



<i>Office Use Only</i>
Application No.: _____
Silt Police Case No.: _____

Victims Assistance and Law Enforcement Board (VALE Board)
Silt VALE Board, 231 N 7th St, Silt, CO 81652

Victim Compensation Fund Application

The applicant must complete every question. If the question is not applicable write "N/A".

1. **Victim Name:** _____ 2. **Telephone:** _____

3. **Parent/Guardian:** _____ 4. **Relationship:** _____

5. **Full Mailing Address:** _____

(Street, City, State, ZIP)

6. **How did you hear about the Victim Compensation Program?** _____

7. **Date Crime Occurred:** _____

8. **Police Officer Name:** _____

9. **Requested Amount: \$** _____

10. **Briefly describe crime/what occurred:**

Check/circle each claim. If not applicable, write "N/A"

_____ **Medical Services** – Submit copies of itemized bills. Physical therapy & chiropractic bills require treating physician's written recommendation.

Hospital/Physician: Yes | No Chiropractic: Yes | No Dental: Yes | No Physical Therapy: Yes | No

Home Nursing: Yes | No Other: _____

_____ **Lost Wages** – Attach letters from employer and physician to document loss of income and inability to work.

Sick Leave: Yes | No Vacation Leave: Yes | No Personal Leave: Yes | No

_____ **Personal Medical Items** – Only medically necessary devices damaged/destroyed during the crime.

Eyeglasses: Yes | No Prosthetic Device: Yes | No Hearing Aid: Yes | No

Dentures: Yes | No Other: _____

_____ **Residential Property** – Describe: _____

_____ **Other** – Describe: _____

Victim Insurance Information

1. Insurance Company:

2. Telephone:

3. Policy Number:

4. Deductible: \$

5. Insurance Agent(s):

RELEASE OF INFORMATION AND VICTIM'S RIGHTS AND RESPONSIBILITIES

I, the applicant of the Victim Compensation Program of Silt, Colorado, do hereby attest that all information given on this application is truthful and accurate to the best of my knowledge.

I hereby authorize the release of all information from my employer, physician, hospital, medical and/or mental health service and/or creditor(s) for the purpose of verifying the claims I have submitted. I understand that untruthful statements will disallow payment of my claims. I further understand that any award is subject to the availability of funds and the discretion of the VALE Board.

I hereby authorize the 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 further agree that if, at a future date, I receive monies relative to this matter, from any collateral source such as the offender, anyone on behalf of the offender or a government program, I will immediately notify the Crime Victim Compensation Office and provide documentation to the office of such receipt. A determination will then be made as to whether reimbursement to the Crime Victim Compensation Fund is required by Section 24-4.1-110 C.R.S. I agree to promptly make any reimbursement required by said sections.

As an applicant you are advised that if your Crime Victim Compensation claim is denied you have the right to request an appeal hearing before the Victim and Law Enforcement Board. You will be entitled to present evidence and witnesses. At said hearing the burden of proof is upon you as an applicant to show that the claim is reasonable and compensable under the terms of the Colorado Crime Victim Compensation Act.

Signature of Victim

Date

Signature of Parent/Guardian

Date

INCLUDE COPIES OF ITEMIZED BILLS TO DATE WITH THIS APPLICATION

Please forward copies of additional bills related to the incident as you receive them to our office located to:

Silt VALE Board
231 N 7th St
Silt, CO 81652