Victim Compensation Board
Department 5031
P.O. Box 20,000
Grand Junction, Colorado, 81502

Telephone: 970-244-1737
Fax: 970-256-1549

21ST JUDICIAL DISTRICT
CRIME VICTIM COMPENSATION
APPLICATION & INSTRUCTIONS

The Victim Compensation Program operates pursuant to C.R.S. 24-4.1-101 et seq.
Total recovery may not exceed the statutory limit of $30,000. Compensation for some categories is limited by Board Policy.

PLEASE READ AND COMPLETE ALL SECTIONS OF THE APPLICATION; INCOMPLETE APPLICATIONS MAY DELAY PROCESSING.

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 victims must cooperate with law enforcement officials (e.g. District Attorney, Police, Sheriff, etc.)
3. The law enforcement agency was notified within 72 hours after the crime occurred.
4. The injury or death of the victim must not have been the result of the victim's own wrongdoing or substantial provocation.
5. The victimization must have 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 month for residential property damage claims.
7. The crime occurred in Mesa County or in another state or country where there is no victim compensation program and the victim is a resident of Mesa County.

**The Crime Victim Compensation Board MAY waive some of these requirement 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.
3. Compensation for property damage may be awarded for the cost of replacement or repair to exterior doors, locks or window 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 itemized 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 60 days.
7. Total recovery may not exceed the statutory limit of $30,000.
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 on 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 even 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 within 30 days.

APPLICATION INSTRUCTIONS

Pursuant to statute 24.4.1-105(2)(a), the applicant must provide the 21st Judicial District Crime Victim Compensation Program with any information requested by the program as needed to process the application. **Incomplete applications will be returned or delayed until all information is received. Failure to provide information may result in the denial of your claim.**

SECTION 1- VICTIM INFORMATION: The *primary victim* is the person who was *injured or killed*. A *secondary victim* is someone with a close, familial type relationship with the victim or someone who is a witness to the crime. A separate application is required for each family member applying.

SECTION 2- CLAIMANT INFORMATION: This is the person who will be contacted regarding this claim. It may be the same person as the primary victim or it may be a legal guardian or family member of the primary victim. **THIS SECTION MUST BE COMPLETED IF VICTIM IS A MINOR OR DECEASED.**

SECTION 3- CRIME INFORMATION: Completing this entire section, to the best of your knowledge, helps us make sure that we have the correct report to go with your application. You DO NOT need to provide a copy of this report.

SECTION 4- INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION: By federal and state statute, Crime Victim Compensation is the payor of last resort. If you have any other resources available for payment for the bills you are submitting you must disclose this information.

SECTION 5- CIVIL LAWSUIT: If you receive benefits or funds in payment of the same expenses for which are received from the Crime Victim Compensation Program you may be asked to reimburse the Program for the amount paid by the Program.

SECTION 6- REQUEST FOR SERVICES: This section has ten subsections. Mark the services you are requesting assistance with or that you anticipate needing assistance.

- **MEDICAL/DENTAL:** All itemized bills submitted must be **directly** related to the crime and are ultimately your responsibility. Crime related bills or estimates should be forwarded to the Crime Victim Compensation Program as you receive them. If you are requesting reimbursement, please submit receipts or other proof of payment with the itemized bill.
- **PERSONAL MEDICAL ITEMS:** This refers to any medically necessary device that was stolen or damaged as a result of the criminal incident. This includes hearing aids, glasses, dentures, etc. Send itemized bills or estimates.
- **PROPERTY DAMAGE:** The Board cannot repair or replace property with the exception of exterior residential doors and windows. The Board can rekey residential or vehicle locks.
- **BURIAL/FUNERAL EXPENSES:** Please let us know if you have already paid for funeral expenses or if the bill remains outstanding. Submit all bills or receipts that you wish to be considered for payment or reimbursement. The person who paid for the funeral is the person eligible to receive reimbursement if the claim is approved.
- **LOST WAGES:** You may request loss of earnings only if you missed work because of physical or emotional injuries related to the crime and you did not take paid leave provided by your employer. A Loss of Wages Form will be mailed to your employer to complete. If you are self-employed, you will be asked to submit a copy of your last year's tax return. A doctor's note may be requested for more than 5 days of lost wages. Loss of income due to the investigation, medical/counseling appointment and court hearings is not eligible. Money stolen during a crime is not an eligible expense.
- **CRIME SCENE CLEANUP:** This refers to cleaning of a personal residence that has been stained with bodily fluids/matter, tear gas or other items that leave the residence uninhabitable as a result of a compensable crime. The service of cleaning a crime scene, in connection with a compensable crime, must be performed by a professional cleaning agency.
- **MENTAL HEALTH COUNSELING:** For primary and secondary victims or witnesses to a crime. The Board will only approve therapy with state licensed therapists or a treatment provider under the direct supervision of one who is so licensed.
- **RELOCATION:** The Board may consider paying up to $2,000 of relocation expenses incurred as a result of a crime. Please submit bill related to moving (truck, movers, etc.) or a copy of a NEW, SIGNED lease for payment of first month's rent.
- **HOUSEHOLD SUPPORT:** This refers to monetary support that a dependent would have received from the accused for the purpose of mandating a home or residence. Bills or receipts for household expenses must be submitted with the application.
- **LOSS OF SUPPORT-DEATH OF VICTIM:** If the primary victim has died as a result of a crime, persons who were wholly or partially dependent upon the primary victim's income may request funds for loss of support.

SECTION7- RELEASE OF INFORMATION AND VICTIM RIGHTS AND RESPONSIBILITES: Your initials by each section, as well as your signature and the date are necessary to complete the application and to authorize the Crime Victim Compensation Program to verify bills on your behalf. An incomplete application may be returned to you and will delay payment.

☐ **EMERGENCY REQUEST**
Emergency Requests must be made within 5 business days of the crime.

APPLICATION

Return application and crime related bills to:
Victim Compensation Program
PO BOX 20,000, Dept. 5031 *Fax: 970-256-1549*
Grand Junction, CO 81502

SECTION 1: CLAIMANT INFORMATION (PLEASE TYPE OR PRINT)

Please complete every question. Write N/A when a question does not apply to you.

Are you the: ____ **Primary Victim** ____ **Secondary Victim**

The person who was **injured or killed** is considered the **primary victim**.
A **secondary victim** is someone with a close, familial type relationship with the victim or someone who is a witness to the crime.

Name ***(First,Middle,Last)*****:** _____

Date of Birth: _____ **Age When Crime Occurred:** _____ **Gender:** ____ Male ____ Female

Mailing Address: _____

City, State, Zip: _____

State of Residency: _____

Primary Telephone: _____ **Secondary Telephone:** _____

Email: _____

Preferred method of receiving communications from the Crime Victim Compensation Program: ____ Mail ____ Email

THE FOLLOWING INFORMATION IS USED FOR STATISTICAL PURPOSES ONLY. IT IS NEEDED TO COMPLY WITH FEDERAL REGULATIONS.

Disabled Prior to Crime: ____ No ____ Yes → **If 'Yes', check all that apply:** ____ Physically ____ Mentally

Race:
____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ Hispanic or Latino
____ Native Hawaiian or Other Pacific Islander
____ White Non-Latino or Caucasian
____ Other _____
____ Multiple Races

Who referred you to the program?
____ District Attorney's Office
____ Hospital/Doctor
____ Human Services
____ Law Enforcement
____ Therapist
____ Victim Advocate
____ Other:_____

SECTION 2: CLAIMANT INFORMATION

Please complete if the victim listed in Section 1 is a minor, deceased or incapacitated. This is the person who will be contacted regarding this claim.

Claimant's Name: _____

Gender: ____ Male ____ Female **Date of Birth:** _____

Relationship to Victim: _____

Mailing Address: _____

City, State, Zip: _____

Primary Telephone: _____ **Secondary Telephone:** _____

Email: _____

Preferred method of receiving communications from the Crime Victim Compensation Program: ____ Mail ____ Email

APPLICATION

SECTION 3: CRIME INFORMATION

Please complete this section as completely as possible**.**

TYPE OF CRIME:

____ Assault ____ Burglary ____ Careless Driving- Injury/Death ____ Child Physical Abuse
____ Child Sexual Assault- Family ____ Child Sexual Assault- Non-Family ____ Criminal Mischief ____ Domestic Violence
____ Drunk Driver ____ Hit & Run Causing Injury ____ Homicide/Murder ____ Kidnapping
____ Robbery ____ Sexual Assault- Adult ____ Vehicular Assault/Homicide
____ Other: _____

CRIME/REPORTING INFORMATION:

Date of Crime: _____ Date Crime Reported to Law Enforcement _____

Crime Report Number**:**_____ Agency Crime Reported To: _____

Law Enforcement Officer Handling Case:_____

County Where Crime Occurred: _____

Did the crime occur at work? ____ Yes ____ No

CASE/SUSPECT INFORMATION:

Court Case Number _____ Who Committed the Crime?_____

Suspect's Relationship to Victim: _____

Briefly describe injuries related to the crime: _____
_____
_____
_____

SECTION 4- INSURANCE INFORMATION

By law the Crime Victim Compensation Program is payor of last resort. Crime expenses must be submitted to **all** available financial assistance programs prior to Program review. Please indicate it the victim is insured.

Do you have health insurance coverage? ____ No ____ Yes *If 'Yes', please indicate which type(s):*

____ Medicaid ____ Medicare ____ CHP+ ____ Colorado Indigent Program ____ Private Insurance

Policy Holder: _____
Company Name:_____
Policy Number: _____ Deductible Amount:_____

Do you have automobile insurance? ____ No ____ Yes

Policy Holder: _____
Company Name:_____
Policy Number: _____ Deductible Amount:_____

Do you have homeowner's insurance? ____ No ____ Yes

Policy Holder: _____
Company Name:_____
Policy Number: _____ Deductible Amount:_____

Do you have any other insurance? ____ No ____ Yes *If 'Yes', please indicate which type(s):*

____ Life Insurance ____ Disability ____ Worker's Compensation ____ Other: _____

Company Name:_____
Policy Number: _____

SECTION 5: CIVIL LAWSUIT INFORMATION

You may be asked to repay the Crime Victim Compensation Fund if you receive payments that cover the same losses for which the Crime Victim Compensation Fund paid.

Are you planning to sue the person(s), business/agency responsible for this injury? ____ No ____ Yes

If, yes, please provide the following information:

Name of Attorney: _____

Mailing Address: _____

City, State, Zip: _____ Phone: _____

The Crime Victim Compensation Board must be notified of any civil action and be provided written evidence of the amount of settlement.

APPLICATION

SECTION 6: REQUEST FOR SERVICES

Please mark the appropriate boxes for services you are requesting. Please include copies of itemized bills. If you do not have itemized bills at this time, please forward them upon receipt.

____ MEDICAL/DENTAL – Please check the appropriate box for the type(s) of medical or dental bills incurred as a result of the crime. Victim Compensation is the payor of last resort. All bills must be submitted to insurance prior to payment by the program.

____ Hospital ____ Chiropractic ____ Physical therapy ____ Physician/Doctor ____ Home Nursing Care ____ Dental

____ PERSONAL MEDICAL ITEMS – Please check the appropriate box for the type(s) of item you are requesting to be repaired or replaced.

____ Eyeglasses/Contact Lenses ____ Dentures ____ Hearing Aids ____ Prosthetic Device

____ PROPERTY DAMAGE – Please check the appropriate box for the repair or replacement of residential entry/exit doors, locks, and windows damaged as a result of the crime. Please check the appropriate box for rekeying of residential or vehicle locks for safety purposes.

RESIDENTIAL: **____** Doors ____ Locks ____ Windows
REKEYING: **____** Residential ____ Vehicle ____ Other (please list)_____

____ RELOCATION OR ____ HOUSEHOLD SUPPORT (YOU CAN NOT APPLY FOR BOTH)

YOU MUST COMPLETE PAGE 6 FOR RELOCATION ASSISTANCE OR HOUSHOLD SUPPORT.

____ BURIAL/FUNERAL EXPENSES- ($10,000 Limit: $6,000 Funeral/Crematory/Burial, $4,000 Cemetery/Grave Marker, $2,000 Transportation of Body out of State for Burial) Please check the appropriate box below. Submit itemized bills.

____ The bill has already been paid. ____ The bill is outstanding.

Name & Phone # of Funeral Home: _____

____ LOST WAGES (Limit of 80% of gross wages for up to 8 weeks) We will contact your employer. If you are self-employed, a copy of last year's tax return must be provided. **Any request for more than five days requires verification from your physician that you were unable to work due to the injuries from the crime.**

Dates Missed: From _____ To _____

Employer's Business Name: _____

Mailing Address:_____

City/State/Zip:_____

Contact Person: _____ Phone Number: _____

Reason for missing work: _____

____ CRIME SCENE CLEAN-UP (<u>$2,500 maximum</u>) This service must be performed by a professional cleaning agency. To be eligible for this service the crime scene must be stained with bodily fluids/matter, tear gas or other items that leave the residence uninhabitable. This award does not include any crime scene damages caused by the collection of evidence for investigation.

____ LOSS OF SUPPORT- DEATH OF VICTIM – (Limit of 80% of gross wages for up to 8 weeks) The Victim must have been the primary source of support to the dependent family. The persons were wholly or partially dependent upon the primary victim's income may request funds for loss of support.

YOU MUST COMPLETE PAGE 7 FOR LOSS OF SUPPORT- DEATH OF VICTIM.

____ MENTAL HEALTH SERVICES – Please check the appropriate box for the mental health services requested. All mental health services must be **directly** related to the crime for which the claim is approved. Verification from your psychiatrist/treating physician that the medications are necessary due to the crime is required for psychiatric medications.

____ Counseling/Therapy ____ Psychiatric Medications

Therapist's Name:_____

License Number: _____

Mailing Address: _____

City/State/Zip: _____

Phone:_____

RELOCATION OR HOUSEHOLD SUPPORT APPLICATION

SELECT ONLY ONE- YOU CANNOT APPLY FOR BOTH

____ **RELOCATION:** Crime Victim Compensation may consider paying up to $2,000 of relocation expenses incurred as a result of a crime. If approved, you will have 60 days from the date of the award to utilize this award. Please submit bills related to moving (truck, movers, etc.) or a copy of a NEW, SIGNED lease for payment of first month's rent.

Is there an active No Contact/Protection/Restraining Order in place? ____ Yes ____ No

If 'No' please explain:_____

Do you have a safe place to relocate to? ____ Yes ____ No

Please, briefly, explain the reason you are requesting relocation assistance as a result of your victimization:

_____

_____

_____

_____

_____

____ **HOUSEHOLD SUPPORT**: CVC may consider paying victims of **Child Sexual Assault- Family** and **Domestic Violence** up to 80% of the offender's gross wages for up to 8 weeks, which has been lost, as a result of the perpetrator/offender being removed from or leaving the family.

Is there an active No Contact/Protection/Restraining Order in place? ____ Yes ____ No

If 'No' please explain:_____

Did you and the offender reside together at the time of the crime? ____ Yes ____ No

Are you and the offender currently/still living together? ____ Yes ____ No

Was the offender providing you financial support at the time of the crime? ____ Yes ____ No

If 'Yes', what level of support was the offender providing? ____ Full ____ Partial ____ No Support

Defendant/Offender's Monthly Income: $_____ ***Provide documentation of defendant's income/ wages (check stubs, tax returns, etc.)***

Victim's Monthly Income: $_____ ***Provide documentation of income (check stubs, tax returns, etc.)***

Sources of Income (check all that apply) ***Amount per Month***

____*Employment:* $_____

____*Child Support:* $_____

____*Food Stamps:* $_____

____*Other:* $_____

Please provide the dollar amount of the monthly expenses paid by each party in the table below.

	OFFENDER PAID	YOU PAID
RENT/MORTGAGE	$	$
GAS/ELECTRIC	$	$
WATER/SEWER	$	$
PHONE	$	$
FOOD	$	$
OTHER (PLEASE LIST):	$	$
TOTAL	**$**	**$**

Number of Dependents: _____

Names and Ages of Dependents: 1. _____

2. _____

3. _____

4. _____

5. _____

LOSS OF SUPPORT- DEATH OF VICTIM

____ **LOSS OF SUPPORT:** The victim **must** have been the primary source of support to the dependent family. The board requires verification of victim income. The Board may consider a maximum of 80% of two months (8 weeks) gross earnings based on the victim's employment. The victim **must** have been lawfully employed. Loss of support awards will be divided among surviving dependents. The Board may request verification of dependency (birth certificate, divorce/custody decree, court orders, etc.).

Victim's Employer Business Name: _____

Mailing Address: _____

City/State/Zip: _____

Phone Number: _____

Victim's Monthly Income: $_____ ***Provide documentation of defendant's income/ wages (check stubs, tax returns, etc.)***

Was the victim providing you financial support at the time of the crime? ____ Yes ____ No

If 'Yes', what level of support was the victim providing? ____ Full ____ Partial ____ No Support

Did the dependents and the victim reside together at the time of the crime? ____ Yes ____ No

PLEASE LIST THE VICTIM'S DEPENDENTS OR OTHERS WHO DEPENDEND ON THE VICITM FOR SUPPORT:

Number of Dependents: _____

Dependent: 1. _____ _____
Name (First,Middle,Last) Date of Birth

_____ Are you the legal guardian? ____ Yes ____ No
Relationship to Victim

Dependent: 2. _____ _____
Name (First,Middle,Last) Date of Birth

_____ Are you the legal guardian? ____ Yes ____ No
Relationship to Victim

Dependent: 3. _____ _____
Name (First,Middle,Last) Date of Birth

_____ Are you the legal guardian? ____ Yes ____ No
Relationship to Victim

Dependent: 4. _____ _____
Name (First,Middle,Last) Date of Birth

_____ Are you the legal guardian? ____ Yes ____ No
Relationship to Victim

Dependent: 5. _____ _____
Name (First,Middle,Last) Date of Birth

_____ Are you the legal guardian? ____ Yes ____ No
Relationship to Victim

Do the dependents have access to other sources of income? ____ Yes ____ No

If, 'Yes', list the dependents' TOTAL Monthly Income: $_____ ***Provide documentation of income (check stubs, tax returns, etc.)***

Sources of Income(check all that apply) ***Amount per Month_____***

____*Employment:* $_____

____*Child Support:* $_____

____*Food Stamps:* $_____

____*Other:* $_____

APPLICATION

ALL APPLICANTS, 18 OR OLDER, MUST INITIAL AND SIGN THIS PAGE.

Initial Each Box

☐ **ALTERNATIVE APPLICATION PROCESS:** If you believe the Victim Compensation Board in the 21st Judicial District is unable to impartially review your claim due to a personal or professional relationship(s) with two or more Board members, it will be sent to another district for review. The 21st Judicial District must receive a request for alternative review in writing. If your claim is approved, bills will be paid from the 21st Judicial District. I understand that this may delay the processing of my claim.

☐ **CERTIFICATE OF APPLICATION:** The information contained in this application for a Crime Victim Compensation is true and correct to the best of my knowledge. I understand that untruthful statements provided or falsified documentation submitted may result in a denial of my claim and is punishable by law.

☐ **CLAIMANT RESPONSIBILITY:** I understand that I am responsible for my bills relating to this crime and the burden of providing any documentation to the Crime Victim Compensation Board to assist with verification of my claim. I must also notify service providers of my application to the Crime Victim Compensation Program.

☐ **COOPERATION:** I understand that my failure to cooperate with law enforcement (police, sheriff, prosecutor, etc.) may result in the denial of my claim.

☐ **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)/out of pocket claimant as applicable to my claim. I understand that any claim request approval is subject to the availability of funds and the discretion of the Board. I understand that the Crime Victim Compensation Fund is the payor of last resort.

☐ **RELEASE OF INFORMATION AUTHORIZATION:** I have been advised of C.R.S. § 24-4. 1-107.5- Confidentiality of Materials. Understanding that this release authorizes the below listed entities to provide materials to the Crime Victim Compensation Board, and that the materials may not be further disseminated without my approval, or order of the court, I authorize the following: I hereby authorize the release of all information from my employer, physician, hospital, Department of Human Services, civil attorney, medical and/or mental health service providers, and/or any other creditors or agency for the purpose of verifying the claims I have submitted to establish validity of a claim. I further understand that any information provided may be subject to disclosure under the law. This authorization may be revoked at any time in writing, except to the extent that action has already been taken in reliance upon it. My signature authorizes release of all such information as specified above. A photocopy or exact reproduction of this signed release shall have the same force and effect as the original.

☐ **REPAYMENT OF CRIME VICTIM COMPENSATION AWARD:** I agree to repay the Crime Victim Compensation Program if payments are received from the offender, including restitution or civil action, insurance, or any other government of private agency as compensation for this injury or death after the receipt of payment from the Victim Compensation Fund.

☐ **RIGHT TO RECONSIDERATION:** Should my claim for compensation be denied, I will be notified of the reason in writing, I understand that I have the right to request reconsideration by the Crime Victim Compensation Board and may do this by submitting a letter which addresses the reason for the denial as stated in the letter. The Crime Victim Compensation Board, in its discretion, may conduct a hearing to reconsider the denied claim. I understand that the burden of proof is upon me as the applicant to show the claim is reasonable and compensable under the Colorado Crime Victim Compensation Act. In the event the denial is upheld by the Board following the reconsideration, I understand that I may have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedures by a district court within 30 days.

☐ **SUBROGATION:** I hereby agree to immediately inform the Crime Victim Compensation Fund Board whenever any crime-related recovery is expected or received. Pursuant to C.R.S. §24-4.1-116, I promise to repay the Crime Victim Compensation award to cover the same losses for which I received payments from the Crime Victim Compensation Fund. I acknowledge and agree that the sources of recovery this subrogation agreement will pertain to include, but are not limited to, the following types of recovery sources: court-imposed restitution, civil judgments against the offender or other liable/obligated third parties, insurance settlements, or settlements/benefits from any other governmental or private agency. I further agree and understand that no part of the recovery to the Crime Victim Compensation Fund may be diminished by any collection fees, attorney's fees, or for any other reason whatsoever.

Information provided to the 21st Judicial District Crime Victim Compensation Board may be discoverable in the criminal case.

I, the applicant to the Crime Victim Compensation of the 21st Judicial District, hereby state that the information provided in this application is accurate.

_____ _____ _____

Printed Name | Signature of Victim or Claimant | Date