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:

	cident must have been reported to the Denver Police Departi ate with the investigation and prosecution if a prosecution re	• • •			
	Check to make sure the application is filled out complete and questions are unanswered, it may be return				
	The application <i>must</i> include the signature of the victim under the age of 18 years old.	or of the claimant if the victim is			
	If you have not yet received medical bills, send the complete as you receive them. If you are sending medical bills itemized bills rather than a payment coupon or letter from	with the application, please send			
	If you are requesting reimbursement for bills you have alread or other proof of payment with an itemized copy of the b				
	If you are requesting assistance with dental treatment, the from the dentist <i>before</i> they will review dental bills. Payr to the crime is limited to \$8,000.				
	Loss of wages must be documented by an employer. A with the application. If self-employed, the Board will only most recent income tax return or quarterly income tax state accompany all requests for more than 2 weeks of lost four months or \$6,000.	y accept documentation from the atements. A doctor's note must			
	If you pursue mental health counseling , be aware that the to a licensed therapist or a counselor directly supervised be will determine the number of sessions for which it will pay less Board will pay up to \$90 per individual sessions and up to \$40.	y a licensed therapist. The Board based on the treatment plan. The			
	The Board cannot repair or replace property with the exclocks, and windows damaged as the result of a crime.	eption of exterior residential doors,			
	The Board cannot replace cash or assist with rent or rele	ocation.			
☐ If you have questions on filling out the application including needing reasonable accommodations for hearing impaired, blind or have limited English proficiency please contact Crime Victim Compensation by phone or email for assistance with application.					
	ent is not guaranteed and no one can make that promise Crime Victim Compensation Board.	to you. All decisions are made			
Return	to: Crime Victim Compensation 201 W. Colfax, Dept 801	720-913-9253(Phone) 720-913-9035 (Fax)			

Denver, CO 80202

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.

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 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 \underline{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/ Cell Number		Work Numbe	r
Email Address	-		
Gender Identity: Male Female			
The following information is used for staregulations.	atistical po	urposes only.	It is needed to comply with federal
Race:	isability:	: Who	referred you to this program?
American Indian or Alaskan Native	No		Police Victim Advocate
Asian	Em	otional	Police Officer
Black or African American	Phy	rsical	District Attorney's Office
Hispanic or Latino			City Attorney's Office
Native Hawaiian or Other Pacific Island	ler		Hospital
White Non-Latino or Caucasian			Therapist
Multiple Races			Social Services
			Other
SECTION 2 - CLAIMANT INFORMA victim, i.e. parent, guardian, or relative of the		omplete only if	person submitting application is not the
Claimant's Name		Date of Birth	
Mailing Address Apt.	#	City / State/ Zip Code	
Home /Cell Number		Work Numbe	r
Email Address			
Relationship to Victim			

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

Type of Crime:				
Domestic ViolenceDUI		/ Vehicular Assault / Vehicular Homicide		
Assault	Child Physi	cal Abuse		
Burglary/Criminal Mischief	Child Sexua	al Abuse - by family member		
Sexual Assault - Adult	Child Sexua	al Abuse - non-family member		
Murder / Homicide	Other			
Date of Crime:		Did crime happen at work?YesNo		
Street Location of Crime:		Law Enforcement Agency Investigating		
Police Report Number		Investigating Police Officer / Detective		
Suspect's Name		Suspect's Relationship to Victim:		
		APPLICATION. PLEASE FORWARD ADDITIONAL AS YOU RECEIVE THEM.		
CRIME RE	LATED BILLS			
SECTION 4 - BENEFITS (Please provide the information requested.)	e check each o	AS YOU RECEIVE THEM.		
SECTION 4 - BENEFITS (Please provide the information requested.)	e check each of copies of item	as you receive them. category for which you are requesting assistance and		
SECTION 4 - BENEFITS (Please provide the information requested.) Medical Services: Submit	e check each of copies of item	eategory for which you are requesting assistance and nized medical bills if available:		
SECTION 4 - BENEFITS (Please provide the information requested.) Medical Services: Submit Hospital: _yesno Name of he Doctor: _yesno	e check each of copies of item	category for which you are requesting assistance and nized medical bills if available: 6no		
SECTION 4 - BENEFITS (Please provide the information requested.) Medical Services: Submit Hospital: _yesno Name of he Doctor: _yesno	e check each of copies of item ospital:yes	eategory for which you are requesting assistance and nized medical bills if available:		
SECTION 4 - BENEFITS (Please provide the information requested.) Medical Services: Submit Hospital: _yesno Name of he Doctor: _yesno Inpatient:yesno Emerge	e check each of copies of item ospital: Dental:yes ency only:y Physical There ubmit copies of	eategory for which you are requesting assistance and nized medical bills if available:		
SECTION 4 - BENEFITS (Please provide the information requested.) Medical Services: Submit Hospital: _yesno Name of he Doctor: _yesno Inpatient:yesno Emerge Chiropractic:yesno Personal Medical Items: Se	check each of copies of item ospital:yes ency only:y Physical There ubmit copies of amaged or destricts	eategory for which you are requesting assistance and nized medical bills if available:		

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:	herapist's name: Telephone number:			
Email Address:		 		
Mailing address: Street ad	dala o o	Office number	City/ Ctata/ Zin	Code
Street at	uaress	Office number	City/ State/ Zip	Code
Lost Wages: Are you s	eeking assistand	e with lost wages?	Yes	No
Employer / Company		Contact Person	1	
Mailing Address:				
	address	City/ State/Z		Phone #
How long employed?		Do you have sid	ck leave?	Annual leave?
	<u> </u>			
Funeral Expenses:	Submit copies of	itemized bills if ava	ailable.	
Desidential Door	··· Code th	a f falle and the	if an all all a	alianha ann ann an t-aire
only for exterior residenti				eimbursement is available
Doors:yesno		•	•	•
				<u>,</u>
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 contact the Crime Victim				ich a fatality has occurred, 253)
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 Insurance				
Medicaid				
Medicare				
CICP				
Worker's Compensation				
Homeowner Insurance				

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

Return completed form to:	Crime Victim Compensation 201 W. Colfax, Dept. 801 Denver, CO 80202	720-913-9253 720-913-9035(fax) VictimComp@denverda.org
Printed Name	Signature of Victim / Claimant/	Parent Date
disclosure under the law.	aim. I further understand that any infor	mation provided may be subject to
creditor(s) for the purpose of	f verifying the claims I have submitted re	elated to this crime, or to establish
	an, hospital, medical and/or mental	
RELEASE OF INFORMATI	ON AUTHORIZATION: I hereby author	rize the release of all information
	n: As an applicant you have the right to be noted in the victim Compensation file, or materials in the victim compensation file, or materials in the victim compensation file, or materials in the victim compensation file.	
100.1		
program or District Attorney	lity: Any materials received, made or kept by concerning an application are confidential.	
Procedure within 30 days.	odard's decision reviewed in accordance with	in the Goldrado Hules of Givil
for the Board to consider. I	hearing before the Board. You will be entitle In the event the denial is upheld by the Boar Board's decision reviewed in accordance wit	d at the reconsideration hearing, you
	nsideration: As an applicant, you are advise	
	n Act to be paid directly to the service provic is subject to the availability of funds and the	
	nds: I hereby authorize release of funds aw	
	the extent of such award to any cause or ri	
·	ngreement: The acceptance of a Victim Cor	nneneation Award by an applicant
Program will be repaid if pa	Crime Victim Compensation Award: The ayments are received from the offender, (restricted agency as compensation for this crip Fund.	stitution, civil judgement), insurance,
	use you know two or more Board members eview. I understand that this may delay the	
	lication process: If you feel the Board in th	
Cooperation: I uprosecutors, etc.) may resu	understand that my failure to cooperate with ılt in the denial of my claim.	law enforcement, (police, sheriff,
·	denial of my claim and is punishable by law	
	pplication: The information contained in the correct to the best of my knowledge. I unde	

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:	d: Signature of Victim or Claimant:				
	Printed Name:				
	Address:				
Social Security Numl	per or Employee ID number:				
The Crime V	Please <i>do not complete</i> this ictim Compensation Program completion	will send th			
	ng sent on behalf of the above of have questions, please call us a				
Employee name: _	Employee name: Employee SSN/ID				
Job title:	Date hired:	Duties:			
Hours lost:	From: Month/Day	y/Year	To: Month/Day/Year		
Net income lost: \$_	(Minus	sick leave)			
Employer's representative:			Position:		
Employer's phone	number:				
If the employer is above.	a temp agency, please send a	print out fo	r the month work prior to date		
201 W. Colfax, Dept. 801 Denver, CO 80202 (FAX) 73		(Phone) 720-913-9253			
		V	(FAX) 720-913-9035		