

Denver Crime Victim Compensation Application Check List

In order to ensure that your application is processed as quickly as possible, please review the following checklist:

The incident must have been reported to the Denver Police Department and the victim/applicant must cooperate with the investigation and prosecution if a prosecution results.

- Check to make sure the application is filled out completely. **If the application is not complete and questions are unanswered, it may be returned to you delaying assistance.**
- The application **must include the signature** of the victim or of the claimant if the victim is under the age of 18 years old.
- If you have not yet received medical bills, send the completed application and forward the bills as you receive them. If you are sending medical bills with the application, please **send itemized bills rather than a payment coupon or letter from a collection agency.**
- If you are requesting reimbursement for bills you have already paid, **please enclose receipts or other proof of payment with an itemized copy of the bill.**
- If you are requesting assistance with **dental** treatment, the Board **requires a treatment plan from the dentist before** they will review dental bills. Payment for **dental treatment related to the crime** is limited to \$8,000.
- Loss of wages** must be documented by an employer. A release of information is included with the application. **If self-employed**, the Board will **only** accept documentation from the most recent income tax return or quarterly income tax statements. A **doctor's note must accompany all requests for more than 2 weeks** of lost wages. The Board may pay up to four months or \$6,000.
- If you pursue **mental health counseling**, be aware that the Board will only consider payment to a licensed therapist or a counselor directly supervised by a licensed therapist. The Board will determine the number of sessions for which it will pay based on the treatment plan. The Board will pay up to \$90 per individual sessions and up to \$45 per group.
- The Board **cannot repair or replace property** with the exception of exterior residential doors, locks, and windows damaged as the result of a crime.
- The Board cannot replace cash or assist with rent or relocation.**

Payment is not guaranteed and no one can make that promise to you. All decisions are made by the Crime Victim Compensation Board.

Return to: Crime Victim Compensation
201 W. Colfax, Dept 801
Denver, CO 80202

720-913-9253(Phone)
720-913-9035 (Fax)
VictimComp@denverda.org

DENVER CRIME VICTIM COMPENSATION APPLICATION 720-913-9253

The Victim Compensation program operates pursuant to C.R.S. 24-4.1, Part 1.

Eligibility Requirements:

1. The crime must be one in which the victim sustains mental or bodily injury or dies; or suffers residential property damage to external door, locks, or windows as a result of a compensable crime.
2. The victim must cooperate fully with law enforcement officials, (police, and prosecutors.)
3. The police were 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 crime against a person and six months from the date of a property crime.

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| NOTE: The Crime Victim Compensation Board may waive some of these requirements for good cause. |
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General Information:

1. The arrest of a suspect does not need to be made for a victim to be eligible for compensation.
2. Compensation may be made for reasonable medical expenses, mental health counseling, dentures, eyeglasses, hearing aids, or other prosthetic or medical devices, loss of earnings, outpatient care, homemaker / home health services, funeral expenses, and loss of support to dependents.
3. Compensation for property damage may be made for the replacement or repair to exterior residential 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, Medicare, etc.
5. Please attach *itemized* bills and receipts. You may apply 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 60 days after the information is complete.
7. If your claim is denied, you have the right to request that the Board reconsider its decision. You must submit new or additional information related to the Board's denial or reduction of your claim. You can arrange for a hearing by contacting the Crime Victim Compensation program within 30 days of notification of the denial or reduction of your claim. In the event the denial is upheld by the Board, you have the right to have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure.

Please complete every question. Write N/A if the question is not applicable.

SECTION 1 - VICTIM INFORMATION

| | | | |
|---|---------------------|--|--|
| _____ | | _____ | |
| Victim's Name | | Date of Birth | |
| _____ | | _____ | |
| Mailing Address | Apt# | City/ State/ Zip Code | |
| _____ | | _____ | |
| Home Telephone | | Work Telephone | |
| _____ | | Sex: ___ Male ___ Female | |
| Cell Phone _____ | | | |
| The following information is used for statistical purposes only. It is needed to comply with federal regulations. | | | |
| Race: | Handicapped: | Who referred you to this program? | |
| ___ African American | ___ Yes | ___ Police Victim Advocate | |
| ___ Asian / Pacific Islander | ___ No | ___ Police Officer | |
| ___ Hispanic / Spanish | ___ Mental | ___ District Attorney's Office | |
| ___ Native American | ___ Physical | ___ City Attorney's Office | |
| ___ White | | ___ Hospital | |
| ___ Other | | ___ Therapist | |
| | | ___ Social Services | |
| | | ___ Other _____ | |
| Marital status: S ___ M ___ D ___ | | | |

SECTION 2 - CLAIMANT INFORMATION (Complete only if person submitting application is not the victim, i.e. parent, guardian, or relative of the victim.)

| | | | |
|------------------------------|--------|------------------------|--|
| _____ | | _____ | |
| Claimant's Name | | Date of Birth | |
| _____ | | _____ | |
| Mailing Address | Apt. # | City / State/ Zip Code | |
| _____ | | _____ | |
| 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"/> DUI / Vehicular Assault / Vehicular Homicide |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Child Physical Abuse |
| <input type="checkbox"/> Burglary/Criminal Mischief | <input type="checkbox"/> Child Sexual Abuse - by family member |
| <input type="checkbox"/> Sexual Assault - Adult | <input type="checkbox"/> Child Sexual Abuse - non-family member |
| <input type="checkbox"/> Murder / Homicide | <input type="checkbox"/> Other _____ |

| | |
|---------------------------|--|
| Date of Crime: | Did crime happen at work? ____ Yes ____ No |
| Street Location of Crime: | Law Enforcement Agency Investigating |
| Police Report Number | Investigating Police Officer / Detective |
| Suspect's Name | Suspect's Relationship to Victim: |

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

SECTION 4 - BENEFITS (Please check each category for which you are requesting assistance and provide the information requested.)

Medical Services: Submit copies of itemized medical bills if available:

Hospital: yes no **Name of hospital:** _____

Doctor : yes no Dental: yes no

Inpatient : yes no Emergency only: yes no

Chiropractic: yes no Physical Therapy: yes no

Personal Medical Items: Submit copies of itemized bills, if available.
(Limited to medically necessary items damaged or destroyed during the crime.)

Eyeglasses: yes no Dentures: yes no

Hearing aid: yes no Prosthetic device: yes no

Counseling: *The choice of therapist is yours alone. You may receive referrals from various sources, but no one can tell you that you **must** see a specific therapist. You should be comfortable with the person, agency, and process.*

Therapist's name: _____ **Telephone number:** _____

Mailing address: _____
 Street address Office number City/ State/ Zip Code

Lost Wages: Are you seeking assistance with lost wages? Yes No

Employer / Company **Contact Person**

Mailing Address: _____
 Street address City/ State/Zip Code Phone #

How long employed? _____ **Do you have sick leave?** _____ **Annual leave?** _____

Funeral Expenses: Submit copies of itemized bills if available.

Residential Property: Submit copies of bills or receipts if available. Reimbursement is available only for exterior residential doors, locks, or windows damaged or destroyed during the crime.

Doors: yes no **Locks:** yes no **Windows:** yes no

Household Support (This benefit is limited to victims whose perpetrator is a member of the household and contributed to the household income. Additional documentation is needed please contact the Crime Victim Compensation Program for information, 720-913-9253)

Lost Support to Dependents (This benefit is limited to crimes in which a fatality has occurred, contact the Crime Victim Compensation Program for information, 720-913-9253)

SECTION 5 - INSURANCE INFORMATION

All applicants seeking compensation must complete the following information on insurance and other sources of assistance.

| SOURCE | YES | NO | Name of insurance company |
|------------------|-----|----|---------------------------|
| Health insurance | | | |
| Automobile Ins. | | | |
| Medicaid | | | |
| Medicare | | | |
| CICP | | | |
| Worker's Comp. | | | |
| Homeowner Ins | | | |

SECTION 6 - RELEASE OF INFORMATION, VICTIM RIGHTS AND RESPONSIBILITIES

The application will be delayed if it is submitted without the signature of the victim or claimant.

Please initial statements below after reading

_____ **Certification 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 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, prosecutors, etc.) may result in the denial of my claim.

_____ **Alternative application process:** If you feel that the Board in this district is unable to review your claim in a fair manner because you know two or more Board members, the application can be sent to another judicial district for review. I understand that this may delay the processing of my claim.

_____ **Repayment of Crime Victim Compensation Award:** The Crime Victim Compensation Program will be repaid if payments are received from the offender, (restitution, civil judgement), insurance, or any other government or private agency as compensation for this crime after receipt of payment from the Crime Victim Compensation Fund.

_____ **Subrogation agreement:** 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 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) 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 claim is denied, you have the right to request a hearing before the Board. You will be entitled to present additional information for the Board to consider. In the event the denial is upheld by the Board at the reconsideration hearing, you have the right to have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure within 30 days.

RELEASE OF INFORMATION AUTHORIZATION: I hereby authorize the release of all information from my employer, physician, hospital, medical and/or mental health service provider(s) and/or creditor(s) for the purpose of verifying the claims I have submitted related to this crime, or to establish the validity of a restitution claim. I further understand that any information provided may be subject to disclosure under the law.

Printed Name

Signature of Victim / Claimant/ Parent

Date

**Return completed form to: Crime Victim Compensation
201 W. Colfax, Dept. 801
Denver, CO 80202**

**720-913-9253
720-913-9035(fax)**

**Crime Victim Compensation
Release of Information for Employment**

I hereby authorize you to release the employment information requested below to a representative of the Crime Victim Compensation Program of the Denver District Attorney's Office. This release is being executed because of my request for financial compensation from the Crime Victim Compensation Program.

Dated: _____ Signature of Victim or Claimant: _____

Printed Name: _____

Address: _____

Social Security Number or Employee ID number: _____

**Please *do not* complete this portion of the form.
The Crime Victim Compensation Program will send this to your employer for
completion.**

This release is being sent on behalf of the above employee. Please provide us the following information. If you have questions, please call us at **720-913-9253**.

Employee name: _____ Employee SSN/ID _____

Job title: _____ Date hired: _____ Duties: _____

Hours lost: _____ From: _____ To: _____
Month/Day/Year Month/Day/Year

Net income lost: \$ _____ (Minus sick leave)

Employer's representative: _____ Position: _____

Employer's phone number: _____

If the employer is a temp agency, please send a print out for the month work prior to date above.

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Denver, CO 80202**

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(FAX) 720-913-9035**