Crime Victim Compensation Board

Twenty-Third Judicial District of Colorado
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PROUDLY SERVING DOUGLAS, LINCOLN AND ELBERT COUNTIES

APPLICATION FORM

ELIGIBILITY REQUIREMENTS

The Crime Victim Compensation (CVC) Program operates pursuant to C.R.S. 24-4.1-101 et. seq. The CVC Board may waive some of the following statutory requirements if good cause exists:

o The victim sustained a mental or physical injury, death, or damage to exterior residential doors, locks, and/or windows as a result of a compensable crime.

o The crime occurred on or after July 1, 1982.

o The crime occurred within Douglas, Lincoln, or Elbert counties. Victims residing in the district may also be eligible for CVC if the crime occurred outside the state or country where CVC is not reasonably accessible.

o The crime was reported to a law enforcement agency, or a forensic exam was completed by a licensed medical provider.

o A completed application for CVC was filed with the Board.

o The victim reasonably cooperated with law enforcement officials (law enforcement, prosecutor, etc.).

o The injury to or death of the victim was not the result of the victim's own wrongdoing or substantial provocation.

GENERAL PROGRAM INFORMATION

o There does not need to be an arrest or charges filed to be eligible for CVC.

o Claims for CVC may not exceed the statutory limit of $30,000.00. The Board has further adopted specific policy limits for individual loss categories.

o Submission of a completed application form does not guarantee approval of CVC funds. The Board will review requests within 45-60 working days from the receipt of a completed application.

o Any materials received, made, or kept by the CVC program concerning an application for CVC funds are confidential pursuant to C.R.S. 24-4.1-107.5. You have the right to be notified of any subpoena for your CVC materials.

o Victims will be notified of all Board decisions concerning a request for CVC funds. If a request is denied, the Victim has the right to request reconsideration from the Board within 90 days from the receipt of a denial letter.

o CVC does not compensate for damage or loss of personal property, loss of cash, damage to motor vehicles, or pain and suffering.

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SECTION 1 – VICTIM INFORMATION

PLEASE COMPLETE ALL FIELDS. INCOMPLETE APPLICATIONS WILL DELAY PROCESSING.

_____

Victim Name (First, Middle Initial & Last) Date of Birth

_____

Mailing Address

_____

City State Zip Code

_____

Phone Email

Is there a language other than English you prefer to communicate in? ☐ YES ☐ NO

If yes, list the language you prefer to communicate in: _____

RACE		DISABILITY
☐ American Indian/Alaskan Native	☐ Native Hawaiian/Pacific Islander	☐ Physical
☐ Asian	☐ White Non-Latino/Caucasian	☐ Mental
☐ Black/African American	☐ Multiple	☐ Cognitive/TBI
☐ Hispanic/Latino	☐ Other: _____	☐ Hearing Impaired
GENDER IDENTITY		☐ Vision Impaired
☐ Male	☐ Non-Binary	
☐ Female	☐ Prefer not to say	
☐ Transgender	☐ Other: _____	
WHO REFERRED YOU TO CVC?		
☐ Police Agency Victim Advocate	☐ Community Organization	
☐ District Attorney Victim Advocate	☐ Hospital/Medical Facility	
☐ Child Advocacy Center	☐ Mental Health Provider	
☐ Human Services	☐ Other: _____	

***Information used for statistical purposes only to comply with federal regulations*

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SECTION 2 – CLAIMANT INFORMATION

Please complete this section only if the victim in Section 1 is under the age of 18, deceased, or otherwise incapacitated.

☐ Claimant Information is the same as Victim Information

Claimant Name (First, Middle Initial, Last) Date of Birth

Mailing Address

City State Zip Code

Phone Email

Claimant's Relationship to Victim

SECONDARY CONTACT INFORMATION

Please complete this section if there is a secondary parent or guardian you would like CVC to contact regarding this claim.

Secondary Contact Name (First, Middle Initial, Last) Date of Birth

Mailing Address

City State Zip Code

Phone Email

Secondary Contact's Relationship to Victim

CONTINUED ON NEXT PAGE

SECTION 3 – INSURANCE INFORMATION

CVC is a payor of last resort by law. All bills must be processed through your insurance and/or other collateral source of payment. Documentation of payment or denial by insurance is required. Check all that apply.

SOURCE	YES	NO	UNK	Name of Insurance Company / Deductible Amount
Private Insurance	☐	☐	☐	
Medicaid/CHP	☐	☐	☐	
Medicare	☐	☐	☐	
Group Insurance	☐	☐	☐	
CO Indigent Care Program	☐	☐	☐	
Worker's Compensation	☐	☐	☐	
Disability	☐	☐	☐	
Automobile Insurance	☐	☐	☐	
Homeowner's/Renter's	☐	☐	☐	
Other	☐	☐	☐	

SECTION 4 – CIVIL LAWSUIT INFORMATION

CVC must be notified of any civil action resulting from the crime. Documentation of any monies received from a civil action is required.

Are you planning to sue the offender(s), their insurance, or other involved party responsible for your injuries?

☐ Yes ☐ No

_____

Civil Attorney Name | Law Firm

_____

Phone | Email

CONTINUED ON NEXT PAGE

SECTION 5 – CRIME INFORMATION

Type of Crime (check all that apply):	
☐ Assault	☐ Burglary/Criminal Mischief
☐ Murder/Homicide	☐ Careless Driving
☐ Sexual Assault – Adult	☐ DUI
☐ Child Sexual Abuse	☐ Vehicular Assault/Vehicular Homicide
☐ Child Physical Abuse	☐ Other: _____

Was this an act of Domestic Violence? ☐ Yes ☐ No ☐ Unsure

What county did the crime occur in? ☐ Douglas ☐ Lincoln ☐ Elbert ☐ Other_____

Who committed the crime (offender name): _____

Offender's relationship to victim:_____

Date of crime:_____ Date crime was reported:_____

Police department reported to: _____

Police department report number (if known): _____

Has the offender been charged in court? ☐ Yes ☐ No ☐ Unsure

Court case number (if known): _____

SECTION 6 – REQUEST FOR SERVICES

Please check the box next to each category you are seeking assistance with and complete all fields with the requested information. Additional eligibility requirements may apply.

☐MEDICAL/DENTAL

Please submit itemized copies of your medical bills. Bills may be submitted at a later date if you have not yet received them, or you receive additional bills. Additional information may be required.

☐ PERSONAL MEDICAL ITEMS

Limited to reimbursement of *medically necessary* items damaged or lost as a result of the crime, or the purchase of new medical items necessary as a result of the crime. The damage or loss *must* be documented in the police report.

☐ Dentures/Dental Device
☐ Eyeglasses/Contact Lenses
☐ Hearing Aids
☐ Prosthetic Device
☐ Mobility Aid
☐ Other: _____

CONTINUED ON NEXT PAGE

☐ MENTAL HEALTH COUNSELING

Are you currently seeing a therapist related to the criminal incident? ☐Yes ☐No

_____

Therapist Name Phone

_____

Email

☐ MENTAL HEALTH COUNSELING – SECONDARY VICTIMS/FAMILY MEMBERS

Please only include family members residing in the same household. *Family members residing in a different household must complete a separate application*.

Name	Relationship to Victim	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE CONTACT OUR OFFICE IF YOU WOULD LIKE ASSISTANCE FINDING A THERAPIST

☐ LOST WAGES

You may be eligible for lost wages due to physical or emotional injuries resulting from the crime not covered by available paid time off. A Lost Wage and Employment Verification Form will be sent to you to provide to your employer. Additional documentation in support of your lost wage request may be required.

☐ LOSS OF HOUSEHOLD SUPPORT

You may be eligible for loss of household support if you are a dependent of the offender and shared a residence with the offender at the time of the crime. *Roommates are not eligible for household support.*

☐ REPLACEMENT SERVICES LOSS

You may be eligible for limited assistance with ordinary or necessary services the primary victim would have performed had the victim not died or been injured as a result of a compensable crime. The services, including dependent care and certain “homemaker” services must not have been performed for income.

☐ RESIDENTIAL SAFETY MODIFICATIONS

You may be eligible for reimbursement of the cost of safety modifications to increase the outer security of your residence if there is an ongoing concern for your safety. Safety modifications may include security systems/cameras, motion/flood lights, and additional locking mechanisms. *Guard pets and weapons of any kind will not be considered*.

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☐ RESIDENTIAL PROPERTY DAMAGE

Please submit itemized estimates or invoices for repair or replacement. Estimates or invoices may be submitted at a later date if you have not yet received them. The damage or loss *must* be documented in the police report.

You may be eligible for repair of motor vehicle doors and/or windows if your vehicle is your primary residence and was damaged as a result of a compensable crime. Please contact our office for more information.

☐ Exterior Door(s)
☐ Exterior Window(s)
☐ Exterior Lock Change/Rekey
☐ Vehicle Towing/Impound Fees
☐ Vehicle Lock Change/Rekey
☐ Crime Scene Cleaning

☐ FUNERAL/BURIAL EXPENSES

Please submit itemized invoices or receipts. You may have the funeral home contact our office directly.

Have the funeral/burial expenses been paid? ☐Yes ☐No

_____

Name of the person(s) who paid the funeral/burial expenses if different from the Claimant

_____

Mailing Address

_____

Phone Email

☐ TRAVEL EXPENSES

You may be eligible for reimbursement of reasonable travel expenses to attend the primary victim's funeral, attend a critical stage court hearing, or attend medical/mental health counseling appointments resulting from the crime.

☐ LOSS OF SUPPORT TO DEPENDENTS

You may be eligible for loss of support to dependents if you were wholly or partially dependent on the primary victim's income at the time of their death. Please submit documentation of the victim's income.

☐ EMERGENCY REQUEST

Emergency requests must be related to an immediate safety concern resulting from the crime and must be made within thirty (30) days from the date of the crime. All eligibility requirements must be met, and you must submit all necessary documentation related to the request. Funding is *not* guaranteed.

Emergency requests for funding are limited to the following:

☐ Relocation
☐ Loss of Household Support
☐ Residential Property Damage
☐ Residential Safety Modifications
☐ Medically Necessary Devices

CONTINUED ON NEXT PAGE

REVIEW AND SIGN

Please read the following statements carefully, initial each statement, and print and sign.

_____ **Certificate of Application:** The information contained in this application for Crime Victim Compensation funds is true and correct to the best of my knowledge. I understand providing falsified information or documentation may result in the denial of my claim and is punishable by law.

_____ **Claimant Responsibility:** I understand I am responsible for all costs related to the crime and have the burden of providing documentation to the Crime Victim Compensation Board. I will notify service providers that an application for Crime Victim Compensation has been submitted.

_____ **Alternate Application:** I have the right to request an alternative application process if my personal or professional relationship with two or more Board members will prohibit the Board from conducting an impartial review of my application. I understand I must make a request for an alternative application process in writing and my application may be sent to a different Judicial District.

_____ **Cooperation:** I understand that my failure to reasonably cooperate with law enforcement, including in the investigation, apprehension, and prosecution of the offender, may result in the denial of my claim.

_____ **Repayment of Crime Victim Compensation:** I agree to reimburse the Crime Victim Compensation Program if payment is subsequently received from the offender (restitution), insurance, or other source as compensation for my injuries if the same expenses were previously approved by the Crime Victim Compensation Board. I further understand restitution may be sought from the offender for payments made by the Crime Victim Compensation Board on my behalf.

_____ **Subrogation Agreement:** I agree to notify the Crime Victim Compensation Program in the event funds become available to me (i.e. from civil lawsuit) for the same expenses previously approved by the Crime Victim Compensation Board. I further agree to retain so much of the recovered funds as necessary to reimburse the Crime Victim Compensation Program to the extent of the funds I received from Crime Victim Compensation.

_____ **Right to Reconsideration:** I have the right to request reconsideration of the Board's decision in the event my claim is denied. I understand the burden of proof is on me to show the claim is reasonable and compensable under the Colorado Crime Victim Compensation Act (C.R.S. 24-4.1-101).

_____ **Release of Funds:** I authorize release of approved Crime Victim Compensation funds directly to my service provider(s).

_____ **Release of Information:** I authorize the release of all information from my employer, medical providers, mental health providers, civil attorney, and/or any other creditor or agency for the purpose of verifying documentation I have submitted or to establish the validity of my claim. I understand any information provided may be subject to disclosure under the law. I understand I have the right to revoke authorization, in writing, at any time. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____

Printed Name of Victim or Claimant

_____

Signature of Victim or Claimant **Date**

MAIL COMPLETED APPLICATIONS TO:
Office of the District Attorney
C/O Crime Victim Compensation
4000 Justice Way, STE 2525A
Castle Rock, CO 80109