CRIME VICTIM COMPENSATION APPLICATION

Weld County District Attorney's Office **Michael J. Rourke -District Attorney**
Post Office Box 1167 • 915 Tenth Street • Greeley, CO 80632 • (970) 356-4010 • Fax (970) 336-7224

SECTION 1: APPLICANT INFORMATION

Enter information about the person applying for assistance. A separate application is required for each person requesting services. If you are filling out this application for someone under 18, incapacitated or deceased put their information in this section. For assistance with this application, contact Weld Victim Compensation at (970) 400-4746 or weldvictimcompensation@weld.gov

Full Legal Name: _____
First *Middle* *Last*

Date of Birth: ___/___/___ **Social Security Number (Last 4 Digits):** XXX – XX - _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary/ Non-conforming ☐ Not Listed ☐ Prefer not to answer

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Other ☐ Prefer not to answer

Mailing Address: _____
Street Address/PO Box

_____
City *State* *Zip Code*

Email Address: _____

Preferred Method of Contact: ☐ Mail ☐ Email

Primary Phone: _____ **Secondary Phone:** _____

Safe Message: _____ **Contact Instructions:** _____

Are you disabled? ☐ Yes ☐ No **Type of Disability:** ☐ Mental ☐ Visually Impaired ☐ Hearing Impaired ☐ Other

Who referred you to the victim compensation program?
☐ Dept. of Human Services ☐ District Attorney's Office ☐ Hospital/Doctor ☐ Law Enforcement
☐ Victim Advocate ☐ Therapist ☐ Other: _____

SECTION 2: CLAIMANT INFORMATION (PARENT/GUARDIAN/LEGAL REPRESENTATIVE)

Leave this section blank if you are over 18 and are requesting services for yourself.
Enter information about the person who will be contacted regarding this claim. The person listed below should be the parent, guardian, conservator, or other individual authorized to apply on behalf of the person listed in Section 1.

Full Legal Name: _____
First *Middle* *Last*

Date of Birth: ___/___/___ **Relationship to Applicant:** _____

Mailing Address: _____
Street Address/PO Box

_____
City *State* *Zip Code*

Email Address: _____

Primary Phone: _____ **Secondary Phone:** _____

Safe Message: _____ **Contact Instructions:** _____

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SECTION 3: ADDITIONAL PARENT/GUARDIAN INFORMATION (OPTIONAL)

Leave this section blank if you are over 18 and are requesting services for yourself.
The person listed below should be a second parent, guardian, conservator, or other individual authorized to make decisions on behalf of the person listed in Section 1.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street Address/PO Box

_____
City *State* *Zip Code*

Primary Phone: _____

Email Address: _____

Relationship to victim: _____

SECTION 4: CRIME INFORMATION

Provide as much information as you are able about the criminal incident.
You do not need to submit a copy of the police/incident report.

Type(s) of Crime:
- ☐ Arson
- ☐ Assault
- ☐ Child Abuse/Neglect
- ☐ Child Pornography
- ☐ Child Sexual Abuse
- ☐ DUI/DWI
- ☐ Homicide
- ☐ Human Trafficking- Sex/Labor
- ☐ Kidnapping
- ☐ Robbery
- ☐ Sexual Assault
- ☐ Stalking
- ☐ Terrorism
- ☐ Unknown
- ☐ Other - Vehicular Crime: _____
- ☐ Other – Domestic Violence: _____
- ☐ Other – Non-Domestic Violence: _____

Was the crime committed in the United States? ☐ Yes ☐ No

If 'No', in what country was the crime committed? _____

Did the crime occur in Colorado? ☐ Yes ☐ No **In what county did the crime occur?** _____

Date of Crime: ____/____/____ **Date Reported:** ____/____/____

Agency Crime Reported To: _____ **Incident/Case Number:** _____

Law Enforcement Officer Handling Case: _____

Who committed the crime? _____

Applicants' relationship to offender, if any: _____

Court Case Number: _____

Did the crime occur at work? ☐ Yes ☐ No

Did the crime involve a motor vehicle? ☐ Yes ☐ No

Were there any active insurance policies on the vehicles? ☐ Yes ☐ No

If 'Yes', provide the auto insurance information: *Carrier:* _____

Policy Number: _____

ⓘ If there are multiple insurance policies and/or claims involved submit the information on an additional piece of paper.

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SECTION 5: CRIME RELATED SERVICES REQUESTED

Select which service(s) are being requested. Depending on the services selected, additional information may be required. All costs are subject to the limits of the 19th Judicial District Crime Victim Compensation policy limits.

☐ **Medical/Dental Expenses**

Medical and/or dental expenses directly related to a crime related injury and not totally covered by insurance. Submit copies of itemized bills and any insurance statement if related.

☐ **Personal Medical Devices**

Repair or replacement of certain medical devices that were damaged or destroyed during the crime and are not totally covered by insurance.

☐ *Dentures* ☐ *Eyeglasses/Contacts* ☐ *Hearing Aids* ☐ *Prosthetic Device* ☐ *Other:* _____

☐ **Medically Necessary Devices**

Expenses for medically necessary devices directly related to a crime related injury and not totally covered by insurance. Reimbursement may be made for wheelchairs, walkers, oxygen equipment, braces, crutches, and other equipment required to meet the victim's disability needs.

☐ **Mental Health Services**

Expenses for mental health services related to the incident and not totally covered by insurance. If you have a provider selected, enter their information below.

Provider Name: _____

Provider Phone: _____

Provider Email Address _____

☐ **Mental Health Services- Family Members**

Expenses for mental health services for immediate family members living in the same household.

Name of Family Members(s)	*Relationship to Victim*	*Date of Birth*	*Gender*	*Race*

Additional family members may be listed on a separate page.

☐ **Lost Wages**

Unpaid time missed at work due to physical or emotional injuries directly caused by the crime. Lost wages exceeding seven (7) days require documentation from a physician or mental health therapist outlining the inability to work due to physical or emotional injuries that are a direct result of the crime.

☐ **Windows / Doors**

Repair or replacement costs for residential windows and/or exterior doors that were damaged, destroyed, or otherwise compromised during the crime that are not totally covered by homeowner's or renter's insurance. Expenses may include emergency board-up services, garage doors, and doors connecting the residence to a garage. Window screens are not eligible for reimbursement.

☐ **Locks & Rekeying**

Repair or replacement costs for residential, motor vehicle locks and other locks necessary to ensure victim's safety that were damaged, destroyed, or otherwise compromised during the crime that are not totally covered by homeowner's or renter's insurance. Rekeying costs may be eligible when the offender is likely to have had access to the victim's keys.

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SECTION 5: CRIME RELATED SERVICES REQUESTED CONTINUED

☐ **Crime Scene Sanitization**	*Costs for the professional removal of bodily fluids/matter, tear gas, or other items that leave the residence uninhabitable and not fully covered by homeowner's or renter's insurance.*
☐ **Security Devices & Modifications**	*Security devices or safety modifications when the safety of the victim is a concern. Guard pets, mace, pepper spray, and weapons are not eligible for reimbursement.*
☐ **Relocation Expenses**	*Reimbursement or payment directly to landlords or property management companies for rental deposit, first month's rent, professional moving services, hotel during long distance move, packing materials, and one-way travel costs to secure safe, violence free housing.*

Please explain the reason(s) you are requesting relocation assistance as a result of the crime:

_____

_____

_____

☐ **Lost Support from Offender**	*Financial assistance for when the offender was 1) living with and contributing to the support of the household at the time the crime occurred, and 2) is no longer in the home as a result of the crime, and 3) is no longer providing financial support to the household. Proof of the offender's income is required.*
☐ **Funeral/Burial Expenses**	*Reasonable costs for funeral or memorial services, crematory and mortuary services, cemetery costs, permanent headstone or similar type item, and transportation of remains out of the 19th Judicial District (Weld County) for burial.*
☐ **Funeral/Burial Travel Expenses**	*Reimbursement for transportation costs to attend funeral/burial services. Eligible expenses include air, train, bus, taxi or rideshare fare, mileage for personally owned vehicles, rental car expenses, gas/fuel costs for rental cars, parking, and meal expenses (excluding alcohol).*
☐ **Lost Support to Dependents**	*Financial assistance for dependents of a victim who died as the result of the crime. The deceased must have been lawfully employed. Payments will be divided among surviving dependents.*
☐ **Replacement Services and Dependent Care**	*Services that an injured or deceased victim would have performed for the benefit of the household or children and due to the crime must be provided for a cost by another professional resource.*
☐ **Towing an Impound Services**	*Assistance for personal motor vehicle towing to and from law enforcement lots and towing to impound lots, repair service or victim's residence for eligible crimes. All applicable insurance must be applied first.*
☐ **Travel Expenses - Medical, Mental Health, and Critical Stages**	*Reimbursement for transportation costs for medical care, mental health care, and costs for victims located outside the 19th Judicial District (Weld) to attend critical stages in which they and are not under subpoena to attend events that qualify as "critical stages" per C.R.S. §24-4.1-302(2). Eligible expenses include air, train, bus, taxi or rideshare fare, mileage for personally owned vehicles, rental car expenses, gas/fuel costs for rental cars, parking, and meal expenses (excluding alcohol). Verification of attendance is required.*

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SECTION 6: INSURANCE INFORMATION

Provide information on the applicant's health, dental, homeowner's/renter's, automobile, worker compensation, disability, or other insurance coverage. Crime Victim Compensation is the payor of last resort and information provided may be used to notify a provider of services that there is another source of payment before the Crime Victim Compensation program.

Health Insurance ☐ Yes ☐ No ☐ Medicaid ☐ Medicare ☐ Private

Carrier: _____ *Policy No.:* _____

Homeowner's/Renter's Insurance ☐ Yes ☐ No *Carrier:* _____

Policy No.: _____

Automobile Insurance ☐ Yes ☐ No *Carrier:* _____

Policy No.: _____

Disability Insurance ☐ Yes ☐ No *Carrier:* _____

Policy No.: _____

Worker Compensation Insurance ☐ Yes ☐ No *Carrier:* _____

Policy No.: _____

Other Insurance: ☐ Yes ☐ No *Carrier:* _____

Policy No.: _____

SECTION 7: CIVIL LAWSUIT AND ATTORNEY INFORMATION

Crime Victim Compensation MUST be notified of any civil action and be provided with written evidence of the amount and terms of settlement. Provide information about any attorney representation you have in a civil suit or insurance claim related to the crime.

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

☐ The applicant is **not** represented by an attorney and does not plan to hire an attorney.

☐ The applicant **is or will be** represented by an attorney.

Name of Attorney: _____

Phone No. _____

Email Address: _____

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SECTION 8: ACKNOWLEDGEMENTS AND RELEASES

Read and initial each statement. All sections must be initialed in order to process the application.

_____ I understand that my failure to reasonably cooperate with law enforcement (police, sheriff, prosecutor, etc.) may result in the denial of my claim. Victims of strangulation who had a medical forensic examination may be considered cooperative.

_____ 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. It is my responsibility to notify service providers and any collection agencies of my application to the Crime victim Compensation program.

_____ I hereby authorize the release of all information from my employer, physician, hospital, Department of Human Services, medical and/or mental health service provider(s) and/or creditor(s) for the purposes of verifying the claims I have submitted. 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 below authorizes release of all such information as specified above. A photocopy or exact reproduction of this signed release shall have the same force and effect as the original.

_____ I am advised that if I believe the Crime Victim Compensation Board is unable to impartially review my claim due to personal or professional relationship(s) with two or more Crime Victim Compensation Board members, it will be sent to another district for review. I understand this may delay the processing of the claim. A request for alternative review must be made in writing. If the claim is approved, bills will be paid from the judicial district where the crime occurred.

_____ I hereby authorize release of funds approved under the Colorado Crime Victim Compensation Act to be paid directly to the service provider(s) and/or out of pocket claimant(s) as applicable to my claim. I understand that any payments are subject to the availability of funds and the discretion of the Crime Victim Compensation Board.

_____ I am advised that 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 information that addresses the reason for the denial. 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 Crime Victim Compensation Board following the reconsideration, I understand that I may have the Crime Victim Compensation Board's decision reviewed in accordance with the Colorado Rules of Civil Procedures by a district court within 30 days.

_____ I agree to repay the Crime Victim Compensation Fund if payments are received from the offender, including restitution or civil action, insurance, or any other government or private agency as compensation for this injury or death after the receipt of payment from the Victim Compensation Fund. Furthermore, I understand that restitution may be sought from the offender(s) through the criminal or juvenile delinquency and may involve release of information necessary to establish the validity of a restitution claim for Crime Victim Compensation Funds paid.

_____ I agree to immediately inform the Crime Victim Compensation Board whenever any crime-related recovery is expected or received. Pursuant to C.R.S. §24-4.1-116, I agree to repay the Crime Victim Compensation Fund to cover the same losses for which payments were made by the Crime Victim Compensation Fund. I acknowledge and agree that the sources of recovery this subrogation agreement will pertain to include, but are not limited to, the following types of recovery sources: civil judgments against the offender or other liable/obligated third parties, insurance settlements, or settlements/benefits from any other governmental or private agency.

_____ I am advised that any materials received, made or kept by the Crime Victim Compensation Program or a District Attorney concerning an application for Crime Victim Compensation are confidential under C.R.S. §24-4.1-100.1 and I have the right to be notified by the District Attorney's Office if a subpoena for my Crime Victim Compensation file or materials in my claim file has been issued by the court under C.R.S. §24—4.1-302.5(VII). Furthermore, I understand that information provided to the Crime Victim Compensation Board may be discoverable in the criminal case.

SECTION 9: SIGNATURE

By signing and submitting this application I certify that the information contained in this application is true and correct to the best of my knowledge. I understand that untruthful statements provided or falsified information submitted may result in the denial of my claim and is punishable by law.

_____ _____

Signature of Applicant or Parent/Guardian *Date*

_____

Name of Applicant or Parent/Guardian (Please print)