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 $10,000.

☐ **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 $120 per individual sessions and up to $50 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.**

☐ **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.**

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

Amended 5/2023

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 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/ Cell Number ____________________ Work Number ____________________

Email Address ____________________

Gender Identity: ____Male____Female

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

Race:
- __American Indian or Alaskan Native
- __Asian
- __Black or African American
- __Hispanic or Latino
- __Native Hawaiian or Other Pacific Islander
- __White Non-Latino or Caucasian
- __Multiple Races

Disability:
- ___No
- ___Emotional
- ___Physical

Who referred you to this program?
- __Police Victim Advocate
- __Police Officer
- __District Attorney's Office
- __City Attorney's Office
- __Hospital
- __Therapist
- ___Social Services
- Other __________________

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 /Cell Number ____________________ Work Number ____________________

Email Address ____________________

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:** 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:** ______________________

Email Address: ______________________________

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/ Email Address**

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. Please answer all questions

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

________**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 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 judgment), 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.

_________**Claimant Responsibility:** I understand that I am responsible for my bills relating to this crime and have the burden of providing any documentation to the Crime Victim Compensation Board to assist with verification of my claim. It is my responsibility to notify service providers and any collection agencies of my application to Crime Victim Compensation Program.

_________ **Confidentiality:** Any materials received, made or kept by the Crime Victim Compensation program or District Attorney concerning an application are confidential. Colorado Revised Statue 24-4.1-100.1

__________**Notification:** As an applicant you have the right to be notified by the District Attorney's office if a subpoena for your Crime Victim Compensation file, or materials in your file has been issued by the court. Colorado Revised Statue 24-4.1-302.5(VII)

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)
VictimComp@denverda.org

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)

Has this employee been terminated from the position:______________If so, please provide termination date _________

Employer's representative completing form (**printed name**):_____________Position: ___________________

Employer's phone number: _________________________

Employer's representative completing form (**signature**): ________

Date: ________

Please return to:

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201 W. Colfax, Dept. 801
Denver, CO 80202

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

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

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