



**SECTION III – CRIME INFORMATION**

Type of Crime

<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Assault	<input type="checkbox"/> Homicide
<input type="checkbox"/> Child Physical Abuse	<input type="checkbox"/> Child Sexual Assault – Family	<input type="checkbox"/> Child Sexual Assault – Non Family
<input type="checkbox"/> Adult Sexual Assault	<input type="checkbox"/> Drunk Driver	<input type="checkbox"/> Burglary/Criminal Mischief
<input type="checkbox"/> Other _____		

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Date of crime \_\_\_\_\_ Date crime was reported \_\_\_\_\_

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Law enforcement agency that took report \_\_\_\_\_ Incident/Case number \_\_\_\_\_

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Law enforcement officer handling case \_\_\_\_\_ Address where crime occurred \_\_\_\_\_

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Name of perpetrator \_\_\_\_\_ Perpetrator relationship to victim \_\_\_\_\_

**SECTION IV – INSURANCE INFORMATION** By law, Crime Victim Compensation is the payor of last resort. All applicable insurance must be utilized prior to Crime Victim Compensation. You may also be required to apply for alternative sources prior to Crime Victim Compensation to include Medicaid, Medicare, etc.

Do you have health insurance coverage? \_\_\_\_\_Yes \_\_\_\_\_No  
Do you have automobile insurance? \_\_\_\_\_Yes \_\_\_\_\_No  
Do you have homeowner’s insurance? \_\_\_\_\_Yes \_\_\_\_\_No

**If YES TO ANY OF THESE, PLEASE READ AND COMPLETE THE FOLLOWING:**

<b>If yes,</b> please check which type:	<b>If yes,</b> please complete:
_____Private Insurance	Policyholder_____
_____Group Insurance	Company Name_____
_____Medicaid	Phone Number_____
_____Medicare	Policy Number_____
_____Worker’s Compensation	Amount of Deductible_____
_____Department of Social Services	
_____CHP	
_____Colorado Indigent Program	
_____Other_____	

**SECTION V – CIVIL LAWSUIT** – The Crime Victim Compensation Board must be notified of any civil action and be provided with written evidence of the amount of settlement.

Are you planning to sue the person(s), business/agency responsible for this injury?  YES  NO

If yes, please provide the following information:

Name of Attorney \_\_\_\_\_

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Mailing Address \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_ Telephone Number \_\_\_\_\_

**PLEASE RETURN APPLICATION TO: VICTIM COMPENSATION, DISTRICT ATTORNEY’S OFFICE, 201 LA PORTE AVE., SUITE 200, FT. COLLINS, CO 80521-2763 (970) 498-7285**

**SECTION VI – TYPE OF CLAIM** - Please mark the appropriate box(s) for services you are requesting compensation for. Specific documentation is required before payment can be made on approved claims. Please include copies of itemized bills with this application. If you do not have itemized bills at this time, please forward them upon receipt.

**MEDICAL/DENTAL**

**MEDICAL ITEMS** – Please check the appropriate box.  
 Eyeglasses/Contact Lenses    Dentures    Hearing Aid    Prosthetic Device

**RESIDENTIAL PROPERTY** – Please check the appropriate box for the repair or replacement of entry/exit doors, locks, and windows of a residence only.  
 Doors    Locks    Windows    Rekeying   Residential insurance deductible amount: \$ \_\_\_\_\_

**RELOCATION** OR  **SHELTER ASSISTANCE** (YOU CAN NOT APPLY FOR BOTH)  
**YOU MUST COMPLETE PAGE 4 FOR RELOCATION OR SHELTER ASSISTANCE.**

**BURIAL EXPENSES** – Maximum of \$6,000.00 for burial or cremation.

**LOSS OF SUPPORT** – Limited to spouse and/or minor children of deceased victim.

Name _____	Date of Birth _____	Relationship to deceased _____
Name _____	Date of Birth _____	Relationship to deceased _____
Name _____	Date of Birth _____	Relationship to deceased _____

**EMPLOYMENT LOSS** – Maximum of \$5,000.00. A letter from your employer will be required. If you are self-employed, a copy of last year's tax return must be provided. Any request for more than three days requires verification from your physician that you were unable to work due to the injuries from this criminal act.

Dates missed: From \_\_\_\_\_ To \_\_\_\_\_

Employer's Business Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number; \_\_\_\_\_

Reason for missing work: \_\_\_\_\_

**PSYCHOLOGICAL COUNSELING** – All mental health sessions must be directly related to the crime in which the claim is approved.

**PLEASE LIST THE NAMES OF ALL PERSONS YOU ARE REQUESTING THERAPY FOR**

Name _____	Date of Birth _____	Relationship to victim _____
Name _____	Date of Birth _____	Relationship to victim _____
Name _____	Date of Birth _____	Relationship to victim _____

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**RELOCATION AND SHELTER ASSISTANCE APPLICATION**

To qualify for relocation or shelter assistance there must be an active "No Contact Order/Protective Order" between the victim and the offender.

**FOR RELOCATION:** Victim Compensation will consider up to \$1000.00 towards relocation. If approved, you will have 60 days from the date of the crime 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/Restraining Order in place?                      Yes      No      Explanation\_\_\_\_\_

Do you have a safe place to relocate to?    Yes      No      Explanation\_\_\_\_\_

**FOR SHELTER:** A maximum of one month rent/mortgage will be considered up to \$1000.00. You must have lost your financial support relating to payment of rent/mortgage as a result of the crime. You must attach a copy of your lease/mortgage statement and proof that rent/mortgage is paid to date. If the offender's name remains on the lease/mortgage, you are eligible for one half of the total monthly payment not to exceed \$500.

Is there an active No Contact/Restraining Order in place?                      Yes      No      Explanation\_\_\_\_\_

Was the offender living with and/or providing you financial support?      Yes      No      Explanation\_\_\_\_\_

PLEASE EXPLAIN BRIEFLY THE REASON YOU ARE REQUESTING RELOCATION/ SHELTER ASSISTANCE AS A RESULT OF YOUR VICTIMIZATION.

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**SECTION VII – RELEASE OF INFORMATION AND VICTIM’S RIGHTS AND RESPONSIBILITIES**  
**Please read and initial each statement.**

\_\_\_\_ **Certification of Application:** The information contained in this application for a Crime Victim Compensation award 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 with Prosecution:** I understand that my failure to cooperate with law enforcement (police, sheriff, prosecutor, etc.) may result in the denial of my claim.

\_\_\_\_ **Alternative Application Process:** If you feel the Compensation Board in your judicial district is unable to fairly review your claim due to a personal or professional relationship with two or more Board members, it will be sent to another district for review. If your claim is approved, bills will be paid from this office. I understand that this may delay the processing of my claim.

\_\_\_\_ **Repayment of Crime Victim Compensation Award:** I agree to repay the Crime Victim Compensation Program if payments are received from the offender (restitution or civil action), insurance, or any other government or private agency as compensation for this injury or death after receipt of payment from the 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 Information Authorization:** I hereby authorize the release of information from my employer, physician, hospital, medical/psychiatric records, school, therapist, the Department of Human Services, investigating law enforcement agency, civil attorney or creditor to the Crime Victim Compensation Board for the purpose of verifying my claim. I also authorize the release of my account ledger from the Crime Victim Compensation Board to my therapist for the purpose of verifying my account balance.

\_\_\_\_ **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 Crime Victim Compensation claim is denied you have the right to request a reconsideration hearing before the Crime Victim Compensation Board. You will be entitled to present evidence and witnesses. At said hearing, the burden of proof is upon you as the applicant to show that the claim is reasonable and compensable under the terms of the Colorado Crime Victim Compensation Act. In the event the denial is upheld by the Board at the reconsideration hearing, the applicant has the ability to have the Board’s decision reviewed in accordance with the Colorado Rules of Civil Procedure.

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE OF VICTIM OR CLAIMANT

\_\_\_\_\_  
DATE

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