COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

APPLICATION FOR INDIGENT DETERMINATION (IME)

Instructions to the Claimant: You have the right to submit an *Application for Indigent Determination (IME)* if you believe that you are unable to pay the fee(s) required to obtain a Division Independent Medical Examination. You must complete this Application and sign the affirmation on page four. **The original Application shall be filed with the Office of Administrative Courts at 1525 Sherman Street, 4th Floor, Denver, CO 80203** and a copy sent to all parties in the case.

Claimant: _____ W.C. Number: _____

Employer: _____ Social Security Number: _____

Insurance Carrier: _____ Carrier Number: _____

Household status of claimant: *

○ Single ○ Married

○ Separated ○ Divorced

○ Common Law

Number of dependents:

☐ Spouse Other _____

Children _____ Ages of children _____

Bank Accounts or other financial Accounts: **Account balance:**

Checking: _____ At _____ $ _____

Savings: _____ At _____ $ _____

Other: _____ At _____ $ _____

Amount of cash on hand: $ _____ $ _____

Estimated Value of property and real estate owned: $ _____ Amt. Owed: $ _____

Vehicles owned:

Year: _____ Make: _____ Value: $ _____ Amt. Owed: _____

Year: _____ Make: _____ Value: $ _____ Amt. Owed: _____

Gross monthly income of all household members: *

Earnings - claimant: $ _____

Earnings - spouse $ _____

Earnings - other members $ _____

Stock, Bonds, Investments $ _____

Monthly expenses of household:

Rent/House payment $ _____

Utilities $ _____

Food $ _____

Clothing $ _____

* Income from roommates should not be included unless the relationship between the applicant and the roommate is such that the applicant can access or use the roommate's income. It follows that if a roommate's income is not included, the applicant should list only his/her individual expenses.

Gross monthly income of *all* household members (cont'd):

List other sources of income for household members. Include income such as AFDC, unemployment, workers' compensation, public assistance, social security, retirement pension, etc.

_____	$ _____		
_____	$ _____		
_____	$ _____		
_____	$ _____		
Value of non-cash income, e.g., room & board in exchange for work performed.	$ _____		
Total household income	$ _____		

Monthly expenses of household (cont'd):

Alimony/Child support	$ _____
Medical/Dental Bills	$ _____
Installment payments (including credit cards)	$ _____
Other	$ _____
Total monthly expenses:	$ _____

The following income guidelines apply when determining whether you are indigent for the purposes of this proceeding. See Workers' Compensation Rule 11-11 for more information.

Family Size	Monthly Income Guidelines	Monthly Income Guideline plus 25%	Yearly Income Guideline	Yearly Income Guideline plus 25%
1	$1,128	$1,410	$13,538	$16,922
2	$1,518	$1,897	$18,213	$22,766
3	$1,907	$2,384	$22,888	$28,609
4	$2,297	$2,871	$27,563	$34,453
5	$2,686	$3,358	$32,238	$40,297
6	$3,076	$3,845	$36,913	$46,141
7	$3,466	$4,332	$41,588	$51,984
8	$3,855	$4,819	$46,263	$57,828

* For family units with more than eight members, add $390 per month for "monthly income" or $4,675 per year for "yearly income" for each additional family member.

ADDITIONAL FINANCIAL INFORMATION

In this proceeding the administrative law judge may consider additional information about your financial status that is not otherwise listed in this Application. You may describe in the space below any other circumstances affecting your current financial condition that you would like the judge to review when considering whether you are indigent and/or unable to pay for the Division IME. You may attach additional pages or documents if necessary.

ADDITIONAL FINANCIAL INFORMATION (continued)

Please note: You must send a copy of this application to the insurance company, self-insured employer or uninsured employer and all attorneys.

Remember to complete the reverse side of this page before filing this application.

If further information or clarification is needed, it may be necessary for the Office of Administrative Courts to contact you. Please provide your address and phone number below:

Phone Number

Street/P.O. Box

City, State, Zip

If claimant is represented by an attorney, please provide name and address of attorney below:

Attorney Name

Phone Number

Street/P.O. Box

Fax Number

City, State, Zip

Email Address

AFFIRMATION

I certify the information contained in this application is true and correct.

Claimant Signature

If, for the purpose of obtaining any order, benefit, award, compensation, or payment under the provisions of articles 40 to 47 of [title 8], either for self-gain or for the benefit of any other person, anyone willfully makes a false statement or representation material to the claim, such person commits a class 5 felony and shall be punished as provided in Section 18-1.3-105, C.R.S., and shall forfeit all right to compensation under said articles upon conviction of such offense. (Section 8-43-402, C.R.S.)

CERTIFICATE OF MAILING

Copies of this document were placed in the U.S. mail or delivered to the following parties this

_____ day of _____, 20___.

List the names and addresses of all persons copied:

Insurance Carrier or Self-Insured Employer:

Attorney for Insurer/Employer:

Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

Copier's Signature: _____