



# Crime Victim Compensation Eighth Judicial District

201 LaPorte Avenue Ste 200  
Fort Collins CO 80521  
970-498-7290

[www.larimer.org/da/vicwit/compensation.htm](http://www.larimer.org/da/vicwit/compensation.htm)

## APPLICATION

The Victim Compensation Program operates pursuant to C.R.S. 24-4.1, Part 1. 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 victim must cooperate with law enforcement officials (District Attorney, police, etc.)
3. The police must have been 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 months for property damage claims.

\*The Compensation Board MAY waive some of these requirements for good cause or in the interest of justice

### SECTION I – VICTIM INFORMATION

Victim's Name (Last, First)	Date of Birth	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (Street)	City, State, Zip	
Primary Telephone	Secondary Telephone	Email Address
Preferred method of notification: <input type="checkbox"/> Mail <input type="checkbox"/> 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 one:  Physical  Mental

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  Some Other Race  
 Multiple Races

Who referred you to this program?  Law Enforcement  District Attorney  Human Services  
 Hospital/Doctor  Therapist  Other \_\_\_\_\_

**SECTION II – CLAIMANT INFORMATION** Complete only if person submitting application is not the victim, i.e.: victim's parent or guardian or relative of victim.

Claimant's Name (Last, First)	Relationship to Victim	Date of Birth
Mailing Address (Street/PO Box, City, State, Zip Code)		
Primary Telephone	Secondary Telephone	Email Address

**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:
<input type="checkbox"/> Private Insurance	Policyholder _____
<input type="checkbox"/> Group Insurance	Company Name _____
<input type="checkbox"/> Medicaid	Phone Number _____
<input type="checkbox"/> Medicare	Policy Number _____
<input type="checkbox"/> Worker's Compensation	Amount of Deductible _____
<input type="checkbox"/> Department of Social Services	
<input type="checkbox"/> CHP	
<input type="checkbox"/> Colorado Indigent Program	
<input type="checkbox"/> 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 \_\_\_\_\_

**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 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 other locks for safety purposes.

RESIDENTIAL    Doors    Locks    Windows  
REKEYING    Residential    Vehicle    Other (please list) \_\_\_\_\_  
Residential insurance deductible amount: \$ \_\_\_\_\_

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

**YOU MUST COMPLETE PAGE 4 FOR RELOCATION ASSISTANCE OR HOUSEHOLD SUPPORT.**

**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 \_\_\_\_\_

**RELOCATION OR HOUSEHOLD SUPPORT APPLICATION**

Only complete relocation section on this page if you are requesting assistance with relocation.  
 Only complete household support section on this page if you are requesting assistance with household support.  
 YOU CANNOT APPLY FOR BOTH.

**RELOCATION:** Crime Victim Compensation may consider paying up to \$1,000.00 of relocation expenses incurred as a result of a crime. 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\_\_\_\_\_

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

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**HOUSEHOLD SUPPORT:** Crime Victim Compensation may consider paying up to \$1,000.00 of Household Support which has been lost as a result of the crime.

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

Did you and the offender reside together at the time of the crime?  Yes  No Explanation\_\_\_\_\_

Are you and the offender currently/still living together?  Yes  No Explanation\_\_\_\_\_

Was the offender providing you financial support at the time of the crime?

Full Support  Partial Support  No Support Explanation\_\_\_\_\_

Is the offender providing financial support to you now?

Full Support  Partial Support  No Support Explanation\_\_\_\_\_

Please provide the dollar amount of the monthly expenses paid by each party at the time of the crime.

	Offender Paid	You Paid
Rent/Mortgage	\$	\$
Gas/Electric	\$	\$
Water/Sewer	\$	\$
Phone	\$	\$
Food	\$	\$
Other (please list)	\$	\$
<b>TOTAL</b>	\$	\$

**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

**Submit completed applications to:  
Crime Victim Compensation  
201 LaPorte Ave Ste 200  
Fort Collins CO 80521-2763  
Fax: 970-498-7250  
Email: VictimComp@co.larimer.co.us**