Crime Victim Compensation Program

Sixth Judicial District
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APPLICATION FOR CRIME VICTIM COMPENSATION (CVC)

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

Eligibility Requirements: (NOTE: The Crime Victim Compensation Board May waive some of these requirements for good cause or in the interest of justice.)

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, in La Plata, Archuleta, or San Juan County.
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.

General Information:

1. There does not have to be an arrest made for a victim to be eligible for compensation. Requests for compensation must be a direct result of the crime committed /reported to law enforcement.

2. Compensation may be considered for medical expenses, mental health counseling, dentures, eyeglasses, hearing aids, or other prosthetic or medically necessary devices, loss of earnings, outpatient care, homemaker or home health services, funeral/burial expenses, loss of support to dependents, household support, and/or rekeying of locks.

3. Compensation for property damage may be awarded for replacement cost or repair to exterior doors, locks or windows that are damaged during the commission of a crime. The Board may also consider requests for modifications to ensure victim safety.

4. By law, you must apply for all other available sources of financial assistance or reimbursement, including private insurance, Medicaid and Medicare, before applying for Victim Compensation Funding.

5. Please attach copies of all bills, receipts, and estimates that are a direct result of the crime. You may apply, even if you have not received any bills, but please submit bills and insurance explanation of benefits as soon as you receive them.

6. Your claim will be verified and presented to the Victim Compensation Board once your packet is completed (i.e. application, law enforcement reports, treatment plans, and miscellaneous forms needed). This process may take up to 60 days.

7. Any award is subject to Funds availability and approval by the Board. Compensation may not exceed $20,000 in total. All expense/loss categories have individual limits.

8. Should your claim be denied, you have a right to request reconsideration of the Board's decision. You will be notified by mail of the reason for the denial and be informed 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 Victim Compensation Program within 30 days from the date of the denial. If the Board denies the reconsideration, you may have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure.

9. If crime related bills have been turned over to a collection agency, please contact the Victim Compensation program at the number above.

10. Any materials received, made, or kept by the Victim Compensation Program, or a District Attorney concerning an application for Victim's Compensation made under the Colorado Revised Statute 24-4.1-100.1 are confidential.

11. Should a subpoena for your Claim file or material within the Claim file by issued by the Court pursuant to C.R.S. 24-4.1-302.5(1)(d)(VII), you have the right to be notified by the District Attorney's Office .

The Victim Compensation Board and staff shall not discriminate on the basis of race, color, national origin, religion, sex, disability, or age when considering a Victim Compensation claim. If you feel a violation has occurred, you may file a complaint at http://ojp.gov/about/ocr/complaint.htm.

Crime Victim Compensation Program

Please complete every question. Write N/A when the question is not applicable. Must be 18 or older to complete application.

Section 1- Victim Information (Please type or Print)

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

Mailing Address | City/State/Zip Code

Primary Contact Number | Victim Alternative Number | Victim Safe Message Number

Preferred Method of Contact (Phone, Email or Mail) | Victim Email | Social Security # (last 4 digits only)

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

Race:
- ☐ Caucasian/White Non-Latino
- ☐ African American/Black
- ☐ Hispanic/Latino
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Multiple Race
- ☐ Some Other Race

Referral Source:
- ☐ Victim Advocate
- ☐ Police Officer
- ☐ District Attorney's Office
- ☐ Social Services
- ☐ Hospital
- ☐ Therapist
- ☐ Other_____

Gender Identity
- ☐ Female
- ☐ Male
- ☐ Transgender Female
- ☐ Transgender Male

Disabled prior to crime?
- ☐ Yes
- ☐ No
- ☐ Mentally
- ☐ Physically

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 | Relationship to Victim

Mailing Address | City/State/Zip

E-mail Address | Home Telephone | Cell/Other Phone

Section 3 – Civil Lawsuit:

Are you planning to sue the person(s) or business/agency responsible for this injury? If yes, you will need to complete a subrogation agreement. Please contact the Victim Compensation Program for the form.
Please provide the following information:

Civil Attorney:_____ Telephone #:_____

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 the settlement.*

Section 4 – Crime Information: **(**Please complete this section as completely as possible.)

Type of Crime: (check **all** that apply)

- ☐ Assault/ Kidnapping
- ☐ Burglary/Criminal Mischief
- ☐ Careless Driving Resulting in Death/Injury
- ☐ Child Physical Abuse
- ☐ Child Sexual Assault by Family Member
- ☐ Child Sexual Assault – Non Family Member
- ☐ Domestic Violence
- ☐ Drunk Driver/Vehicular Assault/Vehicular Homicide
- ☐ Hit and Run Resulting in Death/Injury
- ☐ Murder/Homicide
- ☐ Sexual Assault-Adult
- ☐ Other_____

1. Date of Crime: _____ 2. Reported date:_____

3. Who committed the Crime? _____ 4. Suspect's relationship to victim: _____

5. Police department/agency Crime reported to: _____ 6. Agency report number: _____

7. Law enforcement officer handling case:_____ 8. District Attorney's case number:_____

9.County where Crime occurred: _____ 9.Did the Crime occur at work?_____

11. Did the Crime Involve a Motor Vehicle? _____

Section 5 - Benefits: ***Please check each item for which you are requesting funds, and provide the information requested or mark the category as not applicable (N/A).***

_____**Medical Services:** Submit copies of itemized medical bills, if available, or as you receive them.

Briefly Describe Injuries:_____

_____

(Please check each applicable category that applies to your injuries.)

Hospital: ☐ Yes ☐ No **Physician:** ☐ Yes ☐ No **Chiropractic:** ☐ Yes ☐ No

Dental: ☐ Yes ☐ No **Physical Therapy:** ☐ Yes ☐ No **Home Health Care:** ☐ Yes ☐ No

Eye: ☐ Yes ☐ No **Other:**_____

_____**Personal Medical Items: (Items must have been damaged or destroyed during the commission of the crime. Submit copies of itemized bills if available.)**

Eyeglasses/Contact Lenses: ☐ Yes ☐ No **Dentures:** ☐ Yes ☐ No **Hearing Aids:** ☐ Yes ☐ No

Prosthetic Devices: ☐ Yes ☐ No **Other:** _____

_____**Counseling: (**If you know whom you will be seeing for therapy, or are already in counseling, please provide the following. Your counselor will need to contact the program for their portion of the paperwork.)

Counselor's Name: _____ **Phone #:**_____

Mailing or E-mail Address: _____

_____**Lost Wages: (Your employer will need to complete a lost wage form on your behalf and verify your employment. Lost wages cannot be considered if vacation, sick or personal leave was available. Please request a form from the Victim Compensation Program.)**

_____**Funeral and Burial Expenses:** Submit copies of itemized bills, if available, or have the provider contact the program.

Have the funeral expenses been paid? ☐ Yes ☐ No **If yes, by whom?**_____

_____**Property Damage:** Submit copies of itemized bills or estimates, if available.
(**Reimbursement only for residential exterior doors, locks, and windows damaged during the crime.)**
Doors: ☐ Yes ☐ No **Locks:** ☐ Yes ☐ No **Windows:** ☐ Yes ☐ No
Residential Insurance:_____ **Deductible amount:** $_____

_____**Safety Modifications:** The Board may consider Crime Scene Clean-up, modifications for residential property, as well as the rekeying of locks on such items as vehicles, residences, etc. to ensure victim safety.
*Please be specific in your request and provide documentation for request.*_____
_____

_____**Loss of Support:** The Board may consider only in the case of death of the primary victim, if that person was the primary or partial support to dependents. Additional information will be required in order to verify income. Paystubs or the most current income tax filing can be considered. *Please be specific in your request. List each dependent, relationship to deceased, and date of birth. Verification of dependency will be required.* _____
_____

_____**Household Support:** The Board may consider only if the defendant's criminal conduct was the basis of the dependent's claim. As a result of the criminal event, the offender vacated the home shared with the dependent. *Please be specific in your request. List each dependent, relationship to deceased, and date of birth. Verification of the dependency will be required.* _____
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Section 6 – Emergency Award

_____**Emergency Awards:** Victim Compensation may be able to assist with some emergency requests that cannot wait until the next regular Board meeting, if it appears to the Board that undue hardship will result to the victim if immediate payment is not made. **Emergency awards are intended to cover expenses incurred by crime victims in meeting their immediate short-term needs.**
*Please be specific with you request.*_____
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Section 7 – Insurance/Collateral Source Information: *Applicable expenses must be submitted to insurance prior to any payment from Victim Compensation.* ***This section must be completed!***

Medical Insurance:	☐ Yes ☐ No	Medicare / Medicaid:	☐ Yes ☐ No
Auto Insurance:	☐ Yes ☐ No	Disability:	☐ Yes ☐ No
Military Insurance:	☐ Yes ☐ No	Worker's Compensation:	☐ Yes ☐ No
Homeowner's / Renter's:	☐ Yes ☐ No	Deductible:$_____	
Other:_____			

Please list the company name, telephone number, and policy number for all insurance companies indicated above.
_____
_____

Section 8 – Release of Information / Victim's Rights & Responsibilities:

Please initial each item below, and sign and date the application.

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

_____ **Repayment of Crime Victim Compensation Award:** 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.

_____ **Subrogation Agreement:** I agree to immediately inform the Crime Victim Compensation Board whenever any crime-related recovery is expected or received. Pursuant to C.R.S. §24.4.1.1-116, 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.

_____ **Release of Information:** I hereby authorize the release of all information from my employer(s), physician(s), hospital(s), Department of Human Services, civil attorney, medical and/or mental health service provider(s) and /or creditor(s) for the purpose 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 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 this original.

_____ **Alternative Application Process:** 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.

_____ **Release of Funds:** 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.

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_____ **Right to Reconsideration:** 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.

_____ **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 and any collection agencies of my application to the Crime Victim Compensation Program.

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 Victim / Claimant *(Applications submitted without signature will be returned. Must be 18 or older to sign.)*

Printed Name of Victim/Claimant

Date

Clear Form