



Application to NCADV's Cosmetic and Reconstructive Support Program (CRS™)

One Broadway, Suite 210-B, Denver, CO 80203-3983
Phone: (303) 839-1852 x 109 / mainoffice@ncadv.org

The Cosmetic & Reconstructive Support Program (CRS™) of NCADV was created to connect survivors of domestic violence to medical associations and professionals. Assistance is available for those who need medical treatment or services to repair injuries inflicted by an abusive spouse or intimate partner. Currently, NCADV assists survivors with the application process to medical programs, including FACE TO FACE and Reconstructing Hope. We also refer those in need of different services to other entities, associations, and organizations.

APPLICANTS MUST MEET ALL THE FOLLOWING GUIDELINES TO QUALIFY FOR MEDICAL SERVICES:

The applicant must have received the physical injuries from an abusive intimate partner or spouse.

For example: husband, wife, partner, boyfriend, girlfriend, someone the applicant dated or with whom applicant has a child. Other situations, while traumatic, do not qualify. *If the injury was caused by child abuse, elder abuse (if not a former romantic partner), sibling abuse, caregiver abuse, parent abuse, violent attacks, stranger assault, or accidental injury not related to domestic violence, the application will be denied.*

The applicant must be out of the relationship.

If the applicant is not out of the relationship, the application will be returned to the applicant.

All applicants must have had contact with a domestic violence advocate, social worker, counselor or therapist a minimum of one time.

This application will be returned if Page 4 is not completed properly. *The applicant may visit www.domesticshelters.org to find their nearest local program or contact the National Domestic Violence Hotline at 1-800-799-7233 to get the phone number of the nearest domestic violence agency.*

If you need someone to help you fill out this application, please check one of the following:

Si necesita la ayuda de alguien para llenar la solicitud, verifique marcando uno de los siguientes:

English is not my native language and I need a translator.

Mi idioma nativo no es el inglés y necesito un/una traductor/a.

Physical or literacy challenges make it difficult to fill out the application alone.

Desafíos de analfabetismo y/o problemas físicos me hacen difícil llenar la solicitud sola.

Name of person assisting: _____ **Phone:** () _____
Nombre de la persona que le ayudó a llenar la solicitud *Número de teléfono*

*The information in this application is strictly confidential and will not be released without your consent; however, the media frequently asks for names of applicants so they can follow their progress. **Please sign below ONLY if you are willing to interact with media.** Leave this section blank if you are not interested.*

Signature: _____ **Date:** _____

PLEASE FILL OUT ALL SECTIONS COMPLETELY AS DIRECTED

Please use blue or black ballpoint pen only to fill out this application. PRINT neatly and answer all questions completely. Incomplete or improperly completed applications will be returned.

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ - _____ Other Phone: () _____ - _____

Email Address (optional): _____

If you change your address or phone number, notify NCADV as soon as possible. Your standing in the program could be jeopardized if we cannot contact you. If you do not have a safe phone number, please provide a phone number where we can leave a message.

- **Did an intimate partner or spouse inflict the physical injuries upon you?** (check one) YES NO

If NO, please explain the services you may need _____

- **Are you able to pay for any of the consultation or procedures?** (check one) YES NO

If YES, explain: _____

- **For funding purposes, we must demonstrate the level of family income for referred patients. Please indicate your family income level (check one):**

- | | |
|----------------------|----------------------|
| Less than \$20,000 | \$40,000 to \$45,000 |
| \$20,000 to \$25,000 | \$45,000 to \$50,000 |
| \$25,000 to \$30,000 | \$50,000 to \$55,000 |
| \$35,000 to \$40,000 | More than \$55,000 |

- **Have you had prior cosmetic or reconstructive surgery?** (check one) YES NO

If YES, explain: _____

- **Do you need cosmetic dentistry on your teeth?** (check one) YES NO

- **Do you need laser tattoo removal surgery?** (check one) YES NO

- **Do you need reconstructive surgery?** (check one) YES NO

If YES, explain: _____

- **Do you need different medical attention?** (check one) YES NO

If YES, explain: _____

Please describe your scars and/or injuries. Give the dates they occurred.

(Optional) Please check all that apply. Please include additional supporting documents and/or photos.

Police Reports

Medical Reports

Protection Order(s)

THIS APPLICATION WILL BE RETURNED TO YOU IF THE FOLLOWING SECTION IS NOT COMPLETED

All applicants for the CRS program must see a **counselor, advocate, social worker, therapist, or minister** at least one time before the application is completed. There are two reasons for this requirement:

- To connect the applicant with local support systems within their community
- To have an independent source confirm that after having heard the applicant's story in at least one in-person interview, they believe the applicant received their injuries from an intimate partner or spouse and that the applicant is now out of the abusive relationship.

The applicant may either see someone they have talked with in the past or seek a referral to a local domestic violence program. **To find the phone number to a local domestic violence program, visit www.domesticshelters.org or call the National Domestic Violence Hotline at 1-800-799-7233.**

If the counselor, advocate, social worker, or therapist needs more information about the CRS™ program before completing this application, contact NCADV at 303-839-1852 ext. 109.

Advocate Name: _____

Agency Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ - _____ Email Address (optional): _____

COMMENTS BY (TYPE or PRINT neatly) Counselor / Advocate / Social Worker / Therapist / Minister:

I confirm that I have met with the applicant at least once. Based solely on their explanation, I believe their injuries were caused by domestic violence, and believe they are no longer experiencing domestic violence. I understand I will be contacted.

Signature: _____ Date: _____

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- **Do you give permission to NCADV to contact you and ask about your experience with this program**
Please allow 2 -3 weeks? (check one) **YES NO**
 - **How did you hear about this program?**
Friend Internet search Newspaper Magazine
Agency Radio RV Other: _____

I verify that the statements on this application are true. I authorize release of this information to NCADV and the medical professionals providing the medical care needed to repair the damage caused by domestic violence.

SIGNATURE _____ DATE _____

STOP! BEFORE YOU RETURN YOUR APPLICATION, PLEASE READ THE FOLLOWING:

- 1) Be sure all sections of this application are filled out completely, correctly, and legibly.
- 2) Please do not include additional documents or photos with your application. They will not be reviewed and will be discarded, to ensure your privacy.
- 3) Make sure you are seen by a counselor, domestic violence advocate, social worker, or therapist and have them fill out the appropriate section on Page 4.
- 4) Be sure to sign and date the bottom section of Page 4.
- 5) Make a copy of this application for your files.
- 6) Return the ORIGINAL application to NCADV by mail **or** preferably by email (scanned).

NCADV CRS™ Program
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storralba@ncadv.org

- 7) If your address or phone number changes, please notify NCADV as soon as possible. *If we are unable to contact you, your standing in the program may be jeopardized.* To reach NCADV by phone, call (303) 839-1852 x 109. You may also email us at mainoffice@ncadv.org. Be sure to clarify that you are an applicant to the program.

WHAT HAPPENS AFTER I MAIL MY APPLICATION?

- If there is a problem with your application, it will be returned. Once your application is received and if it is determined that you qualify, you will be notified in writing by NCADV that your application was accepted and forwarded to the appropriate medical agency. If it is determined that you do not qualify, you will be notified in writing by NCADV (please note this may take up to two weeks).

WHAT HAPPENS IF I QUALIFY?

- If accepted, the medical agency will contact you with a referral to a medical professional as close to you as possible. Please know this process takes time and it may take up to 2 months before you are contacted.
- When you see the medical professional for the first time, they will let you know what they can do for you, what they cannot do for you, or *whether you further qualify for the program*. The medical professionals have the final say on whether or not they can do the work that you need. There is no guarantee that you will be able to benefit from this program until you see the medical professional for

the first consultation. **If you must cancel an appointment for any reason, notify the medical professional's office directly (*failing to show up for an appointment without calling could jeopardize your standing in the program*).**

- While the medical professionals directly assisting you are volunteering their services, there is no guarantee that other services will also be free (hospital stays, prescriptions, anesthesiologists, x-rays, follow-up treatment, etc.). Talk with your doctor about how these costs can be reduced or eliminated. You may be able to use your health insurance, Medicaid, or Victim's Compensation to help with other costs; be sure to verify this prior to any services you receive. Costs incurred by you are not reimbursable.