	Suspect's Relationship to Victim:
Did the Crime Occur at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	County Where Crime Occurred:

INCLUDE COPIES OF ITEMIZED BILLS WITH THIS APPLICATION. PLEASE FORWARD ADDITIONAL CRIME RELATED BILLS AS YOU RECEIVE THEM.

SECTION 4 – BENEFITS Please check each type of claim for which you are requesting funds, and provide the information requested within the block or mark the type of claim as not applicable (N/A).

<p>____ MEDICAL SERVICES: Submit copies of itemized medical bills, if available.</p> <p>Hospital: <input type="checkbox"/>yes <input type="checkbox"/>no Physician: <input type="checkbox"/>yes <input type="checkbox"/>no Chiropractic: <input type="checkbox"/>yes <input type="checkbox"/>no</p> <p>Dental: <input type="checkbox"/>yes <input type="checkbox"/>no Physical Therapy: <input type="checkbox"/>yes <input type="checkbox"/>no</p> <p>Home Nursing Care: <input type="checkbox"/>yes <input type="checkbox"/>no Other: _____</p>	
<p>____ PERSONAL MEDICAL ITEMS: Submit copies of itemized bills, if available. (Limited to medically necessary devices damaged or destroyed during the crime.)</p> <p>Eyeglasses/Contact Lenses: <input type="checkbox"/>yes <input type="checkbox"/>no Dentures: <input type="checkbox"/>yes <input type="checkbox"/>no</p> <p>Hearing Aid: <input type="checkbox"/>yes <input type="checkbox"/>no Prosthetic Device: <input type="checkbox"/>yes <input type="checkbox"/>no Other: _____</p>	
<p>____ COUNSELING: Submit copies of itemized bills, if available. If already in therapy, please provide the following:</p> <p>Therapist's Name: _____ Telephone No. _____</p> <p>Mailing Address: _____</p>	

SECTION 4 - BENEFITS (continued):

___ **LOST WAGES:** Was the victim able to use any of the following types of leave due to physical or emotional injury caused by the crime?

Sick Leave: yes no **Vacation Leave:** yes no **Personal Leave:** yes no

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

___ **RESIDENTIAL PROPERTY:** Submit copies of itemized bills, if available.
(Reimbursement for exterior residential doors, locks and windows damaged or destroyed during the crime.)

Doors: yes no **Locks:** yes no **Windows:** yes no

Residential insurance deductible amount: \$ _____

___ **LOST SUPPORT TO DEPENDENTS** (Contact your local district for additional information on this benefit.)

___ **EMERGENCY AWARDS:** The Victim Compensation fund **MAY** assist victims if they are determined to require emergency assistance as a direct result of the crime. By policy, some jurisdictions do not allow emergency awards. Contact your local district to see if emergency awards are available and for additional information on this benefit.

SECTION 5 - INSURANCE INFORMATION

All applicants seeking compensation for medical bills must complete the following information on insurance and other sources available to pay medical bills.

SOURCE:	YES	NO	UNK	Name of Insurance Company/Policy No./Phone No.
Private Insurance				
Medicaid				
Group Insurance				
Medicare				
Worker's Comp.				
Disability Ins.				
Automobile Ins.				
Homeowner's/ Renter's Ins.				
Military Coverage				
Other				

SECTION 6 – CIVIL LAWSUIT

Are you planning to sue the person(s) or business/agency responsible for this injury? yes no

If yes, please provide the following:

Your Civil Attorney's Name: _____

Mailing Address

City/State/Zip

Telephone No.

NOTE: *The Crime Victim Compensation Board must be notified of any civil action and be provided with written evidence of the amount and terms of settlement.*

SECTION 7 - RELEASE OF INFORMATION AND VICTIM'S RIGHTS AND RESPONSIBILITIES

Certification of Application: The information contained in this application for a Crime Victim Compensation award is true and correct to the best of my knowledge. I understand that the filing of false information may result in a denial of my claim and is punishable by law.

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

Alternative Application Process: If you feel the Victim Compensation Board in your judicial district is unable to fairly review your claim due to a personal or professional relationship with two or more board members, it will be sent to another district for review. If your claim is approved, bills will be paid from this office. I understand that this may delay the processing of my claim.

Repayment of Crime Victim Compensation Award: I understand that the Crime Victim Compensation program will be repaid 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 Victim Compensation Fund.

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.

Release of Information Authorization: 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, or to establish the validity of a restitution claim. I further understand that any information provided may be subject to disclosure under the law.

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) applicable to my claim. I understand that any award is subject to the availability of funds and the discretion of the Board.

Right to Reconsideration: As an applicant, you are advised that if your Crime Victim Compensation claim is denied you have the right to request a reconsideration hearing before the Crime Victim Compensation Board. You will be entitled to present evidence and witnesses. At said hearing, the burden of proof is upon you as the applicant to show that the claim is reasonable and compensable under the terms of the Colorado Crime Victim Compensation Act. In the event the denial is upheld by the Board at the reconsideration hearing, the applicant has the ability to have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure within 30 days.

Printed Name

Signature of Victim or Claimant

Date