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 application must be filed with the state or county the crime occurred in if they have a Victim Compensation 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:

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 <u>itemized</u> 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 <u>all</u> 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 of 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.
9. All Victim Compensation applications and supporting documents are considered confidential pursuant to C.R.S. 24-4.1-107.5. If a subpoena or request for records is issued regarding your claim, you have the right under the Victim Rights Act to be notified by the District Attorney's Office. *Your application and information contained in your file may be subject to discovery in court proceedings by order of a judge.*
10. Victims applying for Victim Compensation have the right to request suspension of collection actions while their claim is being reviewed by the Board. For additional details, contact Victim Compensation.
11. If you have any questions about your application, you may call Victim Compensation at 719-520-6000 or e-mail <u>daovictimcompensation@elpasoco.com</u>.

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. If the person listed in Section 1 is a minor then Section 2 is required.

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* or licensure candidates.
- ***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. 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.
- ***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. The Board will require you to submit a copy of your Lease, Marriage license, defendant's paystubs or income tax papers, bank statements showing defendant payroll deposits, and bills that need to be paid. Checks are not paid directly to the victim.
- ***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.
- ***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.

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 required to complete the application and to authorize the Compensation Program to verify bills on your behalf**.**

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***

***This is the person applying for services.**
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
☐ Physical
☐ Mental

Did the crime cause your disability?
☐ Yes ☐ No

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 _____

SECTION 2 – CLAIMANT INFORMATION ☐ SAME AS ABOVE

Complete only if person submitting application is not the victim, i.e.: victim's parent or guardian or relative of victim. This section is required if the victim is a minor, deceased or mentally incapacitated.

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

Type of Crime: (check all that apply)

- ☐ Assault
- ☐ Burglary/Criminal Mischief
- ☐ Careless Driving Resulting in Injury or Death
- ☐ Child Physical Abuse
- ☐ Child Sexual Assault-Family Member
- ☐ Child Sexual Assault-Non-Family Member
- ☐ Domestic Violence
- ☐ Drunk Driver / Vehicular Assault / Vehicular Homicide
- ☐ Hit and Run Resulting in Injury or Death
- ☐ Murder/Homicide
- ☐ Attempted Murder/Homicide
- ☐ Sexual Assault-Adult Victim
- ☐ 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? ☐ YES ☐ NO ☐ UNKNOWN	**9.** DISTRICT ATTORNEY'S OFFICE CASE NUMBER:
10. DID THE CRIME OCCUR AT WORK: ☐ YES ☐ NO	**11.** COUNTY WHERE CRIME OCCURRED:

SECTION 4 – INSURANCE/OTHER COLLATERAL SOURCE INFORMATION

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

Source	Yes	No	Name of Insurance Company/ Phone Number	Policy No./ Group N
Private Insurance				
Medicaid				
Group Insurance				
Medicare				
Worker's Comp.				
Disability Insurance				
Automobile Insurance				
Homeowner's/Renter's Ins.				
Military Coverage				
Other				

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.

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

Submit copies of *crime related bills or estimates* for all services as you receive them.

☐ ***MENTAL HEALTH COUNSELING***

If you are already in therapy, please provide the following:

Therapist Name_____**Telephone Number** _____

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 claimant's mental health therapist or treating physician before the Board will consider a request for compensation of any supplemental mental health treatment modality, including self-defense.

☐ **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)***

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☐ ***MEDICAL:*** The Board may require referrals or treatment plans prior to considering your request.

Hospital: ☐ Yes ☐ No **Physician:** ☐ Yes ☐ No **Dental:** ☐ Yes ☐ No

Physical Therapy: ☐ Yes ☐ No **Chiropractic:** ☐ Yes ☐ No *(Maximum - $1,500)*

Home Nursing Care: ☐ Yes ☐ No *(Maximum - $7,000 per family)* **Other**: _____

Acupuncture: ☐ Yes ☐ No *(Maximum - $1,000 per family)*

Interpreter Services: ☐ Yes ☐ No

☐ ***PERSONAL MEDICAL ITEMS***

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

Please refer to the Application Instructions page and turn in supporting documentation with your application. Failure to provide supporting documentation may result in your application being denied or delayed.

☐ **LOSS OF SUPPORT TO DEPENDENTS**

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. For homicide cases only.

☐ **LOSS OF HOUSEHOLD SUPPORT**

Awards may be applied to specific household expenses only. For domestic violence and child sexual assault cases only.

* Request must be submitted within 10 days of the offender being legally removed from home. Loss of Support is paid up to 85% of gross wages for an 8-week period. Victim Compensation will not pay more than $6,500 per family for Loss of Support. See the instruction page or call Victim Compensation to get a list of required documentation. **Loss of Support form must be turned in with your application.**

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 /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 REQUEST: At this time the 4th Judicial District Victim Compensation Board does not accept emergency requests.

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

Civil Attorney's Name:_____ Mailing Address: _____

Phone Number: _____ NOTE: *The Crime Victim Compensation Board must be notified of any civil action and be provided 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 1/7/20

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

APPLICANT'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.** You must supply the following documentation:

1) This form must be completed and returned with two paystubs or a complete copy of your most recent tax returns if you are self-employed before your request will 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 Loss of 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? ☐ YES ☐ NO
First day of missed work:_____ Last day of missed work:_____	HAS THIS PERSON RETURNED TO WORK? ☐ YES ☐ NO	IF YES, DATE RETURNED? / /
WAS THIS PERSON INJURED WHILE AT WORK? ☐ YES ☐ NO	IF YES, WAS WORKERS COMP PAID ☐ YES ☐ NO	IF YES, THROUGH WHAT PERIOD FROM: TO:
WAS SICK LEAVE / ANNUAL LEAVE / FMLA OR DISABILITY PAID? ☐ YES ☐ 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 ☐ HOURLY ☐ WEEKLY ☐ COMMISSION $_____ ☐ MONTHLY ☐ DAILY ☐ 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:** _____

****Incomplete Applications submitted or Applications without signatures may be denied.*** Revised: 1/7/20

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

LOST SUPPORT REQUEST

Victim/Applicant Name:_____
Offender Name:_____

Were you and the offender living in the same residence when the crime occurred? ___ Yes ___ No
Are you and the offender still living together? ___ Yes ___ No
Has the offender been legally removed from the home? ___ Yes ___ No
Are there any immediate plans for reunification between you and the offender? ___ Yes ___ No

Was the offender legally employed or receiving benefits through a benefits program (ex. Workman's Comp., Disability, Etc.) at the time the crime occurred? ___ Yes ___ No

Please provide documentation for the two prior months from the date of the application.

Offender's Employer Contact Information:

Company Name: _____
Address: _____
Phone Number: _____
Supervisor: _____

When the crime occurred the offer was providing: ___ Total Support ____ Partial Support ____ No Support
Did you and the offender have any other sources of income besides salaries? ___ Yes ___ No
If "yes", please list:_____

Is the offender providing support to you now? ___ Yes ___ No

If you are awarded compensation, 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 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. Informing the Board in writing does not guarantee approval of your request.
- 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:	Offender 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):		
TOTAL:		

* Please note, 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:**