



Office Use Only

Claim No. _____

Crime Victim Compensation Board

Office of the District Attorney, 20th Judicial District

1035 Kimbark Street, Longmont, CO 80501

Phone (303) 682-6801 Fax (303) 682-6711

CRIME VICTIM COMPENSATION FUND APPLICATION

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 exterior 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, and 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 and within six months for residential property damage claims.
7. The crime occurred in Boulder County or in another state or country where there is no victim compensation program and the victim is a resident of Boulder County.

** The Crime Victim Compensation board may waive some of the above listed requirements for good cause or in the interest of justice.*

General Information:

1. There does not have to be an arrest for a victim to be eligible to apply to the Compensation Program.
2. Compensation may be made for medical expenses, mental health counseling, dentures, eyeglasses, hearing aids, or other prosthetic or medically necessary devices, loss of earnings due to injury, outpatient care, home health services, funeral expenses, exterior residential doors/locks/windows and loss of support to dependents in the event of death. Requests must be *directly related* to the crime reported to the law enforcement agency.
3. Compensation for property damage may be awarded for the cost of replacement or repair to exterior doors, locks or windows that were damaged during the commission of the crime. Claimant must supply bill or estimate.
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 itemized bills, receipts and estimates directly related to the crime. You may apply even if you have not received any bills as of this date. In this case, forward bills to us as you receive them.
6. Your claim will be verified and presented to the Victim Compensation Board, a three-member panel of volunteers appointed by the elected District Attorney. This process may take up to 60 days from the receipt of all required documentation necessary to present a claim request to the Board.
7. Total recovery may not exceed the statutory limit of \$20,000. Compensation in individual categories is limited by Board policy; please contact the program for specific category limits as they apply to your claim.
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, which relates 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 of 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 Board upholds the denial, you have a right to have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure within 30 days.

Your application and information contained in your file may be subject to discovery in court proceedings.

CRIME VICTIM COMPENSATION APPLICATION FORM INSTRUCTIONS

Pursuant to statute 24-4.1-105(2) (a), the applicant must provide the Compensation Program with any information requested by the program as needed to process the application. Incomplete applications will be returned or delayed until all information is received.

SECTION 1 – VICTIM INFORMATION: The primary victim is the person who was injured or killed. A secondary victim is someone with a close, familial type relationship with the victim or someone who is a witness to the crime. A separate application is required for each family member applying. It is very important that you provide a complete mailing address, including city, state and zip code so that we can continue to keep you notified of the status of your application. A telephone number and/or email address allows us to contact you with questions. The Social Security number is used only to verify bills submitted for payment.

SECTION 2- CLAIMANT INFORMATION: This is the person who will be contacted regarding this claim. It may be the same person as the primary victim or it may be a legal guardian or family member of the primary victim. Please note the relationship to the victim and provide a telephone number or email address for contact.

SECTION 3 – CRIME INFORMATION: The majority of this information will be obtained from a copy of the offense report taken by the investigating law enforcement agency. You *DO NOT* need to provide a copy of this report. Completing this entire section, to the best of your knowledge, helps us make sure that we have the correct report to go with your application.

SECTION 4 – INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION: By federal and state statute, Crime Victim Compensation is the payer of last resort. If you have any other resources available for payment for the bills you are submitting, you must disclose this information. Incomplete applications will be returned to you.

SECTION 5 – REQUEST FOR SERVICES: This section has nine subsections: Mark the services you are requesting assistance with or that you anticipate needing assistance. Write not applicable (N/A), if you are not requesting assistance for that subsection.

- **Medical:** All itemized bills submitted must be **directly** related to the crime and are ultimately your responsibility. Crime related bills or estimates should be forwarded to the Compensation Program as you receive them. All bills received will be verified to confirm date, type and cost of service before a payment determination will be made.
- **Personal Medical Items:** This refers to any medically necessary device that was stolen or damaged as a result of the criminal incident. This includes hearing aids, glasses, dentures, etc. Send itemized bills or estimates.
- **Mental Health Counseling:** For Primary and Secondary victims. The Board will only approve therapy with *state licensed therapists*. Consideration will be made on a case-by-case basis when there are special circumstances. In that instance, a state licensed therapist must supervise the therapist.
- **Self-Defense Course:** Only the *primary victims of a compensable crime* may apply for a self-defense course.
- **Loss of Earnings:** You may request loss of earnings *only* if you missed work because of physical or emotional injuries related to the crime *and* you did not have paid vacation or sick leave provided by your employer. You must provide a recent pay stub and your employer must verify the unpaid time you missed from work on a form available from the Compensation Program. If you are self-employed, you will be asked to submit a copy of your last year's tax return.
- **Funeral Expenses:** Please let us know if you have already paid for funeral expenses or if the bills remain outstanding. Submit all bills or receipts that you wish to be considered for payment or reimbursement. The person who paid for the funeral is the person eligible to receive reimbursement if the claim is approved.
- **Residential Property:** Please note if you have a homeowner's insurance deductible and list the deductible amount. If you do not have homeowner's insurance, please write "N/A" in the space provided.
- **Loss of Support to Dependents:** If the primary victim has died as a result of a crime, persons who were wholly or partially dependent upon the primary victim's income may request funds for loss of support. Also, if certain criteria are met, loss of support can be awarded in domestic violence related cases. Please contact us for more information
- **Emergency Request:** ER requests must be received no later than 90 days from the date of the crime. Contact the Program Director for more information regarding emergency assistance and eligibility.

SECTION 6 - - CIVIL LAWSUIT: By signing the application, you agree to repay any funds you receive in a civil lawsuit for expenses paid by the Compensation Program.

SECTION 7 – RELEASE OF INFORMATION AND VICTIM RIGHTS AND RESPONSIBILITIES: Your initials by each section, as well as your signature and the date are necessary to complete the application and to authorize the Compensation Program to verify bills on your behalf. Incomplete applications may be returned to you and will delay payment.

Return application and crime related bills to: Victim Compensation Program, Office of the District Attorney – 20th Judicial District, 1035 Kimbark St., Longmont, CO 80501

SECTION 1 – VICTIM INFORMATION (PLEASE TYPE OR PRINT):

Primary Victim

Secondary Victim

Victim's Name (First, Middle, Last)

Last Four Digits of Social Security Number

Mailing Address

City/State/Zip

Home Telephone

Work Telephone

Other Phone/E-mail

State of Permanent Residency

Date of Birth

Age at time of crime

Gender: Male Female

The following information is used for statistical purposes only. It is required to comply with federal regulations.

Handicapped:

- Yes Physical
 No Mental

Race:

- Caucasian
 African American
 Hispanic/Spanish
 Native American
 Asian Pacific
 Unknown
 Other: _____

Who Referred You to the Victim Compensation Program?

- Victim Advocate
 Police Officer
 District Attorney's Office
 Social Services
 Hospital
 Therapist
 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 (Parent/Guardian/Relative)

Last Four Digits of 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 Victim | <input type="checkbox"/> Child Sexual Assault – Non-Family Member |
| <input type="checkbox"/> Murder/Homicide | <input type="checkbox"/> Other _____ |

1. Date of Crime:	2. Date Crime Reported:	3. Police Dept./Agency Crime Was Reported To:	4. Victim(s) Name:
4. Police Officer Assigned to Case:	5. Police Report Number:	6. Name of Person Who Committed Crime:	
7. Did the Crime Occur at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. Has the Offender Been Charged In Court: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
9. County Where Crime Occurred:		10. Court Case Number:	

SECTION 4 – INSURANCE/OTHER COLLATERAL SOURCE INFORMATION

By law, Crime Victim Compensation is the “payer of last resort”; therefore, you are required to submit all bills to your insurance carrier or other collateral source related to your request for assistance. Please check all sources of alternate payment for bills submitted to the Compensation Program.

*(This section **must** be completed before this claim may be processed.)*

- Do you have health insurance coverage? _____ Yes _____ No
- Do you have automobile insurance? _____ Yes _____ No
- Do you have homeowner’s insurance? _____ Yes _____ No

IF YES TO ANY OF THESE, PLEASE READ AND COMPLETE THE FOLLOWING:

If yes, please check which type:

- _____ Private Insurance
- _____ Group Insurance
- _____ Medicaid
- _____ Medicare
- _____ Worker’s Compensation
- _____ Department of Social Services
- _____ CHP
- _____ Colorado Indigent Care Program
- _____ Other

If applicable, please complete:

- Policyholder _____
- Company Name _____
- Phone Number _____
- Policy Number _____
- Amount of Deductible _____
- (add additional sheets as needed)

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

SECTION 5 – REQUEST FOR SERVICES: Please check each section and mark the services that you are requesting assistance with or that you anticipate needing assistance. Write not applicable (N/A), if you are not requesting assistance for that subsection.

_____ **MEDICAL SERVICES:** Submit copies of *crime related* itemized medical bills as you receive them.

Hospital: Yes No

Physician: Yes No

Chiropractic: Yes No

Dental: Yes No

Physical Therapy: Yes No

Home Nursing Care: Yes No

Other: _____

NOTE: If plastic surgery, reconstructive surgery, major dental work, ongoing physical therapy, etc. are being recommended, your provider must complete our *Medical Service Treatment Plan* form that explains how the injuries and treatment relate to the crime and an estimate of total cost for the procedure. The Victim Compensation Board will then review your request and you will be informed as to whether or not we will be able to assist with the cost. Please contact our office at 303-682-6801 for a copy of this form.

If possible, please list service providers noting if the bill is paid or outstanding. You may add additional sheets if needed.

Service Provider _____ Paid Outstanding Estimate

_____ **PERSONAL MEDICAL ITEMS:** Submit copies of *crime related* itemized bills or estimates. (Limited to medically necessary devices lost or destroyed during the crime.)

Was the item stolen, damaged or destroyed during the criminal incident? Yes No

Eyeglasses/Contact Lenses: Yes No

Dentures: Yes No

Hearing Aid: Yes No

Prosthetic Device: Yes No

Other: _____

_____ **MENTAL HEALTH COUNSELING:**

Are you (victim) currently seeing a therapist related to this crime? Yes No

Therapist's Name: _____ **Telephone #:** _____

The Board will only approve therapy with *state licensed therapists*. Consideration will be made on a case-by-case basis if an applicant has special circumstances. In that instance, a state licensed therapist must supervise the therapist. If you need names of qualified therapists, please call 303-682-6801.

_____ **SELF DEFENSE COURSE (Only the primary victims of a compensable crime may apply for a self-defense course.)**

_____ **LOSS OF EARNINGS DUE TO PRIMARY VICTIM'S INJURY ONLY**

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

To qualify for lost wages, you have to have been employed at the time of the incident. If you were paid for your time away from work through your employer's sick or vacation benefits, you cannot apply to Victim Compensation for additional pay. You can only apply to this program for UNPAID time away from your job. If you are self-employed you must furnish copies of the past year's tax return so we can accurately determine lost wages.

PLEASE NOTE: We cannot pay for lost wages due to time spent reporting the crime, testifying in court, interviews with police and/or D.A., or any other time spent related to the criminal case.

A "Claim for 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 was directly related to this criminal incident. *You will be asked to include a copy of a recent pay stub and if you are requesting more than one week of lost wages a note from a doctor or therapist.*

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

Have funeral expenses been paid? Yes No

Funeral Service Provider and Telephone Number

Name of person who paid for funeral expenses

Telephone Number

_____ **RESIDENTIAL PROPERTY** (*Only damaged exterior doors, locks and windows are applicable.)

Please check those that apply:

Exterior Doors: _____ **Exterior Windows:** _____ **Re-key Exterior Locks** _____

Crime Scene Cleanup (if no other resources are available): _____

Residential insurance deductible amount: \$ _____

*In some cases modifications to a residential home for safety reasons may be awarded.

Please note that compensation for personal property, i.e., automobiles, money, clothing, etc. cannot be awarded per statute.

_____ **LOSS OF SUPPORT TO DEPENDENTS:** Relatives who were wholly or partially dependent upon the victim's income at the time of death may be eligible for compensation. Also, in certain cases, a primary victim of domestic violence may qualify for loss of support if specific criteria are met. Please call for more information.

Dependents Name

Date of Birth

Relationship to Victim

_____ **EMERGENCY AWARDS:** The Victim Compensation fund **MAY** assist victims if it is determined they require emergency assistance as a direct result of the crime. By policy, some jurisdictions do not allow emergency awards. Please contact our program for additional information on this benefit.

SECTION 6 – CIVIL LAWSUIT *See also Section 7 – Repayment of Crime Victim Compensation & Subrogation Agreement

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: _____ Telephone # _____

Mailing Address

City/State

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

Please Read Carefully, Initial Each Section, Sign and Date

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.

CLAIMANT RESPONSIBILITY: I understand that I am responsible for my bills relating to this crime and have the burden of providing 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. In addition, I am further aware that if I fail to cooperate with the prosecution of the case from which my losses were sustained, I will be ineligible for any further compensation and will be fully liable to reimburse the Crime Victim Compensation Program any and all compensation awards received.

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 is the payer of last resort. I hereby 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 promise to repay the Crime Victim Compensation Fund from those recoveries a sum that is equal to the amount of the Crime Victim Compensation award to cover the same losses for which I received payments from the Crime Victim Compensation Fund. I acknowledge and agree that the sources of recovery this subrogation agreement will pertain to include, but no limited to, the following types of recovery sources: court-imposed restitution, civil judgments against the offender or other liable/obligated third parties, insurance settlements, or settlement/benefits from any other governmental or private agency. I further agree and understand that no part of the recovery to the Crime Victim Compensation may be diminished by any collection fees, attorney's fees, or for any other reason whatsoever.

RELEASE OF INFORMATION AUTHORIZATION: I hereby authorize the release of all information from my employer, physician, hospital, Department of Human Services, civil attorney, medical and/or mental health service provider(s) and/or any other creditor(s) or agency for the purposes of verifying the claims I have submitted, or to establish the validity of a restitution claim. By doing so, I do not intent to waive my privilege in all of my past, current, or future medical or mental health records. I further understand that any information provided may be subject to disclosure under the law. My signature authorizes release of all such information as specified above. A photocopy or exact reproduction of this signed release shall have the same effect as the original.

***SUBROGATION AGREEMENT:** I hereby agree to notify the Crime Victim Compensation Program in the event that benefits become available to me, including but not limited to a civil lawsuit action, in payment of the same expenses for which I receive from the Crime Victim Compensation Program. I further agree to retain as many of the recovered funds as needed to reimburse the Compensation Program for the exact amount I received.

RELEASE OF FUNDS: I hereby authorize release of funds awarded to me under Colorado Crime Victim Compensation be paid directly to the service provider(s) named in 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 are entitled to present evidence and witnesses. At the hearing, the burden of proof is upon you, 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 Board upholds the denial, the applicant can request to have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure within 30 days.

Printed Name of Victim or Claimant

Signature of Victim or Claimant

Date

Mail to: Boulder District Attorney's Office, Attn: Victim Compensation, 1035 Kimbark St., Longmont, CO 80501

Please call the District Attorney's Office at 303-682-6801 or email kstalnacker@bouldercounty.org if you have questions or need help completing this application. Website: www.bouldercounty.org/da. Fax #: 303-682-6711