CRIME VICTIM COMPENSATION
18TH JUDICIAL DISTRICT
SERVING ARAPAHOE, DOUGLAS, ELBERT AND LINCOLN COUNTIES

6450 S. REVERE PARKWAY
CENTENNIAL, CO, 80111
(720) 874-8787
FAX (720) 733-4697
Email VictimComp@da18.state.co.us

Claim #_____

LOST WAGES REQUEST AND EMPLOYMENT VERIFICATION FORM

Victim/Employee Name: _____ DOB: _____

The Victim Compensation Board may only consider lost wages due to physical or emotional injuries, **immediately after, and directly related** to the crime. Victim Compensation may consider lost wages due to court attendance for critical stages of the case. Victim Compensation does NOT pay for time lost from work already paid by vacation, sick, or PTO time. Victim Compensation does NOT cover lost wages for medical or therapy appointments.

This program reserves the right to verify any information supplied on this form with your employer. Any false information may result in the denial of your claim. Additional documentation may be required to process your lost wages request. Your lost wages request will not be processed until all requested documentation is received and verified.

To qualify you must supply all of the following documentation (please check each box):

- ☐ Employer completed lost wage form (Or Federal tax return if self-employed).
- ☐ Pay stubs for the time **directly prior to and during** the absence noted on the form.
- ☐ If you are requesting more than 1 week of lost wages, a letter is required from your treating physician or therapist indicating your inability to work due to injuries sustained as a result of the crime. The letter must include the release date for returning to work.

Please take this form to your employer and have them complete it

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Victim/Employee's Job Title: _____

Was this person employed on the date of crime? ☐ Yes ☐ No

Has this person returned to work? ☐ Yes ☐ No If yes, date of return? _____

Reason for missed work: _____

Dates missed (Please list exact dates and hours missed for each day the employee was scheduled during the absence):

Or attach a copy of employee's schedule during the absence.

Average hours worked per day: _____ Average hours worked per week: _____

Rate of pay: $ _____ ☐ hour ☐ weekly ☐ monthly ☐ daily ☐ commission ☐ other

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Were ANY of the lost wages/earnings paid in part/full by the following sources?

☐ Workers' Compensation ☐ Short Term/Long Term Disability

☐ PTO/Sick Leave/Vacation Leave/Bereavement Leave, etc.

If yes, Start Date: _____ End Date: _____Amount of time/pay received:_____

Total amount of lost wages (Gross): $ _____

Business/Company Name:_____

Mailing Address:_____

_____

Telephone number:_____

Name of Supervisor/HR Representative Completing Form:_____

Job Title :_____

Direct Phone number: _____ Email: _____

By signing this form, I affirm that the information provided is true and correct.

Employee Signature: _____ Date:_____

Signature of Supervisor/HR Representative Completing Form: _____

Date: _____