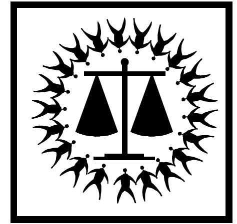
CRIME VICTIM COMPENSATION BOARD
Fourth Judicial District
El Paso and Teller Counties
105 E Vermijo, Suite 111
Colorado Springs, CO 80903
Phone (719) 520-6036 Fax (719) 520-6172



VICTIM COMPENSATION FUND APPLICATION

The Crime 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 residential *exterior* locks, windows or doors as a result of a compensable crime.
2. The victim must fully cooperate with law enforcement officials (law enforcement, district attorney, etc.)
3. The crime must be reported to a law enforcement agency within 72 hours of occurrence.
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.
7. The crime occurred in El Paso or Teller County; or, in another state or country and the victim is a resident of El Paso or Teller 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. An arrest does not have to be made in order for a victim to become eligible to apply to the Compensation Program.
2. Compensation may be requested for medical expenses, mental health therapy, medically necessary devices (dentures, eyeglasses, hearing aids, and prostheses), loss of earnings due to injury, outpatient care, home health services, funeral expenses, exterior residential doors/locks/windows, and loss of support to dependants 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 residential* doors, locks, and windows that are damaged during the commission of a crime. Claimant must supply a bill or estimate.
4. By law, you must apply for all other 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 if you have not received any bills as of this date, forwarding bills 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.
8. Compensation for an entire claim may not exceed the statutory limit of $20,000. Compensation for individual categories is limited by Board policy; please call if you have questions about specific category limits.
9. Should your request be denied, you have a right to request reconsideration of the Board's decision. Notification by mail of the reason for the Board's denial 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 Compensation Program within 60 days from the date on which you receive notice of the denial and you will receive further information regarding the reconsideration process. If the Board denies the reconsideration, you may have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure.

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 pertinent requested information to process this application. Incomplete applications will be returned or delayed until all information is received.

SECTION I – VICTIM INFORMATION: The name of the person who was injured or killed is considered the primary victim. 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 at with any questions. The Social Security number is used *only* to verify bills submitted for payment.

SECTION 2 – CLAIMANT INFORMATION: This is the person to who contact and correspondence regarding this claim should be made. 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 an 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 right offense report related to 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 available any other sources of payment for the bills you are submitting, you must disclose this information.

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

- ***Mental Health Counseling***: For Primary and Secondary victims; Secondary victims are persons that have a close, familial type relationship with the primary victim. (Paid at $70 per session with a licensed therapist)
- ***Medical:*** All bills submitted must be ***directly*** related to the crime and are ultimately your responsibility. Crime related bills or estimates can be forwarded to the Compensation Program as you receive them. All bills and insurance correspondence received will be verified to confirm date, type and cost of service before a payment determination can be made. (Paid at 80%)
- ***Personal Medical Items:*** This refers to any medically necessary device that was stolen or damaged as a result of the criminal incident. This may be hearing aids, glasses, dentures, etc. Send crime related bills or estimates.
- ***Loss of Earnings:*** You may request loss of earnings *only* if you missed work because of your 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 doctor's note, a recent pay stub and your employer must verify the unpaid time you had to miss from work on a form provided by the Compensation Program. If you are self-employed, you will be asked to submit a copy of your last year's tax return. (1 month maximum for mental health & 2 months maximum for physical health reasons)
- ***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 or whose income will now be decreased or lost because of the primary victim's death can request loss of support. This may include court ordered child support.
- ***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. ($500 maximum)
- ***Funeral Expenses:*** Please note if you have 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 approved. ($6000 maximum $4000 funeral $2000 burial)
- ***Alternatives to Mental Health:*** With a proper referral you may apply for self defense and/or massage therapy.

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 – EMERGENCY REQUEST: Based on requests received no later than 14 days from the date of crime. Please speak with the Coordinator or Program Assistant for more information regarding emergency assistance and eligibility.

SECTION 8 – RELEASE OF INFORMATION & VICTIM RIGHTS AND RESPONSIBILITIES: Your initials by each section, signature and date are necessary for a complete application and authorize the Compensation Program to verify bills on your behalf. Incomplete applications may be returned to you, and will delay payment consideration of your requests.

Return application and crime related bills to:
Victim Compensation Program
105 E. Verjmijo, Suite 111
Colorado Springs, CO 80903 ***Fax: 520-6172***

SECTION 1 – VICTIM INFORMATION – PLEASE PRINT

Victim Name (First, Middle, Last)

Mailing Address

City	**State**	**Zip Code**
County of Residency	**State of Permanent Residency**	**Social Security Number**
Work Phone	**Home Phone**	**Other Phone/E-mail**
Birth Date	**Age at time of crime**	**Gender:** ☐ **Male** ☐ **Female**

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

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

Disabled:
- ☐ Yes
- ☐ No
- ☐ Mentally
- ☐ Physically

Did the crime cause your disability?
- ☐ Yes
- ☐ No

Race:
- ☐ Caucasian
- ☐ African American
- ☐ Hispanic/Latin American
- ☐ Native American
- ☐ Asian/Pacific
- ☐ Unknown
- ☐ Other ____________________

Referral Source:
- ☐ Police Agency Victim Advocate
- ☐ District Attorney Victim Advocate
- ☐ District Attorney's Office
- ☐ Social Services
- ☐ Hospital
- ☐ Therapist
- ☐ Other ____________________________

SECTION 2 – CLAIMANT INFORMATION

☐ **SAME AS ABOVE (only if crime victim is claimant)**

Claimant's Name (Parent/Guardian/Relative)	**Social Security Number**
Mailing Address	**City/State/Zip**
Home Telephone	**Work Telephone/Other**

Relationship to Victim ____

SECTION 3 – CRIME INFORMATION

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

- ☐ Assault
- ☐ Burglary/Criminal Mischief
- ☐ Careless Driving Resulting in Death
- ☐ Child Physical Abuse
- ☐ Child Sexual Assault-Family Member
- ☐ Child Sexual Assault-Non-Family Member
- ☐ Domestic Violence
- ☐ Drunk Driver
- ☐ Hit and Run Resulting in Death
- ☐ Murder/Homicide
- ☐ Sexual Assault-Adult
- ☐ Vehicular Assault/Vehicular Homicide Other: _________

1. DATE OF CRIME: **2.** DATE CRIME REPORTED	**3.** POLICE DEPARTMENT/AGENCY CRIME REPORTED TO:
4. POLICE OFFICER ASSIGNED: **5.** POLICE REPORT NUMBER:	**6.** WHO COMMITTED THE CRIME? **7.** RELATIONSHIP TO VICTIM:
8. HAS THE OFFENDER BEEN CHARGED IN COURT? ☐ YES ☐ NO ☐ UNKNOWN	**9.** DISTRICT ATTORNEY'S OFFICE CASE NUMBER:
10. DID THE CRIME OCCUR AT WORK: ☐ YES ☐ NO	**11.** COUNTY WHERE CRIME OCCURRED:

SECTION 4 – INSURANCE/OTHER COLLATERAL SOURCE INFORMATION

You are required to submit all bills to your insurance carrier or other collateral source related to your request for assistance; check all sources of alternate payment for bills submitted to the Compensation Program.

Please indicate if the following applies to you *and* your claim request:

Medical Insurance: ☐ Yes ☐ No
Auto Insurance: ☐ Yes ☐ No
Life Insurance: ☐ Yes ☐ No
Medicare: ☐ Yes ☐ No
Medicaid: ☐ Yes ☐ No
Disability: ☐ Yes ☐ No
Worker's Compensation: ☐ Yes ☐ No
Homeowner's/Renters: ☐ Yes ☐ No
Other: ____________________________
Deductible for Homeowner/Renter's Insurance:$_________

Please list the company, telephone number and policy number of any insurance listed above (add additional sheets as needed):

____

SECTION 5 – REQUEST FOR SERVICES (Please check all boxes that apply)

☐ MENTAL HEALTH COUNSELING

Are you (victim) currently seeing a therapist related to this crime? ☐ Yes ☐ No
If yes, please list the name and phone number of the therapist below.

Therapist Name____ **Telephone Number** ________________________

☐ ALTERNATIVES TO MENTAL HEALTH COUNSELING (for Primary Victims only)

- ☐ Massage therapy – Requires a referral from treating physician or mental health therapist ($500 max)
- ☐ Self defense course – Requires a referral from mental health therapist or law enforcement ($500 max)

SECTION 5 CONTINUED– REQUEST FOR SERVICES

☐ **MEDICAL:** Submit copies of *crime related* itemized 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: ______________________

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

Service Provider ____ ☐ Paid ☐ Outstanding ☐ Estimate

Service Provider ____ ☐ Paid ☐ Outstanding ☐ Estimate

Service Provider ____ ☐ Paid ☐ Outstanding ☐ Estimate

☐ **PERSONAL MEDICAL ITEMS** Submit copies of *crime related* itemized bills or estimates

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 **Medication:** ☐ Yes ☐ No **Other:** ___________________

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

Loss of earnings is not applicable for lost wages due to reporting the crime, testifying in court, interviews with police/DA, etc.
Please complete if you missed work **due to your physical or emotional injuries** and you ***did not*** have paid vacation, sick or bereavement leave time. A "Claim for Lost Wages" form is included for 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. You will be asked to include **a note from a doctor or therapist** and provide a copy of a recent pay stub. If you are self-employed, you must furnish a copy of the past year's tax return.

☐ **LOSS OF SUPPORT TO DEPENDENTS** *DUE TO VICTIM'S DEATH ONLY*

Persons who were wholly or partially dependant upon the victim's income at the time of death or whose income has been severely lessened or lost because of this criminal incident may be eligible for compensation. Please include a copy of the dependent's birth certificate, proof of permanent guardianship and/or copy of marriage license, and proof of income of deceased at the time of death.
1) Relationship to deceased _________________ 2) Date of Birth ___________

☐ **RESIDENTIAL PROPERTY** *(Damaged or destroyed during the crime - $500 maximum)*

Exterior Doors: ☐ Yes ☐ No **Exterior Windows:** ☐ Yes ☐ No

Re-key Exterior Locks: ☐ Yes ☐ No **Crime Scene Cleanup:** ☐ Yes ☐ No **Insurance Deductible Amount: $**_______

☐ **FUNERAL EXPENSES: Submit copies of itemized bills, if available. ($6000 maximum $4000 funeral $2000 burial)**

Have funeral expenses been paid? ☐ Yes ☐ No

____
Funeral Service Provider and Telephone Number

____
Name of person who paid for funeral expenses

____
Telephone Number

SECTION 6 – CIVIL SUIT

CIVIL LAWSUIT: Are you planning to sue the person(s) or business responsible for this injury? ☐ Yes ☐ No
If yes, please note that you must notify the Compensation Board with written evidence of the amount and terms of settlement.

SECTION 7 – EMERGENCY REQUEST

☐ **EMERGENCY REQUEST:** The Victim Compensation Program ***may*** be able to assist with some emergency requests if it is determined undue hardship would result to the applicant if payment were not made in 72 hours.

SECTION 8 – RELEASE OF INFORMATION / RIGHTS & RESPONSIBILITIES

PLEASE READ CAREFULLY, INITIAL EACH SECTION, SIGN AND DATE

Initial Each Box Below

☐ **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. 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 for any and all compensation awards received.

☐ **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 so much of the recovered funds as necessary to reimburse the Compensation Program to the extent of the compensation I received from the Program.

☐ **ALTERNATIVE APPLICATION PROCESS:** If you feel the Victim Compensation Board in the Fourth 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 once the conflict has been declared by the Board. The Fourth Judicial District must receive a request for alternative review in writing. If your claim is approved, bills will be paid from the Fourth Judicial District. I understand 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.

☐ **RIGHT TO RECONSIDERATION:** Should my claim for compensation be denied, I would 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 within 60 days which addresses the reason for the denial as stated in the letter. You must then appear in person at the next scheduled Board meeting to present your case. 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 Procedures by a district court.

☐ **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 any 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 effect as the original.

______________________________ **Signature of Victim/Claimant**

______________________________ **Date**

Applications submitted without signatures will be returned.

______________________________ **Printed Name of Victim/Claimant**

VICTIM COMPENSATION PROGRAM
Fourth Judicial District
105 E. Vermijo, Suite111
Colorado Springs, CO 80903
(719) 520-6036   Fax: (719) 520-6172

Please print

LOSS OF WAGES

VICTIM'S NAME: ____________________

THE PROGRAM WILL ONLY COMPENSATE THE VICTIM FOR WAGES LOST DUE TO PHYSICAL OR EMOTIONAL INJURIES DIRECTLY CAUSED BY THE CRIME. LOST WAGES WILL NOT BE PAID FOR TIME LOST DUE TO COURT APPEARANCES, APPOINTMENTS WITH CRIMINAL JUSTICE PERSONNEL OR APPOINTMENTS WITH SERVICE PROVIDERS.

IF YOU ARE REQUESTING LOSS OF WAGES, TAKE THIS FORM TO YOUR EMPLOYER AND HAVE IT COMPLETED AND SIGNED BY YOUR SUPERVISOR/EMPLOYER EACH MONTH. IF YOU ARE SELF-EMPLOYED YOU MUST SUBMIT COPIES OF YOUR TAX RETURNS. IF CLAIMING LOST WAGES, YOU MUST SUPPLY THE FOLLOWING DOCUMENTATION:

1) **THIS FORM MUST BE COMPLETED AND RETURNED BEFORE YOUR REQUEST FOR LOST WAGES CAN BE PROCESSED. PLEASE RETURN THE ORIGINAL FORM WITH YOUR APPLICATION OR SEND TO THE ADDRESS LISTED ABOVE.**
2) **A LETTER FROM YOUR TREATING PHYSICIAN OR THERAPIST INDICATING YOUR INABILITY TO WORK DUE TO INJURIES SUSTAINED AS A RESULT OF THE CRIME AND INDICATING LENGTH OF TIME OF INABILITY TO WORK.**
3) **IF REQUESTING LOST WAGES FOR MORE THAN MORE MONTH YOU MUST TAKE THIS FORM TO YOUR EMPLOYER EACH MONTH FOR VERIFICATION**

EMPLOYEE'S NAME:	JOB TITLE:	SOCIAL SECURITY NUMBER
WAS THIS PERSON EMPLOYED ON THE DATE OF INJURY? ☐ YES ☐ NO	HAS THIS PERSON RETURNED TO WORK? ☐ YES ☐ NO	IF YES, DATE RETURNED? / /
WAS THIS PERSON INJURED WHILE AT WORK? ☐ YES ☐ NO	IF YES, WAS WORKERS COMP PAID ☐ YES ☐ NO	IF YES, THROUGH WHAT PERIOD FROM: TO:
WAS SICK LEAVE / ANNUAL LEAVE OR DISABILITY PAID? ☐ YES ☐ NO	IF YES, THROUGH WHAT PERIOD FROM: TO:	HOURS WORKED PER DAY
HOURS WORKED PER WEEK	HOURS WORKED PER MONTH	NUMBER OF DAYS MISSED
RATE OF PAY $________________	☐ HOURLY ☐ WEEKLY ☐ COMMISSION	☐ MONTHLY ☐ DAILY ☐ OTHER ____________________

TOTAL AMOUNT OF LOSS OF WAGES: $ ____________________

EMPLOYER'S (FIRM) NAME: ____________________

ADDRESS: ____________________

CITY, STATE, ZIP: ____________________

EMPLOYER (SUPERVISOR/REPRESENTATIVE) NAME: ____________________

JOB TITLE: ____________________

PHONE NUMBER: ____________________

EMPLOYER (SUPERVISOR/REPRESENTATIVE) SIGNATURE: ____________________

EMPLOYEE (VICTIM) SIGNATURE: ____________________ 6/09