

Instructions for Completing the Application for Indigent Determination

Please read all pages

This form is “**fillable**.” That means you can type the information onto the form from your computer and print the form. You will not be able to save the form onto your computer’s hard drive.

When you open the form, click in the “Claimant” box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you cannot continue to type information into a field if it doesn’t fit into the space provided.

Use numbers only to fill in the fields for Social Security Number and dollar amounts. Do not use dashes or dollar signs; when you tab out of the field, it will fill in automatically. If a dollar amount contains cents, do type the period. To fill in a **check box**, click inside the box with your mouse.

To clear or delete all the information you have typed onto the form, click on the red “**Clear Entire Form**” button. To clear all information on a single page, click on the red “**Clear This Page**” button. To change the information in one field, use the backspace or delete key.

Adobe Acrobat - [WC035 Application for Indigent Determination.pdf]

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
1515 ARAPAHOE STREET
DENVER, CO 80202-2117

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APPLICATION FOR INDIGENT DETERMINATION
Pursuant to C.R.S. Section 8-43-213

Claimant _____

**"Clear Entire Form" button
Clears all information at once**

Social security number _____

Carrier number _____

Household status of claimant: **"Check Box"
Click in box**

Single _____

Separated _____

Divorced _____

Number of dependents:

Spouse _____

Other _____

Children _____

Ages of children: _____

Bank accounts or other financial accounts: _____

Account balance: _____

Checking At _____ \$ _____

Savings At _____ \$ _____

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Thursday
5/22/2003

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
 DIVISION OF WORKERS' COMPENSATION
 633 17th ST., SUITE 400
 DENVER, CO 80202-3626

APPLICATION FOR INDIGENT DETERMINATION
Request For Hearing Transcript

Pursuant to C.R.S. Section 8-43-213

Claimant _____	W.C. number _____
Employer _____	Social security number _____
Insurance carrier _____	Carrier number _____

Household status of claimant:		Number of dependents:	
Single _____	Married _____	Spouse _____	Other _____
Separated _____	Divorced _____	Children _____	Ages of children: _____

Bank accounts or other financial accounts:	Account balance:
Checking ____ At _____	\$ _____
Savings ____ At _____	\$ _____
Other ____ At _____	\$ _____
Amount of cash on hand.....	\$ _____

Value of property and real estate owned: \$ _____

Vehicles owned:

Year _____	Make _____	Value \$ _____
Year _____	Make _____	Value \$ _____

Gross monthly income of <u>all</u> household members:		Monthly expenses of household:	
Earnings - claimant	\$ _____	Rent/House payment	\$ _____
Earnings - spouse	\$ _____	Utilities	\$ _____
Earnings - other members	\$ _____	Food	\$ _____
List other sources of income for household members. Include income such as AFDC, unemployment, welfare, social security, retirement pension, etc.:		Clothing	\$ _____
		Alimony/Child support	\$ _____
		Medical bills	\$ _____
		Installment payments	\$ _____
	\$ _____	Other	\$ _____
	\$ _____		
Total household income:	\$ _____	Total monthly expenses:	\$ _____

If further information or clarification is needed, it may be necessary for the Division of Workers Compensation to contact the claimant, in writing. Please provide the claimant's current address below:

Street/PO Box

City, State, Zip

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

Attorney name

Street/PO Box

City, State, Zip

Please note: A copy of this application will be sent to the insurance company, self-insured employer or uninsured employer and all attorneys. The Director, in considering this request, may use a standard of indigency accepted by the courts of the State of Colorado as an initial guideline. Please see the Supreme Court Directive on the subject of indigency and court-appointed attorneys. A dispute between the parties regarding this application may be referred for hearing before an Administrative Law Judge.

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

Claimant signature

State of Colorado
County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, _____.

Notary public

SEAL

Address

My commission expires

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 18-1.3-401, 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.)