Crime Victim Compensation Board 20th Judicial District
1035 Kimbark Street, Longmont, CO 80501
Phone: (720)564.2835 Fax: (303) 416.8721
Email: victimcomp@bouldercounty.gov

CRIME VICTIM COMPENSATION FUND APPLICATION

Eligibility Requirements*:

- The victim sustained mental injury, physical injury, death or damage to exterior residential doors, locks or windows as the result of a compensable crime.
- The victim cooperated with law enforcement officials (law enforcement, district attorney, police, etc.).
- The crime was reported to a law enforcement agency within 72 hours.
- The injury or death of the victim was not the result of the victim's own wrongdoing or substantial provocation.
- The victimization occurred on, or after July 1, 1982.
- The application was submitted within one year from the date of the crime, or, six months for residential property damage to exterior doors, locks, or windows.
- The crime occurred in Boulder County, or, the victim is a resident of Boulder County, but the crime occurred in state or country that does not have a CVC program.

* The Crime Victim Compensation board may waive some of the above listed requirements for good cause or in the interest of justice.

General Information:

- There does not need to be an arrest or charges filed for a victim to be eligible.
- Compensation may be requested for medical/dental expenses, mental health therapy, medically necessary devices (dentures, eyeglasses, hearing aids, prostheses), loss of income due to injury, funeral expenses, exterior residential doors/locks/windows, car re-keying, loss of support to dependents in the event of death, household support, self-defense and security systems.
- Requests must be directly related to the crime reported to law enforcement. Services may be limited by CVC policy.
- Compensation for property damage may be awarded for the repair or replacement of exterior residential doors, locks, and windows that are damaged during the commission of a crime. Re-keying of vehicle or other safety lock may be considered.
- By law, you must apply for all other sources of financial assistance or reimbursement, including private insurance, Medicaid and Medicare.

- Please attach all bills, receipts, and estimates directly related to the crime. You may apply if you have not received an invoice or bill, but please forward bills as you receive them. If any crime related bills have been turned over to a collections agency, please contact the CVC program using the contact information on this application.
- Your claim will be verified and presented to the CVC Board. This process can take 45-60 days.
- Compensation may not exceed $30,000. Compensation for individual categories is limited by Board policy. You will be notified in writing of the Board's decision and payments made to providers.
- If you need emergency financial assistance, please contact the police/law enforcement agency where the crime was reported and inquire about emergency financial assistance.
- The Crime Victim Compensation Program does not discriminate on the basis of race, color, national origin, religion, gender, disability, age, or sexual orientation.
- If the victim/applicant is hearing or vision impaired, please contact the CVC program for assistance using any of the contact information on this application for accommodations.
- If the victim/applicant has limited English proficiency, please contact the CVC program for assistance using any of the contact information on this application for accommodations.
- All materials made or kept by the CVC program or the District Attorney concerning an application made under C.R.S. 24-4.1-100.1 are confidential. However, your application and information in your claim file may be subject to discovery during the court process.
- Victims have a right to be notified by the District Attorney's Office if a subpoena has been issued by the court for the CVC claim file, or materials in the CVC claim file, for which the victim submitted an application.

SECTION 1 – VICTIM INFORMATION:

Please complete every question. Write N/A when a question is not applicable.

Victim Name (First, Middle, Last):		
Birth Date:		
Gender:	☐ Male	☐ Female
Age at time of crime:		
Mailing Address:		
City:		
State:		
Zip:		
Phone Number:		
Email Address:		

Disabled prior to crime?

Mentally	☐ Yes	☐ No
Physically	☐ Yes	☐ No

Race

☐	African American / Black
☐	Asian
☐	Hispanic / Latin American
☐	Pacific Islander / Native Hawaiian
☐	American Indian / Alaskan Native
☐	White Non-Latino or Caucasian
☐	Multiple Race
☐	Other:

Referral Source

☐	Police Agency Victim Advocate
☐	District Attorney Victim Advocate
☐	Service Provider
☐	Social Services
☐	Hospital / Medical Facility
☐	Mental Health Counselor
☐	Other:

SECTION 2 - CLAIMANT INFORMATION:

Please complete if the victim is a minor, deceased or incapacitated.

Claimant's Name (First, Middle, Last):		
Birth Date:		
Gender:	☐ Male	☐ Female
Relationship to Victim:		
Mailing Address:		
City:		
State:		
Zip:		
Phone Number:		
Secondary Phone / Email Address:		

Section 3 – Crime Information:

☐	Adult Sexual Assault	☐	Child Physical Abuse	☐	Drunk Driver
☐	Assault	☐	Child Sexual Assault	☐	Murder / Homicide
☐	Burglary / Criminal Mischief	☐	Domestic Violence	☐	Other:

Date of Crime:	
Reported Date:	
Police Agency that took report:	
Incident / Case number:	
Police Officer assigned:	
Who committed the crime?	
Relationship to victim	

SECTION 4 – INSURANCE/OTHER COLLATERAL SOURCE INFORMATION:

Crime expenses must be submitted to all available financial assistance programs prior to CVC review. Please indicate if the victim is insured.

Medical Insurance:	☐ Yes	☐ No
Disability:	☐ Yes	☐ No
Auto Insurance:	☐ Yes	☐ No
Worker's Compensation:	☐ Yes	☐ No
Life Insurance:	☐ Yes	☐ No
Homeowner's / Renters Insurance:	☐ Yes	☐ No
Medicare / Medicaid:	☐ Yes	☐ No
Other:		

SECTION 5 - REQUEST FOR SERVICES:

Please check the boxes for the service(s) you would like to request.
Additional eligibility requirements may apply.

☐ **MENTAL HEALTH COUNSELING:**

Please list the names of secondary victims that would like mental health counseling. All persons over 18 must sign the last page of the application. Add paper as necessary.

Name of Family Member	Relationship to Victim	Date of Birth	Medical Insurance	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

☐ **MEDICAL/DENTAL OR PERSONAL MEDICAL ITEMS:**

You must submit copies of crime related itemized bills. Please select the services that you have received and/or will need due to the crime

☐	Hospital	☐	Chiropractic / Physical Therapy
☐	Physician	☐	Eyeglasses / Contact Lenses
☐	Medication	☐	Dental
☐	Dentures	☐	Hearing Aid
☐	Home Nursing Care	☐	Prosthetic Device

☐ **LOSS OF SUPPORT TO DEPENDENTS:**

Persons who were wholly or partially dependent upon the victim's income may be eligible for compensation. A "Loss of Support to Dependents" form will be sent to you if this box is checked.

☐ **RESIDENTIAL PROPERTY/SECURITY SYSTEM:**
Please submit an estimate/receipt for repair/replacement of exterior residential doors, locks and/or windows. Security system is limited to equipment and installation, no subscriptions.

☐	Rekeying Residential Locks
☐	Exterior Door
☐	Exterior Window
☐	Security System

☐ **FUNERAL/BURIAL:**
Please submit copies of itemized bills, if available.

Name of Funeral Home and/or Cemetery		
Have the services been paid?	☐ Yes	☐ No
Who paid for the funeral service?		

☐ **LOST WAGES:**
You may request loss of income for missed work due to crime related injuries or bereavement, and you did not have paid sick or vacation time. A "Lost Wages" form will be sent to you. Employment, rate of pay, unpaid time off and ability to work will be verified. Lost wages are not eligible for reporting the crime, testifying in court, interviewing with police or D.A., making household repairs or attending appointments.

☐ **SELF DEFENSE/EMPOWERMENT COURSE:**
(Primary victims only)

☐ **CRIME SCENE CLEAN-UP:**
For the professional clean-up of bodily fluids at a crime scene.

☐ **EMERGENCY AWARDS:**
Victim Compensation MAY assist victims with immediate safety concerns that are a direct result of the crime and must be requested within 90 days of the crime. Please contact our office at 720.564.2835 or victimcomp@bouldercounty.gov to discuss eligibility and required documentation.

SECTION 6 - CIVIL LAWSUIT:

Are you planning to sue the person(s), their insurance or business responsible for this injury? ☐ Yes ☐ No

If yes, please note that you must notify the CVC Board with written evidence of the amount and terms of settlement.

RELEASE OF INFORMATION AND VICTIM'S RIGHTS AND RESPONSIBILITIES:

Please Read the Following Carefully, Sign and Date

CERTIFICATE 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 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 have 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.) result in the denial of my claim.

SUBROGATION AGREEMENT:

I hereby agree to notify the CVC Program in the event that benefits/funds become available to me, including but not limited to a civil lawsuit action, in payment of the same expenses for which I receive from the CVC Program. I further agree to retain so much of the recovered funds as necessary to reimburse the CVC Program to the extent of the compensation I received from the Program.

ALTERNATIVE APPLICATION PROCESS:

If you feel the CVC Board in the Twentieth Judicial District or the staff is unable to impartially review your claim due to personal or professional relationship(s) with two or more Board members, it will be sent to another district for review. The Twentieth Judicial District must receive a request for alternative review in writing. If your claim is approved, bills will be paid from the Twentieth Judicial District. I understand this may delay the processing of my claim.

REPAYMENT OF CRIME VICTIM COMPENSATION:

I hereby agree to repay the Crime Victim Compensation Fund 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 Crime 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(s) 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.

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.

RELEASE OF INFORMATION AUTHORIZATION:

I hereby authorize the release of all information from any employer, physician, hospital, Department of Social Services, civil attorney, medical and/or mental health service providers and/or any other creditor or agency for the purpose of verifying the claims that 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 for and effect as the original.

_____

Printed name of Victim or Claimant

_____

Signature of Victim or Claimant (if victim is under 18)

_____

Date

Email application to: victimcomp@bouldercounty.gov
Mail to: Boulder District Attorney's Office, Attn: Victim Compensation, 1035 Kimbark St., Longmont, CO 80501
For further information about CVC contact: 720.564.2835 or victimcomp@bouldercounty.gov

The Crime Victim Compensation program operates pursuant to C.R.S. § 24-4.1-101 et seq.