

DENVER CRIME VICTIM COMPENSATION APPLICATION INFORMATION

Attached is the application for Crime Victim Compensation. The information on the following page and the directions with the application are self-explanatory.

In order to ensure that your application is processed as quickly as possible, please be aware of the following:

- Check to make sure the application is filled out completely. If the application is not complete, it may be returned to you delaying assistance.
- The application **must include the signature** of the victim or claimant.
- If you are sending bills with the application, please **send itemized bills not a payment stub or letter from a collection agency**. If you have not yet received bills, send the completed application and forward the bills as you receive them. Our address is below.
- If you are requesting reimbursement for bills already paid by you, please enclose receipts or other proof of payment.
- 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 \$6,000.
- **Loss of wages can only be paid for time missed from work due to injury**. All requests must be documented by an employer. A release of information is included with the application. If you are self-employed, the Board will only accept documentation of income from a tax return. A doctor's note must accompany any request over 2 weeks. The Board may pay for up to four months or \$6,000.
- The Board can assist up to a **maximum of \$15,000 per claim**. The Board cannot pay for property repair or replacement. The Board cannot pay for pain and suffering

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

Please call the Crime Victim Compensation Program concerning questions about this application or the assistance we can provide. Thank you.

Crime Victim Compensation 720-913-9253
201 W. Colfax, Dept. 801 720-913-9035 (fax)
Denver, CO 80202

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 door, locks, or windows as a result of a compensable crime.
2. The victim must cooperate fully with law enforcement officials, (police, 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.

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

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 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 may 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		Social Security Number	

Mailing Address		Apt#	City/ State/ Zip Code

Home Telephone		Work Telephone	

Date of Birth		Sex: ___ Male ___ Female	

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?	
<input type="checkbox"/> African American	<input type="checkbox"/> Yes	<input type="checkbox"/> Police Victim Advocate	
<input type="checkbox"/> Asian / Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Police Officer	
<input type="checkbox"/> Hispanic / Spanish	<input type="checkbox"/> Mental	<input type="checkbox"/> District Attorney's Office	
<input type="checkbox"/> Native American	<input type="checkbox"/> Physical	<input type="checkbox"/> City Attorney's Office	
<input type="checkbox"/> White		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Other		<input type="checkbox"/> Therapist	
		<input type="checkbox"/> Social Services	
		<input type="checkbox"/> 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		

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:

- Domestic Violence DUI / Vehicular Assault / Vehicular Homicide
 Assault Child Physical Abuse
 Burglary/Criminal Mischief Child Sexual Abuse - by family member
 Sexual Assault - Adult Child Sexual Abuse - non-family member
 Murder / Homicide 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: Hospital: <input type="checkbox"/> yes <input type="checkbox"/> no Doctor : <input type="checkbox"/> yes <input type="checkbox"/> no Inpatient : <input type="checkbox"/> yes <input type="checkbox"/> no Chiropractic: <input type="checkbox"/> yes <input type="checkbox"/> no	Submit copies of itemized medical bills if available: Name of hospital: _____ Dental: <input type="checkbox"/> yes <input type="checkbox"/> no Emergency only: <input type="checkbox"/> yes <input type="checkbox"/> no Physical Therapy: <input type="checkbox"/> yes <input type="checkbox"/> no
--	---

____ Personal Medical Items: Submit copies of itemized bills, if available. (Limited to medically necessary items damaged or destroyed during the crime.) Eyeglasses: <input type="checkbox"/> yes <input type="checkbox"/> no Hearing aid: <input type="checkbox"/> yes <input type="checkbox"/> no	Dentures: <input type="checkbox"/> yes <input type="checkbox"/> no Prosthetic device: <input type="checkbox"/> yes <input type="checkbox"/> no
--	---

SECTION 6 - RELEASE OF INFORMATION, VICTIM RIGHTS AND RESPONSIBILITIES

The application for Crime Victim Compensation will be delayed without the appropriate, original signature.

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 or Claimant

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: _____

**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: _____

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: _____

Please return to : **Crime Victim Compensation**
 201 W. Colfax, Dept. 801
 Denver, CO 80202
 (Phone) 720-913-9253 **(FAX) 720-913-9035**