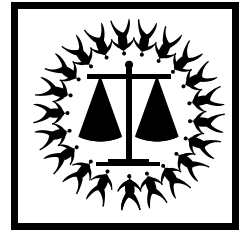




# CRIME VICTIM COMPENSATION BOARD

Fourth Judicial District  
El Paso and Teller Counties  
105 E Vermijo, Suite 111  
Colorado Springs, CO 80903

Phone (719) 520-6000 Fax (719) 520-6172



## VICTIM COMPENSATION FUND APPLICATION

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

### ELIGIBILITY REQUIREMENTS \*:

1. The crime must be one in which the victim sustains mental or bodily injury, dies or suffers property damage to residential *exterior* locks, windows or doors as a result of a compensable crime.
2. The victim must fully cooperate with law enforcement officials (law enforcement, district attorney, etc.)
3. The crime must be reported to a law enforcement agency within 72 hours of occurrence.
4. The injury or death of the victim was not the result of the victim's own wrongdoing or substantial provocation.
5. The victimization occurred on or after July 1, 1982.
6. The application for compensation must be submitted within one year from the date of the crime and within six months for residential property damage claims.
7. The crime occurred in El Paso or Teller County; or, in another state or country and the victim is a resident of El Paso or Teller County.

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

### GENERAL INFORMATION:

1. An arrest does not have to be made in order for a victim to become eligible to apply to the Compensation Program.
2. Compensation may be requested for medical expenses, mental health counseling, medically necessary devices (dentures, eyeglasses, hearing aids, and prostheses), loss of earnings due to injury, outpatient care, home health services, funeral expenses, exterior residential doors/locks/windows, and loss of support to dependents in the event of death. Requests must be *directly related* to the crime reported to the law enforcement agency.
3. Compensation for property damage may be awarded for the cost of replacement or repair to *exterior residential* doors, locks, "other locks", and windows that are damaged during the commission of a crime. Claimant must supply a bill or estimate.
4. By law, you must apply for all other sources of financial assistance or reimbursement, including private insurance, Medicaid and Medicare.
5. Please attach all itemized bills, receipts and estimates directly related to the crime. You may apply if you have not received any bills as of this date, forwarding bills as you receive them.
6. Your claim will be verified and presented to the Victim Compensation Board, a three-member panel of volunteers appointed by the elected District Attorney. This *process* may take up to 60 days from the receipt of all required documentation necessary to present a claim request to the Board.
7. **Compensation for an entire claim may not exceed the statutory limit of \$30,000.** Compensation for individual categories is limited by Board policy; please call if you have questions about specific category limits.
8. Should your request be denied, you have a right to request reconsideration of the Board's decision and have the right to submit new or additional information, which relates to the reason(s) for the Board's denial or reduction or your claim. You may arrange for reconsideration by contacting the Victim Compensation program within 60 days of the date in which you receive notice of the denial or reduction of your claim. You may appear in person, or by written letter to the Board. In the event the Board upholds the denial, you have a right to have the Board's decision reviewed in accordance with the Colorado Rules of Civil Procedure within 30 days.

*Your application and information contained in your file may be subject to discovery in court proceedings.*

## CRIME VICTIM COMPENSATION APPLICATION FORM INSTRUCTIONS

*Pursuant to statute 24-4.1-105 (2)(a), the applicant must provide the Compensation Program with any pertinent requested information to process this application. Incomplete applications will be returned or delayed until all information is received.*

**SECTION I – VICTIM INFORMATION:** The name of 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. A separate application is required for each family member applying. It is very important that you provide a *complete* mailing address, including city, state and zip code so that we can continue to keep you notified of the status of your application. A telephone number and/or email address allows us to contact you with any questions. Your Social Security number may be requested *only* to verify bills submitted for payment.

**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. Please note the relationship to the victim and provide a telephone number or email address for contact.

**SECTION 3 – CRIME INFORMATION:** The majority of this information will be obtained from a copy of the offense report taken by the investigating law enforcement agency. You *DO NOT* need to provide a copy of this report. Completing this entire section, to the best of your knowledge, helps us make sure that we have the right offense report related to your application.

**SECTION 4 – INSURANCE AND OTHER COLLATERAL SOURCE INFORMATION:** By federal and state statute, Crime Victim Compensation is the payer of last resort. If you have available any other sources of payment for the bills you are submitting, you must disclose this information. Incomplete applications will not be able to be processed.

**SECTION 5 – REQUEST FOR SERVICES:** This section has nine subsections. Mark the services you are requesting assistance with or that you anticipate needing assistance. Write (N/A) not applicable, if you are not requesting assistance for that subsection. Submitting a request for compensation does not guarantee the Board will approve your request.

- **Mental Health Counseling:** For Primary and Secondary victims. Secondary victims are persons that have a close, familial type relationship with the primary victim or someone who is a witness to the crime. The Board will only approve therapy with *state licensed therapists* (Paid at \$100 per session/\$50 group) or licensure candidates (paid half the rate.)
- **Medical:** All bills submitted must be *directly* related to the crime and are ultimately your responsibility. Crime related bills or estimates can be forwarded to the Compensation Program as you receive them. All bills and insurance correspondence received will be verified to confirm date, type and cost of service before a payment determination can be made.
- **Personal Medical Items:** This refers to any medically necessary device that was stolen or damaged as a result of the criminal incident. This may be hearing aids, glasses, dentures, etc. Send crime related bills or estimates.
- **Loss of Earnings:** 1-month max benefits for mental health reasons or 2 months max for physical health reasons. You may request loss of earnings *only* if you missed work because of your physical or emotional injuries related to the crime *and* you did not have paid vacation or sick leave provided by your employer. You must provide a doctor's note, a recent pay stub, and your employer must verify the unpaid time you had to miss from work on a form provided by the Compensation Program. If you are self-employed, you must submit a copy of your last year's tax return.
- **Loss of Support to Dependents (Non-DV):** 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 or whose income will now be decreased or lost because of the primary victim's death can request loss of support. This may include court ordered child support.
- **Loss of Support to Dependents (DV & Sexual Assault on Child):** If certain criteria are met, loss of support can be awarded in cases where the victim was living with and financially dependent upon the offender. Loss of support requests must be submitted within 10 days of the offender being legally removed from the home. Please contact the Victim Compensation office for more information.
- **Residential Property:** Please note if you have a homeowner's insurance deductible; please list the deductible amount. If you do not have homeowner's insurance, please write "N/A" in the space provided. (\$1000 or deductible maximum)
- **Funeral Expenses:** If you have paid for funeral expenses or if the bills remain outstanding, please 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 approved. Please note: There is a \$9000 per decedent maximum for funeral / burial expenses.
- **Emergency Reimbursement Request:** Please speak with the Coordinator or the Program Assistant for more information regarding emergency reimbursement eligibility.

**SECTION 6 – CIVIL LAWSUIT:** By signing the application, you agree to repay any funds you receive in a civil lawsuit for expenses paid by the Compensation Program.

**SECTION 7 – RELEASE OF INFORMATION & VICTIM RIGHTS AND RESPONSIBILITIES:** Your initials by each section, as well as your signature and the date are necessary to complete the application and to authorize the Compensation Program to verify bills on your behalf.

***\*Incomplete applications or Applications without signatures may be denied and will delay payment.***

**SECTION 1 – VICTIM INFORMATION – PLEASE PRINT**

Return application and crime related bills to:  
 Victim Compensation Program  
 105 E. Vermijo Ave., Suite #111  
 Colorado Springs, CO 80903 Fax: 520-6172

Primary Victim Secondary Victim 

The name of 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.

Victim Name (First, Middle, Last)

Mailing Address

City

State

Zip Code

County of Residency

State of Permanent Residency

E-mail

Work Phone

Home Phone

Other Phone

Birth Date

Age at time of crime

Gender:  Male  Female
 Marital Status:  Married  Single  Separated  Divorced  Widowed

The following information is used for statistical purposes only. This information is needed to comply with Federal regulations.

**Disabled:**

- Yes  
 No  
 Mentally  
 Physically

**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  
 Some Other Race  
 Multiple Races

**Referral Source:**

- Police Agency Victim Advocate  
 District Attorney Victim Advocate  
 District Attorney's Office  
 Social Services  
 Hospital  
 Therapist  
 Other \_\_\_\_\_

**Did the crime  
 cause your disability?**

- Yes  
 No

**SECTION 2 – CLAIMANT INFORMATION**
 SAME AS ABOVE (only if crime victim is claimant)

Complete only if person submitting application is not the victim, i.e.: victim's parent or guardian or relative of victim.

Claimant's Name (Parent/Guardian/Relative)

Home Telephone

Mailing Address

Cell Telephone /Work Telephone

City/State/Zip

Email

Date of Birth

Relationship to Victim

**\*Incomplete Applications submitted or Applications without signatures may be denied by the Board.**

### SECTION 3 – CRIME INFORMATION

<b>Type of Crime: (check all that apply)</b> <input type="checkbox"/> Assault <input type="checkbox"/> Burglary/Criminal Mischief <input type="checkbox"/> Careless Driving Resulting in Injury or Death <input type="checkbox"/> Child Physical Abuse <input type="checkbox"/> Child Sexual Assault-Family Member <input type="checkbox"/> Child Sexual Assault-Non-Family Member		<input type="checkbox"/> Domestic Violence <input type="checkbox"/> Drunk Driver / Vehicular Assault / Vehicular Homicide <input type="checkbox"/> Hit and Run Resulting in Injury or Death <input type="checkbox"/> Murder/Homicide <input type="checkbox"/> Attempted Murder/Homicide <input type="checkbox"/> Sexual Assault-Adult Victim <input type="checkbox"/> Other: _____
1. DATE OF CRIME:	2. DATE CRIME REPORTED	3. POLICE DEPARTMENT/AGENCY CRIME REPORTED TO:
4. POLICE OFFICER ASSIGNED:		5. POLICE REPORT NUMBER:
6. WHO COMMITTED THE CRIME?		7. RELATIONSHIP TO VICTIM:
8. HAS THE OFFENDER BEEN CHARGED IN COURT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		9. DISTRICT ATTORNEY'S OFFICE CASE NUMBER:
10. DID THE CRIME OCCUR AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. COUNTY WHERE CRIME OCCURRED:

### SECTION 4 – INSURANCE/OTHER COLLATERAL SOURCE INFORMATION

**You are required to submit all bills to your insurance carrier or other collateral source related to your request for assistance; check all sources of alternate payment for bills submitted to the Compensation Program.**

**Please indicate if the following applies to you *and* your claim request:**

Do you have health insurance coverage:  Yes  No If yes, please provide the Policy #: \_\_\_\_\_

Group # \_\_\_\_\_ Company name and address: \_\_\_\_\_

Do you have auto insurance:  Yes  No

Do you have Homeowner's/Renters:  Yes  No Deductible for Homeowner/Renter's Insurance \$ \_\_\_\_\_

Disability Insurance:  Yes  No

**If yes to any of these, please read and complete the following:**

Private Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No
Group Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No
Department of Social Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	Worker's Comp: <input type="checkbox"/> Yes <input type="checkbox"/> No
CHP / CHP+: <input type="checkbox"/> Yes <input type="checkbox"/> No	Military Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Colorado Indigent Care Program: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other: <input type="checkbox"/> Yes <input type="checkbox"/> No	

### SECTION 5 – REQUEST FOR SERVICES (Please check all boxes that apply)

**MENTAL HEALTH COUNSELING**

Are you (victim) currently seeing a licensed mental health therapist as a result of this crime?  Yes  No  
 If yes, please list the name and phone number of the therapist below.

Therapist Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

(The Board will only approve therapy with state licensed therapists.) Do you require a language interpreter?  Yes  No

**SUPPLEMENTS TO MENTAL HEALTH COUNSELING** (may be approved on a case by case basis)  
*- Detailed referrals are required to be submitted by the victim or claimant's mental health therapist or treating physician before the Board will consider a request for compensation of any supplemental mental health treatment modality.*

**SELF-DEFENSE TRAINING** (requests may be reviewed on a case-by-case basis and, in the discretion of the board, a waiver of a referral by a mental health therapist or treating physician may be granted)

**\*Incomplete Applications submitted or Applications without signatures may be denied by the Board.**

**MEDICAL:** Submit copies of *crime related* itemized bills as you receive them.

**Hospital:**  Yes  No

**Physician:**  Yes  No

**Dental:**  Yes  No

**Physical Therapy:**  Yes  No Requires a referral from treating physician **Chiropractic:**  Yes  No (*Maximum - \$1,500*)

**Home Nursing Care:**  Yes  No (**must be provided by a Certified Home Care Health Agency**) (*Maximum - \$7,000 per family*)

**Acupuncture:**  Yes  No (*Maximum - \$1,000 per family*) **Interpreter Services:**  Yes  No **Other:** \_\_\_\_\_

NOTE: If plastic surgery, reconstructive surgery, major dental work, ongoing physical therapy, etc., are being recommended, your provider must complete a treatment plan that explains how the injuries and treatment relate to the crime and an estimate of total cost for the procedure. The Victim Compensation Board will review your request and you will be informed as to whether or not we will be able to assist with the cost.

**If possible, please list service providers noting if the bill is paid or outstanding. You may add additional sheets if needed.**

Service Provider \_\_\_\_\_  Paid  Outstanding  Estimate

Service Provider \_\_\_\_\_  Paid  Outstanding  Estimate

Service Provider \_\_\_\_\_  Paid  Outstanding  Estimate

**PERSONAL MEDICAL ITEMS** Submit copies of *crime related* itemized bills or estimates

**Was the item stolen, damaged or destroyed during the criminal incident?**  Yes  No

**Eyeglasses/Contact Lenses:**  Yes  No (*Max - \$600*) **Dentures:**  Yes  No **Hearing Aid:**  Yes  No

**Prosthetic Device:**  Yes  No **Medication:**  Yes  No **Other:** \_\_\_\_\_

**LOSS OF WAGES DUE TO PRIMARY VICTIM'S INJURY ONLY**

*Loss of earnings is not applicable for lost wages due to reporting the crime, testifying in court, interviews with police/DA, etc.*  
To qualify for lost wages, you have to have been employed at the time of the incident.

Was the victim able to use any of the following types of leave due to physical or emotional injury caused by the crime?

**Sick Leave:**  Yes  No **Vacation Leave:**  Yes  No **Personal Leave:**  Yes  No **FMLA:**  Yes  No

If you are self-employed you must furnish a copy of the past year's tax return so we can accurately determine lost wages. A "Claim for Lost Wages" form is included for you to give to your employer to verify your rate of pay and that the unpaid time from work that is directly related to this criminal incident. You will be asked to include **a copy of a recent pay stub and if you are requesting more than a week of lost wages, a note from your doctor or therapist.**

**LOSS OF SUPPORT TO DEPENDENTS** (*up to 85% gross wage for 8 weeks, Maximum - \$6,500 per family*)

Persons who were wholly or partially **dependent upon the victim's income** at the time of death or whose income has been severely lessened or lost because of this criminal incident may be eligible for compensation. Please include a copy of the dependent's birth certificate, proof of permanent guardianship and/or copy of marriage license, and proof of income of the deceased at the time of death. Request must be submitted within 10 days after the victim's death.

1) Dependent's name \_\_\_\_\_ 2) Date of Birth \_\_\_\_\_ 3) Relationship to Victim \_\_\_\_\_

**LOSS OF HOUSEHOLD SUPPORT** (*up to 85% gross wage for 8 weeks, Maximum - \$6,500 per family*)

In certain cases, and if certain criteria are met, victims who were wholly or primarily **dependent upon the offender's income** before the offender was legally removed from the home due to the crime incident may be eligible for compensation. Please call 719-520-6000 for more information.

Additional documentation will be required by the Crime Victim's Compensation Board to support your request. Request must be submitted within 10 days of the offender being legally removed from home. Awards may be applied to specific household expenses only.

**RESIDENTIAL PROPERTY** (*Damaged or destroyed during the crime / Maximum - up to deductible amount*)

**Exterior Doors:**  Yes  No **Exterior Windows:**  Yes  No **Other Locks:**  Yes  No

**Re-key Exterior Locks:**  Yes  No **Crime Scene Cleanup:**  Yes  No **Insurance Deductible Amount:** \$ \_\_\_\_\_

**Security System Request:**  Yes  No (*Must be a homeowner / Based on specific crimes / Maximum - \$1,000 or up to deductible amount*)

**FUNERAL EXPENSES:** Submit copies of itemized bills, if available. (*\$9,000 maximum for funeral / burial.*)

**Have funeral expenses been paid?**  Yes  No

\_\_\_\_\_  
Funeral Service Provider and Telephone Number

\_\_\_\_\_  
Name of person who paid for funeral expenses

\_\_\_\_\_  
Telephone Number

**EMERGENCY REIMBURSEMENT REQUEST:** The Victim Compensation Program *may* be able to assist with some emergency reimbursement requests if it is determined undue hardship would result to the applicant if the expense was not paid. Victim Compensation can only consider reimbursement for the repair or replacement of exterior windows, doors or locks for your primary residence or motor vehicle.

Agency that made payment: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**\*Incomplete Applications submitted or Applications without signatures may be denied by the Board.**



## SECTION 6 – CIVIL SUIT

**CIVIL LAWSUIT:** Are you planning to sue the person(s) or business responsible for this injury?  Yes  No  
If yes, please note that you must notify the Compensation Board with written evidence of the amount and terms of settlement.

## SECTION 7 – RELEASE OF INFORMATION / RIGHTS & RESPONSIBILITIES

**PLEASE READ CAREFULLY, INITIAL EACH SECTION, SIGN AND DATE.**

**Applications without each box initialed will be considered incomplete.**

- 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) may result in the denial of my claim. In addition, I am further aware that if I fail to cooperate with the prosecution of the case from which my losses were sustained, I will be ineligible for any further compensation and will be fully liable to reimburse the Crime Victim Compensation Program for any and all compensation awards received.
- SUBROGATION AGREEMENT:** I hereby agree to notify the Crime Victim Compensation Program in the event that benefits 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 Crime Victim Compensation Program. I further agree to retain so much of the recovered funds as necessary to reimburse the Compensation Program to the extent of the compensation I received from the Program.
- ALTERNATIVE APPLICATION PROCESS:** If you feel the Victim Compensation Board in the Fourth Judicial District 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 once the conflict has been declared by the Board. The Fourth Judicial District must receive a request for alternative review in writing. If your claim is approved, bills will be paid from the Fourth 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 would 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 within 60 days which addresses the reason for the denial as stated in the letter. You must then appear in person at the next scheduled Board meeting to present your case. 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.
- 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 effect as the original.

\_\_\_\_\_  
Signature of Victim/Claimant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Victim/Claimant

Revised 9/11/19

**\*Incomplete Applications submitted or Applications without signatures may be denied by the Board.**

VICTIM COMPENSATION PROGRAM  
Fourth Judicial District  
105 E. Vermijo, Suite #111  
Colorado Springs, CO 80903  
(719) 520-6000 Fax: (719) 520-6172

Please print

**LOSS OF WAGES**

**VICTIM'S NAME:** \_\_\_\_\_

THE PROGRAM WILL ONLY COMPENSATE THE VICTIM FOR WAGES LOST DUE TO PHYSICAL OR EMOTIONAL INJURIES DIRECTLY CAUSED BY THE CRIME. LOST WAGES WILL NOT BE PAID FOR TIME LOST DUE TO COURT APPEARANCES, APPOINTMENTS WITH CRIMINAL JUSTICE PERSONNEL OR APPOINTMENTS WITH SERVICE PROVIDERS.

IF YOU ARE REQUESTING LOSS OF WAGES, **TAKE THIS FORM TO YOUR EMPLOYER AND HAVE IT COMPLETED AND SIGNED BY YOUR SUPERVISOR/EMPLOYER EACH MONTH.** IF YOU ARE SELF-EMPLOYED YOU MUST SUBMIT COPIES OF YOUR TAX RETURNS. IF CLAIMING LOST WAGES, YOU MUST SUPPLY THE FOLLOWING DOCUMENTATION:

- 1) THIS FORM MUST BE COMPLETED AND RETURNED BEFORE YOUR REQUEST FOR LOST WAGES CAN BE PROCESSED.
- 2) A LETTER FROM YOUR TREATING PHYSICIAN OR THERAPIST INDICATING YOUR INABILITY TO WORK DUE TO INJURIES SUSTAINED AS A RESULT OF THE CRIME AND INDICATING LENGTH OF TIME OF INABILITY TO WORK. **ANY REQUEST OVER 5 DAYS OF LOST WAGES REQUIRES A DOCTOR'S NOTE.**
- 3) IF REQUESTING LOST WAGES FOR MORE THAN ONE MONTH YOU MUST TAKE THIS FORM TO YOUR EMPLOYER EACH MONTH FOR VERIFICATION

EMPLOYEE'S NAME:	JOB TITLE:	WAS THIS PERSON EMPLOYED ON THE DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO
First day of missed work: _____ Last day of missed work: _____	HAS THIS PERSON RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE RETURNED? / /
WAS THIS PERSON INJURED WHILE AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WAS WORKERS COMP PAID <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, THROUGH WHAT PERIOD FROM: TO:
WAS SICK LEAVE / ANNUAL LEAVE / FMLA OR DISABILITY PAID? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, THROUGH WHAT PERIOD FROM: TO:	HOURS WORKED PER DAY
HOURS WORKED PER WEEK	HOURS WORKED PER MONTH	NUMBER OF DAYS MISSED
RATE OF PAY <input type="checkbox"/> HOURLY <input type="checkbox"/> WEEKLY <input type="checkbox"/> COMMISSION \$ _____ <input type="checkbox"/> MONTHLY <input type="checkbox"/> DAILY <input type="checkbox"/> OTHER _____		

**TOTAL AMOUNT OF LOSS OF WAGES:** \$ \_\_\_\_\_

EMPLOYER'S (FIRM) NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

EMPLOYER (SUPERVISOR/REPRESENTATIVE) NAME: \_\_\_\_\_

JOB TITLE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

**EMPLOYER (SUPERVISOR/REPRESENTATIVE) SIGNATURE:** \_\_\_\_\_

I certify that I have read and agree to all of the information provided on the Loss of Wages Form above. Furthermore, I am aware that the information provided on the above Loss of Wages Form is true and correct to the best of my knowledge. I understand that untruthful statements will disallow my eligibility for any and all further benefits from the Crime Victim Compensation Fund.

**EMPLOYEE (VICTIM) SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**LOST SUPPORT REQUEST  
4<sup>TH</sup> JUDICIAL DISTRICT  
CRIME VICTIM COMPENSATION PROGRAM**

*Return application and crime related bills to:  
Victim Compensation Program  
105 E. Vermijo Ave., Suite #111  
Colorado Springs, CO 80903 Fax: 520-6172*

Victim Name: \_\_\_\_\_  
Suspect/Defendant Name: \_\_\_\_\_

Were you and the suspect/defendant living in the same residence when the crime occurred? \_\_\_ Yes \_\_\_ No  
Are you and the suspect/defendant still living together? \_\_\_ Yes \_\_\_ No  
Are there any immediate plans for reunification between you and the offender? \_\_\_ Yes \_\_\_ No

Was the suspect/defendant legally employed or receiving benefits through a benefits program (ex. Workman's Compensation, Disability, etc.) at the time the crime occurred? \_\_\_ Yes \_\_\_ No  
Please provide documentation for the two prior months from the date of the application.

**Suspect's Employer Contact Information:**

Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Supervisor: \_\_\_\_\_

The suspect/defendant was providing: \_\_\_ Total Support \_\_\_ Partial Support \_\_\_ No Support when the crime occurred.  
Did you and the suspect/defendant have any other sources of income besides salaries? \_\_\_ Yes \_\_\_ No

If "yes", please list: \_\_\_\_\_

Is the suspect/defendant providing financial support to you now? \_\_\_ Yes \_\_\_ No

If you are awarded compensation for lost support, will the offender benefit from or have access to it?: \_\_\_ Yes \_\_\_ No

If "yes", please explain: \_\_\_\_\_

**Please provide proof of the following information:**

- Copies of the offender's paystubs (two months) dated up to the date of incident / or the suspect's most recent income tax return if self-employed / or proof of direct deposits. If you do not have access to financial documents, please inform the Board in writing of your situation.
- Lease agreement for primary shared residence & proof of protection order (mandatory, temporary or permanent)
- Utility bill(s), internet service bill (cable excluded), phone bill (if primary source of communication), other household expense receipts or invoices
- Proof of application and eligibility status for governmental assistance (TANF, Food Stamps, LEAP, etc.)

**Please fill in each box below related to household expenses:**

\$ Amount:	Suspect/Defendant Paid (List \$ Amount):	You Paid (List \$ Amount):
Rent/Mortgage for primary residence:		
Utilities:		
Internet (cable excluded):		
Phone (if primary source of communication):		
Food:		
Other household necessities (Please list):		
<b>TOTAL:</b>		

\* Please note, if the Crime Victim's Compensation Board grants an award- no monies will be distributed without documentation supporting the amounts. Depending on the bills paid- some bills will be paid directly to the provider and some will be categorized as reimbursable expenses.

**I certify that I have read and agree to all of the statements and conditions on the Crime Victim Compensation Fund Application; furthermore, I am aware that all of the information provided in this Request for Lost Support form is subject to those conditions. I certify that the information contained in this Request for Lost support is true and correct to the best of my knowledge, and I understand that any untruthful statements will disallow my eligibility for any and all further benefits from the Crime Victim Compensation Fund.**

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Incomplete Applications submitted or Applications without signatures may be returned.** Revised: 9/11/19