COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Application for Indigent Determination (DIME)

Instructions to the Claimant: You have the right to submit an *Application for Indigent Determination (DIME)* if you believe that you are unable to pay the fee(s) required to obtain a Division Independent Medical Examination (DIME). 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):		**Monthly expenses of household (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.			
______________	$ ______________	Alimony/Child support	$ ______________
______________	$ ______________	Medical/Dental Bills	$ ______________
______________	$ ______________	Installment payments (including credit cards)	$ ______________
______________	$ ______________	Other	$ ______________
Value of non-cash income, e.g., room & board in exchange for work performed.	$ ______________		
Total household income	$ ______________	Total monthly expenses:	$ ______________

Income guidelines apply when determining whether you are indigent for the purposes of this proceeding. See Workers' Compensation Rule 18 for more information.

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 DIME. 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 final 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: ______________________________