



Crime Victim Compensation Eighth Judicial District

201 LaPorte Avenue Ste 200
Fort Collins CO 80521

Office Use Only

Claim No. _____

970-498-7290

www.larimer.org/da/vicwit/compensation.htm

*Application for crimes on or after 5/15/24

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.

Typical processing time for this application ranges from 45 to 60 days.

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 have reasonably cooperated with law enforcement officials (District Attorney, police, etc.).
3. The injury or death of the victim must not have been the result of the victim's own wrongdoing or substantial provocation.
4. The victimization must have occurred on or after July 1, 1982.
5. The crime occurred in Larimer or Jackson Counties or in another state or country where there is no victim compensation program and the victim is a resident of Larimer or Jackson County. NOTE: For contact information on programs in other judicial districts, please contact our office.
6. The crime must have been reported to law enforcement or the victim must have presented to a licensed or registered nurse or medical provider for a forensic examination.
7. For property related crimes, the police must have been notified within 72 hours after the crime occurred and the application for compensation must be submitted within six months from the date of the crime.

*The Compensation Board MAY waive some of these requirements 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, dependent care, motor vehicle towing & impound fees, travel expenses, 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 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 and Medicare.
5. Please attach all bills and receipts currently in your possession. 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 Crime Victim Compensation Board.
7. 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 a 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 a reconsideration of the Board's decision, further information concerning the reconsideration process will be mailed to you. In the event the denial is upheld by the Board, you have a right to have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure within 30 days.
8. All materials received, made or kept by the CVC Program or district attorney concerning an application for victim's compensation made under C.R.S. 24-4.1-100.1 are confidential.
9. 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.
10. Contact the CVC Program if crime related bills have been turned over to a collection agency.

ADDITIONAL RESOURCES:

1. For further information regarding Crime Victim Compensation, please contact CVC Administrator at 970-498-7290 or victimcomp@co.larimer.co.us.
2. If the victim/applicant is hearing impaired, you may contact the CVC program via email at victimcomp@co.larimer.co.us.
3. If the victim/applicant is visually impaired, you may contact the CVC program via telephone at 970-498-7290.
4. If the victim/applicant has limited English proficiency, please contact the CVC program via telephone or email and accommodations will be made using a confidential translator.



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SECTION I – VICTIM INFORMATION

Victim's Name (First, Middle, Last) _____ Date of Birth _____ Sex: Male Female

Mailing Address (Street) _____ City, State, Zip _____

Primary Telephone _____ Secondary Telephone _____ Email Address _____

Preferred method of notification: 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 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 Social Services
 Hospital/Doctor Therapist Victim Advocate
 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 (First, Middle, Last) _____ 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 _____ | | |

Date of crime

Date crime was reported or of forensic exam

Law enforcement agency or hospital

Incident/Case number

Law enforcement officer handling case

Address where crime occurred

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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have automobile insurance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have homeowner’s insurance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

If yes, please check which type:

If yes, please complete:

- Private Insurance
- Group Insurance
- Medicaid
- Medicare
- Worker’s Compensation
- Department of Social Services
- CHP
- Colorado Indigent Program
- Other _____

Policyholder _____

Company Name _____

Phone Number _____

Policy Number _____

Amount of Deductible _____

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 _____

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

REPLACEMENT SERVICES – Expenses reasonably incurred in obtaining necessary services that an injured or deceased victim would have otherwise performed for the benefit of the victim’s self or family.

TRAVEL EXPENSES – Limited to funeral, medical appt, mental health appt, and critical events in the criminal case.

RESIDENTIAL/VEHICLE 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. Please check the appropriate box for vehicle towing and impound fees when it is determined the vehicle was the scene of the crime.

RESIDENTIAL: Doors Locks Windows

REKEYING: Residential Vehicle Other security devices

VEHICLE: Towing Impound Fees

Residential and/or vehicle 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 \$10,000.00 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 \$8,000.00. 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 \$2,500.00 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:

HOUSEHOLD SUPPORT: Crime Victim Compensation may consider paying up to \$2,500.00 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	\$	\$
Dependent Care	\$	\$
Other (please list)	\$	\$
TOTAL	\$	\$

SECTION VII – RELEASE OF INFORMATION AND VICTIM’S RIGHTS AND RESPONSIBILITIES
Please read and initial each statement. Failure to do so will result in the inability to process your application.

____ **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 reasonably 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**