VICTIM COMPENSATION APPLICATION
ELEVENTH JUDICIAL DISTRICT
STATE OF COLORADO

RETURN COMPLETED APPLICATION TO: *Victim Compensation*
136 Justice Center Rd.
Rm. 203
Canon City, CO 81212
Phone: 719-269-0170
Fax: 719-269-0181

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, 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; six months for residential property damage claim.
7. For further information regarding CVC, please call 719-269-0170
8. If the victim/applicant is hearing impaired, you may contact the CVC program by emailing levans@da11thjd.org.
9. If the victim applicant is blind, please contact the CVC Program by calling 719-269-0170 or going to your local district attorney office.
10. If the victim/applicant does not speak English, please contact the CVC Program by coming to 136 Justice Center Rd., Rm. 203, Canon City, CO or 104 Crestone Ave., Rm. 120, Salida, CO 81201 or 310 4th St., Fairplay, CO 80440 so you can meet with a CVC staff member and interpreter.
11. All materials received, made, or kept by the CVC Program or district attorney concerning an application for victim's compensation made under CD.R.S. 24-4.1-100.1 are confidential. Victims have a right to be notified by the district attorney's office if a subpoena has been issued by the court for the CVC claim file, or materials in the CVC claim file, for which the victim submitted an application.

NOTE: The 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. Victims of domestic violence are not eligible for loss of household support if they reunite with their perpetrator.
3. Compensation for property damage may be awarded for the cost of replacement or repair to 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 forty-five days.
7. Total recovery may not exceed the statutory limit of $30,000. Compensation for some categories is limited by Board policy.
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 in 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.
9. Contact the CVC Program at 719-269-0170 if crime related bills have been turned over to a collection agency.

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) _____ Email Address _____

Mailing Address _____ City/State/Zip _____

Home Phone _____ / Work phone _____ Cell Phone _____

Date of Birth _____ Age when crime occurred _____

State of Residency _____ Sex: ☐ Male ☐ Female

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

Handicapped:

☐Yes ☐Physical

☐No ☐Mental

Race:

☐ White Non-Latino or Caucasian

☐ Black or African American

☐ Hispanic or Latino

☐ American Indian or Alaska Native

☐ Asian

☐ Native Hawaiian or Other Asian Pacific

☐ Multiple Races

☐ Some Other Race

Who Referred You to the Compensation Program?

☐ District Attorney Victim Advocate

☐ Law Enforcement Victim Advocate

☐ Police Officer

☐ Human 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 _____ _____

Mailing Address _____ City/State/Zip _____

Home Telephone _____ Work Telephone _____

Relationship to Victim _____

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

Type of Crime:

- ☐ Domestic Violence
- ☐ Assault
- ☐ Burglary/Criminal Mischief
- ☐ Sexual Assault – Adult
- ☐ Murder/Homicide
- ☐ Drunk Driver/Vehicular Assault/Homicide
- ☐ Child Physical Abuse
- ☐ Child Sexual Assault by Family Member
- ☐ Child Sexual Assault - Non-Family Member
- ☐ 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? ☐Yes ☐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).*

____ **MEDICAL SERVICES:** Submit copies of itemized medical bills, if available.

Hospital: ☐yes ☐no **Physician:** ☐yes ☐no **Chiropractic:** ☐yes ☐no
Dental: ☐yes ☐no **Physical Therapy:** ☐yes ☐no
Home Nursing Care: ☐yes ☐no **Other:** _____

____ **PERSONAL MEDICAL ITEMS:** Submit copies of itemized bills, if available.
(Limited to medically necessary devices damaged or destroyed during the crime.)

Eyeglasses/Contact Lenses _____Yes _____No **Dentures** _____Yes _____No

Hearing Aids _____Yes _____No **Prosthetic Device** _____Yes _____No

Other _____Yes _____No

_____

____ **COUNSELING**: Submit copies of itemized bills, if available. If already in therapy, please provide the following:

Therapist's Name: _____ Telephone No. _____

Mailing Address: _____

_____**LOSS OF WAGES:** Please submit the attachment titled "Loss of Wages", page 6.
Did you use any of the following?
Paid Sick Leave _____ Paid Vacation Leave_____ Paid Personal Leave_____

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

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

Doors_____ ☐Yes ☐ **No** **Locks:**_____ ☐Yes ☐ No
Residential insurance deductible amount: $ _____

_____**RELOCATION ASSISTANCE**: You must provide address where you are relocating, name and phone number of landlords, family member, friend, etc. of where you are relocating to, estimated cost of relocation (with attached written estimates) or receipts if requesting reimbursement.

COMMENTS:
_____
_____

_____ **LOSS OF SUPPORT TO DEPENDENTS** (You **MUST** provide verification of the income of the individual whose support you have lost. If you do not provide the requested verification it will delay processing of your claim)

Number children under the age of 18? _____
Are you employed? _____Yes, _____No. If yes, where? _____
Where is defendant employed? _____

_____ **EMERGENCY AWARDS:** The compensation fund **MAY** assist victims if they are determined to require emergency assistance as a direct result of the crime. Contact the Victim Compensation Administrator at 719-269-0170 to see if emergency awards are available and for additional information on this benefit.

SECTION 5 - INSURANCE INFORMATION

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

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				

_____**TRAVEL:** Please explain in detail what you are requesting travel for. Please provide copies of receipts for reimbursement (*You may be eligible for travel assistance to attend counseling or medical appointments related to injuries received in the crime. Verification of your attendance at an appointment is required)*

_____

_____

_____

_____**LODGING:** Please explain in detail what you are requesting lodging for. Please provide copies of receipts for lodging costs for _____

_____

_____

(Lodging, travel and meals provided for attending funeral of victim who is deceased as the result of a crime or immediate family members attending a sentencing hearing will be awarded on a case by case basis)

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 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 services 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 _____

FOR FURTHER INFORMATION AND ASSISTANCE CONTACT THE VICTIM COMPENSATION ADMINISTRATOR AT 136 JUSTICE CENTER RD., ROOM 203, CANON CITY, CO 81212. PHONE: 719-269-0170.

VICTIM COMPENSATION PROGRAM
Eleventh Judicial District
136 Justice Center Rd., Room 203
Canon City, CO 81212
(719) 269-0170

Please print

LOSS OF WAGES

VICTIM 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 physical or emotional 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:	
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
TOTAL NUMBER OF DAYS **MISSED**		
RATE OF PAY ☐ HOURLY ☐ WEEKLY ☐ COMMISSION $_____ ☐ MONTHLY ☐ DAILY ☐ OTHER _____		

TOTAL AMOUNT OF GROSS LOSS OF WAGES: $ _____

Employer's (firm) name: _____
Address: _____
City, State, Zip Code _____
Employer (supervisor/representative) name: _____
Job title: _____
Phone number: _____
Employer (supervisor/representative) Signature _____ Date _____
Employee (victim) signature: _____ Date _____

11th JUDICIAL DISTRICT
CRIME VICTIM COMPENSATION PROGRAM
LOSS OF HOUSEHOLD SUPPORT REQUEST

Victim Name:_____ Defendant Name:_____

Are there any dependents? Y / N Names/Ages:

Were you and the defendant living in the same residence at the time of the crime? Y / N

At the time of the crime the defendant was providing: ____Total Support ____Partial Support ____No support

Income: Defendant: $_____ per ____ Your: $_____ per _____ **(YOU MUST PROVIDE DOCUMENTATION OF DEFENDANTS SUPPORT)**

Are there any other sources of income? Y / N If "yes," please list:

To your knowledge, is the defendant refusing to continue providing financial support? Y / N
Please itemize the following **monthly** expenses and **provide documentation**:

	Defendant pays:	You pay:	Total:
Housing (rent or mrtg.)			
Gas			
Electric			
Water/Sewer			
Phone			
Food			
Other-List:			
Total:			

Will the defendant benefit from any lost support payments made by the CVC Program? Y / N
If "yes," please explain:

I certify that I have read and/or understand and agree to all of the statements in the Application for Crime Victim Compensation, Section H - Declarations; furthermore, I am aware that all of the information provided in this Request for Lost Support is subject to those Declarations. I certify that the information contained in this application for lost support is true and correct to the best of my knowledge, and I understand that any untruthful statements will disallow my eligibility for any and all benefits from the Crime Victim Compensation Fund

Signature: _____ Date_____